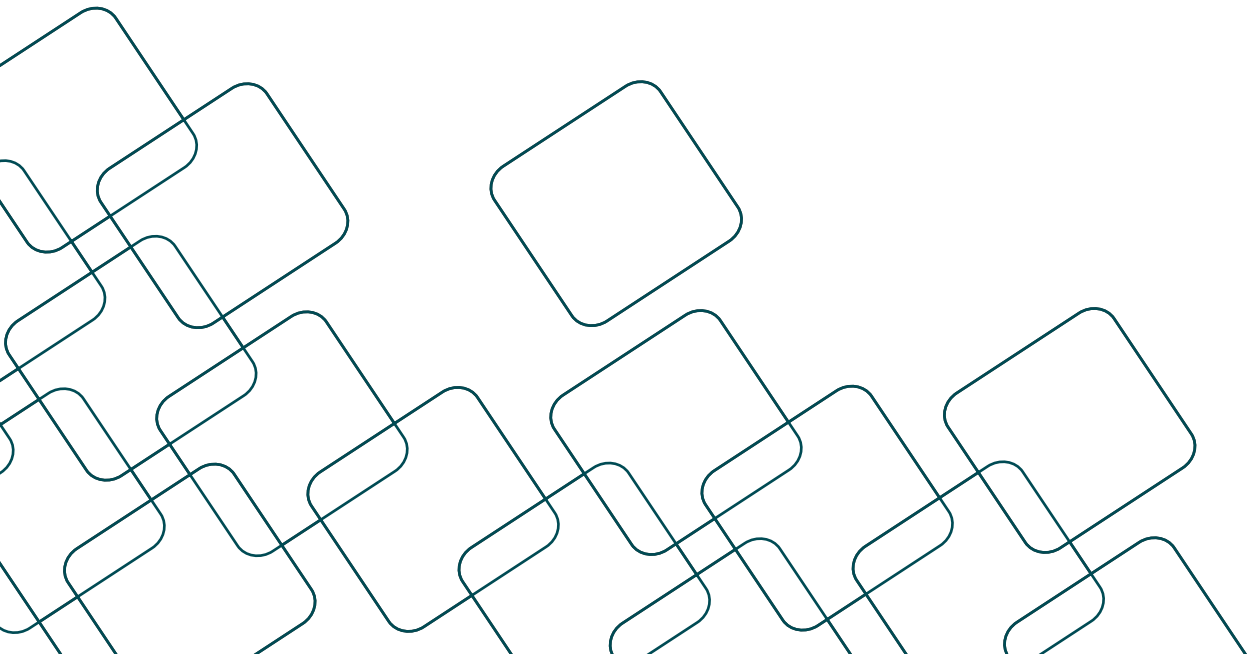
NSW Ombudsman

Annual Report 2002–2003



Integrity

Openness

Honesty

Accountability

Objectivity

Contents

Letter to Parliament

October 2003

The Hon Meredith Burgmann MLC
President Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

The Hon John Aquilina MP
Speaker Legislative Assembly
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Madam President and Mr Speaker

I am pleased to present our 28th annual report to the NSW Parliament.

This report contains an account of our work for the twelve months ending 30 June 2003 and is made pursuant to ss.30 & 31 of the *Ombudsman Act.*

The report also provides information about my office's functions under the *Police Act* and information that is required pursuant to the *Annual Reports (Departments) Act, Freedom of Information Act and Disability Services Act.*

The report includes updated material on developments and issues current at the time of writing (July-September 2003).

Yours sincerely

Bruce Barbour
Ombudsman

Ombudsman's message

The essential characteristic of this office is its integrity. It is on this foundation that we have established our reputation as a leader in setting standards of effective administration. We conduct our business – which this year has expanded significantly – with openness, honesty, accountability and objectivity. We expect of others no more than we ask of ourselves.

Some key principles guide our work. These include ensuring we have clear and accountable internal structures – good communication and sound policies, practices and procedures – as well as a consistent and fair approach to issues and agencies. Giving reasons for our decisions is one way in which we ensure that the standards we apply to complaints and notifications are consistent and reasonable. It also allows scrutiny of our work by those we serve.

We do not do our work by sitting back and waiting for problems to arise. Neither do we impose solutions. We work closely with many organisations and individuals to help them identify strengths and weaknesses in their systems and performance, find solutions and implement practical and effective reforms.

Working as we do for the public interest, it is essential that fairness and impartiality underpin all the decisions we make. We advocate neither for complainants or individuals nor for agencies, their staff or their policies and procedures.

We review the usefulness of systems and the conduct of individuals to ensure the delivery of a diverse range of fundamental services is of the best possible standard. In making judgements we bring to bear an extraordinary range and depth of skill and experience.

As this report documents, the growth of this office and its responsibilities over the past few years has been significant. It becomes ever more important that we are strategic and proactive in the way we approach these responsibilities. We have worked hard to ensure that we encompass the opportunities brought by growth without in any way compromising our integrity and independence or the quality of our work.

The continued strength of the office has rarely been more evident than in this reporting year. The amalgamation of the Community Services Commission brought with it the challenge of merging two organisations with their own histories, standards and cultures without compromising the core work of either. We had to integrate IT and personnel functions as well as physically move more than 40 staff.

The newly established community services division was then restructured to ensure that staff could work as effectively as possible and new functions were appropriately supported. The new structure is also aligned with existing structures in the office, ensuring parity, but also allowing for flexibility and movement within the office.

That this has been possible is just one example of the professionalism and dedication of our staff. I am indebted to their commitment and loyalty and unfailingly impressed by the integrity with which they approach their work.

I am confident that we will continue to be responsive and open to the challenges of our expanded jurisdiction and functions in the year ahead.

Bruce Barbour
Ombudsman

About us

Who we are

The NSW Ombudsman is an independent and impartial watchdog body. Our job is to make sure that the public and private sector agencies and employees we watch over fulfil their functions properly. We help agencies to be aware of their responsibilities to the public, to act reasonably and to comply with the law and best practice in administration.

We are independent of the government of the day and accountable to the public through the NSW Parliament.

We are the State's Parliamentary Ombudsman. Our office was established by an Act of Parliament in 1975. Like many other Ombudsman around the world, the office was modelled on the Justitie-Ombudsman created in Sweden in 1809. The primary purpose of that body was to investigate complaints about government administration. Loosely translated, the term Ombudsman means 'the citizen's defender' or 'representative of the people'.

Today, many countries have adopted the Ombudsman concept. There are more than 150 Ombudsman-type bodies affiliated to the International Ombudsman Institute. Australia has a Commonwealth Ombudsman and a Parliamentary Ombudsman in every state and the Northern Territory.

Every member of the public has the right to complain to us, so much of our work is generated by complaints. We believe that complaints are one of the best sources of client and staff feedback on how an agency is performing. This is why we encourage agencies to set up and maintain effective complaint handling systems so that they can use the information in complaints to improve the way they function.

During the year the former Community Services Commission was amalgamated with our office. This brought new jurisdiction over providers of community services, enabling us not only to deal with complaints and work with service providers to improve their complaint handling systems, but also to work to ensure that community services in NSW are of the highest possible standard.

Our key aim is to improve the delivery of services, including community services, by NSW agencies and service providers and our corporate goals reflect this objective.

Corporate Plan

Our vision

Fair, accountable and responsive administration in NSW agencies.

Our mission

To promote good conduct and fair decision-making in the interests of the NSW community.

Our goals

- To assist agencies to remedy deficiencies and improve their service delivery
- To be a cohesive and effective organisation
- To be accessible and responsive
- To be a leader in standards of service.

Our values

In everything we do we will:

- act fairly, with integrity and impartiality
- treat individuals and organisations courteously and sensitively
- use resources efficiently and effectively
- ensure we are accessible to everyone.

Our guarantee of service

We guarantee to give all matters referred to us proper consideration and attention. If we decide to investigate a matter we will do so as quickly as possible, acting fairly and independently.

If we decide not to investigate, we will provide reasons for our decision.

If there are alternative ways of dealing with a matter we will provide an explanation.

What we do

Our office helps agencies in the public sector, and some in the private sector, to address any problems that arise in the exercise of their functions and discharge of their responsibilities. We use our experience and knowledge to help agencies and individuals become aware of their responsibilities to the public, to act reasonably as well as lawfully. We do this by assisting them to identify problems in their systems and operations, solve those problems and improve the way they function.

Our mandate is to improve the conduct and decision-making of agencies within our jurisdiction. Traditionally, we fulfilled this mandate by responding to complaints and recommending improvements to the way agencies perform in relation to individual matters and broader issues. Over the years our functions have become much wider. We now oversee the investigation of complaints about police, the handling of child abuse allegations and convictions by persons and agencies within jurisdiction, and the use of powers to conduct controlled operations.

We review the delivery of community services, the causes and patterns of deaths of certain children and people with a disability, the determination of Freedom of Information (FOI) applications and the operation of a number of new pieces of legislation conferring additional powers on police and correctional officers. We audit complaint handling systems of NSW agencies and community service providers, and telephone interception records.

Our jurisdiction

We currently have jurisdiction in relation to:

NSW agencies

- Several hundred state public sector agencies, including departments, statutory authorities, boards, area health services and NSW Police
- 172 local councils
- Various private sector organisations and individuals such as the operators of Junee Correctional Centre, private certifiers (who sometimes perform certain local council functions) and accreditation bodies for those private certifiers.

Children's services

- Over 7,000 agencies providing children's services, non-government schools, child care centres and agencies providing substitute residential care
- Over 100,000 people who work for private agencies providing children's services.

Community services providers

- All community services provided by the Department of Community Services and the Department of Ageing, Disability and Home Care
- Several thousand non-government service providers who are funded, licensed or authorised by the Minister for Community Services, and the Minister for Ageing and Disability Services. These include licensed boarding houses and fee for service agencies.

Using the name Ombudsman

Over the years we have been pleased to see many agencies recognise the value of establishing systems to handle complaints made about them. Sometimes agencies, particularly local councils and universities, have set up a separate complaint-handling body and called it an Ombudsman.

In some other countries, only the Parliamentary Ombudsman is permitted to use the name. We are comfortable with others using the word Ombudsman in their name as long as:

- they publicly distinguish themselves from our office, because we are independent of both the government of the day and all the agencies we oversight
- the name is clear enough to ensure that the public cannot confuse them with our office
- their policies and practices ensure that they are as independent as possible from the agency that they handle complaints about
- their standards of service and professionalism are of the highest quality, to protect the reputation of all of us who share the name.

Our legislative functions

We have the following responsibilities under a range of legislation. Details of the work that we can do can be found in the relevant chapters of this report.

Investigating and resolving complaints	Legislation
• Deal with complaints about NSW public sector agencies including local councils, government departments, the commercial activities of universities and the conduct of entities controlled by universities. • Deal with child abuse allegations against employees of agencies providing children's services and complaints about how such an allegation was handled by the agency concerned. • Deal with complaints about the provision, failure to provide, withdrawal, variation or administration of a community services.	Ombudsman Act 1974 Community Services (Complaints, Reviews and Monitoring) Act 1993 Enabling legislation for each NSW university, as amended by the Universities Legislation Amendment (Financial and Other Powers) Act 2001
• Deal with complaints about how agencies have handled freedom of information applications and the merits of their decisions	Freedom of Information Act 1989
• Deal with complaints about police officers and complaints about the way such complaints are investigated by police	Police Act 1990 (formerly the Police Service Act 1990)
• Deal with protected disclosures from public sector staff / officials about maladministration	Protected Disclosures Act 1994
• Respond to complaints from participants in the witness protection program	Witness Protection Act 1995
Assessing notifications, reviewing the handling of complaints and monitoring investigations	
• Receive notifications of child abuse allegations or convictions against employees of government and certain non-government agencies. • Monitor the progress of agency investigations of child abuse allegations. • Determine whether a matter was properly investigated and whether appropriate action was taken as a result of the investigation.	Ombudsman Act
• Assess decisions of police not to investigate complaints against police — we decide whether they should be investigated and, if so, require police to investigate these complaints. • Determine whether a complaint not requiring investigation was otherwise properly dealt with. • Monitor the progress of investigations. • Determine whether investigations were conducted properly and in a timely manner and whether appropriate action was recommended and taken as a result.	Police Act
Keeping systems under scrutiny	
• Keep under scrutiny the systems established by certain agencies to prevent child abuse by their employees and to handle and respond to child abuse allegations or child abuse convictions involving their employees.	Ombudsman Act
• Keep under scrutiny the systems established by the police to deal with complaints about officers.	Police Act
• Review complaint handling systems of community service providers. • Review the situation of children, young people and people with a disability who are in out-of-home care. • Review the deaths of certain children and young people and people with a disability in care. • Monitor, review and set standards for the delivery of community services. • Inspect visitable services where children, young people, people with a disability live.	Community Services (Complaints, Reviews and Monitoring) Act

Keeping systems under scrutiny (continued)	Legislation
• Review compliance by law enforcement agencies with accountability requirements relating to the use of telephone intercepts and undercover operations	Law Enforcement (Controlled Operations) Act 1997 Telecommunications (Interception)(NSW) Act 1987
Reviewing the implementation of certain legislation	
• Review and report on the implementation of various Acts that give greater powers to police and correctional officers and certain other people	Child Protection (Offenders Registration) Act 2000 Children (Criminal Proceedings) Act 1987 – as amended by the Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001 Crimes (Administration of Sentences) Amendment Act 2002 Crimes (Forensic Procedures) Act 2000 Crimes Legislation Amendment Act 2002 (Schedule 10) Crimes Legislation Amendment (Penalty Notices) Act 2002 Firearms Amendment (Public Safety) Act 2002 Justice Legislation Amendment (Non-Association and Place Restriction) Act 2001 Law Enforcement (Powers and Responsibilities) Act 2002 – legislation scheduled to take effect in 2004 Police Powers (Drug Detection Dogs) Act 2001 Police Powers (Drug Premises) Act 2001 Police Powers (Internally Concealed Drugs) Act 2001 Police Powers (Vehicles Act) 1998 - as amended by the Police Powers (Vehicles) Act 2001 Summary Offences Amendment (Places of Detention) Act 2002.
Hearing appeals	
• Hear appeals against certain decisions and orders made by the Commissioner of Police about participation in or exclusion from the witness protection program	Witness Protection Act

Annual Report 2002-2003 Snapshot

Complaints and notifications

Informal complaints received in 2002- 2003	25,733
Informal complaints received since establishment	274,937
Formal complaints received in 2002 –2003	8,652
Formal complaints received since establishment	162,555
Notifications since child protection function established in 1998	7,017

Reports

Reports making adverse findings in 2002 – 2003	486
Reports making adverse findings since establishment (approx)	6,753
Special reports to Parliament in 2002 – 2003	2
Special reports to Parliament since establishment (approx)	185

Resources

Recurrent funds 2002-2003	16.7m
Total funds allocated (approx) in 28 years since establishment in 1974 - 1975	112.2m

Our organisation

Our staff

Our staff are our most important resource. The success of the office has always depended on them.

The people who work for us come from a wide range of backgrounds including state, federal and overseas police, other investigative backgrounds, state and local government, town planning, youth, community and social work, child protection, journalism, teaching and the law.

This unique mix of people and expertise ensures that we thoroughly understand the workings of the agencies within our jurisdiction and can consistently make positive and useful recommendations.

We have a dedicated team of 186 officers working on either a full or part-time basis. These people are an energetic and diverse mix of experience and skill. Over 48% of our staff started less than two years ago, with 40% of this figure representing staff of the former commission who arrived in December 2002. About 11% have been with the office for over 10 years, and three staff have been here for more than 20 years. For more details about our staffing, please see 'Corporate support'.

Our internal structure

Our office is divided into five teams — the general, police and child protection teams, each headed by an Assistant Ombudsman, the community services division headed by a Deputy Ombudsman, and the corporate support team, led by the Manager Corporate support.

The general team

The work of the general team is very broad. They:

- resolve, conciliate and investigate complaints about all NSW state and local government agencies (except the police), including complaints about freedom of information applications and protected disclosures
- provide advice or assistance to people who telephone or visit the office to make inquiries
- provide constructive advice and guidance to agencies on a range of issues relating to good administration and complaint handling
- audit records of investigative agencies undertaking covert operations and using telephone intercepts
- hear appeals and handle complaints from participants in or applicants to the witness protection scheme
- visit juvenile justice centres and correctional centres
- keep under scrutiny the implementation of new legislation in the corrections area
- conduct customer service audits
- provide training in conducting investigations and complaint management.

There are more details about the work of the team in 'Investigations and complaint resolution', 'Scrutiny' and 'Appeals'.

The police team

The police team deals exclusively with NSW Police (the police). They:

- oversight the investigation of individual complaints about police officers
- directly investigate matters that have not been properly investigated by the police
- facilitate the resolution of complaints, particularly where ongoing relationships between police officers and the community are at stake
- keep the police's complaint handling system under scrutiny
- work with the police to improve the way complaint-related information is analysed and used to improve organisational performance and the management of individual officers
- keep under scrutiny the implementation of new legislation giving police additional powers.

The work of the team is discussed in detail in 'Scrutiny'.

Bruce Barbour LLB
Ombudsman

Chris Wheeler
BTRP (Melb) MTCP (Syd)
LLB (Hons) (UTS)
Deputy Ombudsman

Community Services Division
Robert Fitzgerald AM
LLB (UNSW), B.Comm (UNSW)
Deputy Ombudsman
Community and Disability Services Commissioner

General Team
Greg Andrews
BA (Hons) M Env Loc Gov Law
General Cert Public Sect Mgt
Assistant Ombudsman (General)

Child Protection Team
Anne Barwick
BA Dip Soc Wk M Mgt (Community)
Assistant Ombudsman (Children and Young People)

Police Team
Steve Kinmond
BA LLB Dip Ed Dip Crim
Assistant Ombudsman (Police)

Corporate and Executive Support

The child protection team

The child protection team is responsible for ensuring that agencies comply with their child protection obligations. They:

- oversight and monitor the investigation by employers of child abuse allegations against their staff
- directly investigate matters that have not been properly investigated
- keep under scrutiny the systems established by agencies for preventing child abuse by their employees and for handling child abuse allegations
- educate and advise agencies about their reporting obligations, how to establish child protection systems, how to properly respond to allegations of child abuse, how to conduct effective investigations, and how to properly respond to investigative findings that allegations have been substantiated
- conduct research into trends and patterns of abuse to help develop a strong foundation for future child protection strategies.

The work of the team is discussed in detail in 'Scrutiny'.

The community services division

The community services division is responsible for reviewing and promoting improvements in standards of delivery of community services. They:

- resolve, conciliate and investigate complaints about government and non-government community service providers
- review complaint handling systems
- provide information and training about the making, handling and resolution of complaints about the delivery of community services
- review the situation of persons in care and make any necessary recommendations to the relevant Minister about how the circumstances of the child or person might be improved
- review the deaths of certain children and people with a disability, identifying any ways in which those deaths could be prevented or reduced
- monitor and review the delivery of community services, making recommendations for improvements as necessary
- coordinate the Official Community Visitor scheme.

The work of the team is discussed in detail in 'Community services'.

The corporate support team

The corporate support team are responsible for:

- providing personnel, information technology and financial services
- managing the office's public relations and producing a wide range of publications, including reports, guidelines, fact sheets, brochures and posters
- records and document management, mail and library services
- managing and coordinating office-wide projects and policies.

The work of the team is discussed in detail in 'Corporate support'.

Highlights

Goal

To assist agencies to remedy deficiencies and improve their service delivery

Strategies

Agencies assisted to address deficiencies in service delivery and conduct

Focus our resources on complaints that relate to systemic issues or serious abuse of power

Assist agencies to improve customer service through such things as agency liaison, review of agencies' policies, provision of training

Develop and review guidelines to assist agencies in relation to service delivery and good conduct issues

Highlights for this year

Hosting the 20th Australasian and Pacific Ombudsman Conference in November 2002. About 40 delegates from countries across the region attended the conference whose theme was 'Ombudsman – Future Options and Directions'

Issued two special reports to Parliament, both about NSW Police – one on police practice in relation to speedometers and speeding fines and the other on improving the management of complaints

Investigated many delayed police complaint investigations resulting in seriously delayed matters being finalised and the adoption of timeliness benchmarks by the police

Reviewed the operation of eight laws conferring new powers on police

Successfully conciliated complex complaints against police officers

Started projects examining police access to confidential information, use of closed circuit television in police stations and police interactions with Aboriginal communities

Extended the class or kind determinations in the education sector to exempt certain child abuse matters from notification

Received significant increase in notifications from agencies as a result of scrutinising agency systems for responding to allegations of child abuse

Received Increased number of notifications of more serious child abuse received and monitored

Provided extensive assistance to agencies investigating child sexual abuse allegations, resulting in increased sustained findings

Conducted audits of systems of independent schools for responding to allegations of child abuse

Conducted audits of schools for special purposes, resulting in recommendations about accredited training for staff and use of appropriate methods of restraint

The National Parks & Wildlife Service changed its guidelines in accordance with our advice that submissions about proposed national parks should be made public

Minister for Education and Training circulated to all universities in NSW our recommendations that they adopt and publish policies on proper attribution of prior work in all research grant applications and publications, and protect students and junior staff from improper or inequitable use of their work by more senior staff.

Conducted an audit of the complaint management systems of Warringah Council and made recommendations for improvements

Conducted a mystery shopper audit of the customer service standards of Baulkham Hills Shire Council

Organised and hosted (with the ICAC) the 4th National Investigation Symposium – 'Sherlock or sheer luck?' It was attended by nearly 200 investigators from national and international agencies

In response to our recommendations following investigation of an FOI matter, the Department of Minerals and Energy released four reports relating to mining practices at Chain Valley Bay

Began quarterly liaison meetings with Director General and senior staff of Department of Juvenile Justice

Developed a MoU between us, Department of Corrective Services and former Inspector General to support Corrective Services Support Line – an internal complaint resolution service

Developed a MoU with Department of Community Services undertaking to work together to identify problems and deal with complaints appropriately and quickly.

Finalised three reports on community services issues.

Completed a review of complaint handling by 21 disability respite care services and two non-government disability services

Conducted 14 workshops for non-government community service providers on resolving consumer complaints

Co-hosted a seminar on 'The right to good health' for people with an intellectual disability

Conducted seven seminars for disability service providers about new requirements for reporting deaths in their services

Official Community Visitors raised 2,849 issues in their visits to 1,161 services providing residential care to children, young people and people with a disability

Consulted with non-government disability services and peak body ACROD in six regional areas on service improvement issues in disability services and barriers to achieving quality focused practice

Prepared a new edition of 'Good conduct and administrative practice' guidelines

Distributed 'Enforcement guidelines for councils' to all local councils

Published fact sheets on 'Apologies', 'Bad Faith, Bias and Breach of Duty' and 'Conflict of Interests'

Goal

To be a cohesive and effective organisation

Strategies

Structures and operational practices of the office maximise flexibility, cohesion and efficiency

Staff are supported as main resource of office

Improve sharing of knowledge and information across the office

Highlights for this year

Amalgamation of the Community Services Commission and establishment of the Community Services Division

Successful adoption of an enterprise document management system, including integration of our existing case management systems. A range of supporting records management policies and procedures were also developed

Full accreditation under the Australian Information Security Standard AS7799 – and being the first fully accredited agency in Australia

Comprehensive review of office policies

Review and restructure of the community services division

Planning and implementation of new areas of community services jurisdiction – reviewable deaths and licensed boarding houses

Establishment of two advisory committees to assist the Ombudsman in implementation of the reviewable death functions

Implementation of a Storage Area Network to address electronic storage needs for the next three to five years

Review of reception and interviewing security arrangements and development of new security policy

General team manual reviewed, updated and re-issued

Providing occupational health and safety training for all managers and supervisors and ergonomic training for all staff

Goal

To be accessible and responsive

Strategies

Implement effective access and awareness and information programs

Maintain a strong identity to ensure continuing relevance and better recognition

Consider the views of people we deal with

Highlights for this year

Reviewed our access and awareness plan and began to develop an 'access and equity action plan'.

Held 11 information seminars about the role of the Ombudsman in community services

Met with thousands of police to discuss the police complaints system

Made presentations to student police officers, front line officers from local commands, complaint investigators and local commanders

Met with Aboriginal community representatives, community legal services, youth groups, advocates for people with disabilities, drug and alcohol counsellors, minority ethnic communities and the homeless to discuss their interactions with local police

Provided advice to agencies on assessing allegations, investigative practice, policy development and risk management in relation to child abuse allegations

Conducted 21 workshops in Sydney and regional areas for consumers of Home and Community Care services (older people and people with a disability) about their rights to quality services and how to raise concerns with service providers

Participated in joint consultations with Disability Council of NSW, with Arabic-speaking and Greek communities about the service needs of people with disabilities and their carers

Goal

To be a leader in standards of service

Strategies

Have in place appropriate internal standards and policies relating to administrative conduct

Continue to improve the quality of our service

Provide effective and meaningful reporting and performance measurement strategies

Ensure best practice in complaint handling, investigative and other practices

Highlights for this year

Information sharing and complaint referral arrangements made with other watchdog agencies

Developed and adopted a conflict of interests policy for staff

Reviewed our internal systems for capturing information about agency notifications and their findings against employees in relation to child abuse allegations

Reviewed and formalised internal process to ensure targeting of resources for more serious allegations of child abuse

Changed our handling of police complaints to maximise the benefits of the new computerised complaint information systems

Developed new systems to monitor how police implement management action following sustained findings against police officers, and the outcome of that action

Winning a silver award for our 2001-2002 annual report

Management overview

Where we are now: a snapshot

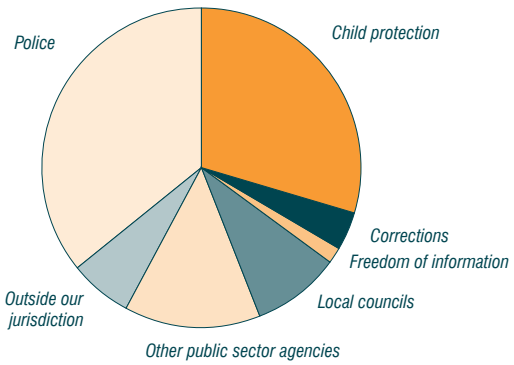
Year at a glance

Complaints, notifications and oral inquiries

This year we received 8,739 complaints and notifications (see figure 1) and 26,067 oral inquiries (see figure 2).

Most complaints were from members of the public and employees of agencies within our jurisdiction and some were referred to us by the police or other complaint handling bodies. About 9,800 oral and written complaints were made about matters that are outside our jurisdiction (see figure 5). This is fewer than the last two years. We gave referral advice and information in these cases.

*Figure 1: Written complaints and notifications received**

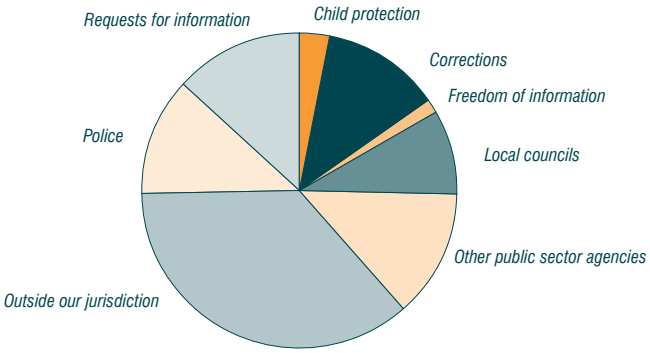


	01/02	02/03
Child protection	1,528	2,560
Corrections	334	336
Freedom of information	138	140
Local councils	760	774
Other public sector agencies	1,140	1,280
Outside our jurisdiction	588	550
Police	3,804	3,099
Total	8,292	8,739

** Does not include notifications about police officers*

The number of complaints referred from the police this year is less than previous years because we expanded our class or kind agreement with them. This means that the police do not need to notify us of complaints about relatively minor matters.

Figure 2: Oral complaints and inquiries received



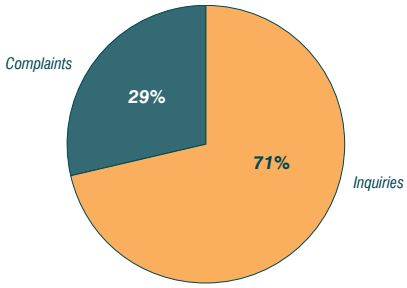
	01/02	02/03
Child protection	661	795
Corrections	3,715	3,133
Freedom of information	306	367
Local councils	2,247	2,226
Other public sector agencies	3,546	3,719
Outside our jurisdiction	10,111	9,316
Police	3,354	3,114
Requests for information	2,593	3,397
Total	26,533	26,067

The law also requires certain agencies providing children's services to report allegations of child abuse against their employees to us. We call these matters 'notifications'. We have entered into class or kind agreements with the Department of Education and Training and the Catholic Commission for Employment Relations whereby certain child abuse allegations need only be reported to us by monthly schedule.

The number of complaints and inquiries includes those received by the former Community Services Commission prior to 1 December 2002 as well as those we have received since then.

The legislative schemes under which we receive complaints and notifications and the specific processes that we use to assess and act on them are explained in greater detail in 'Investigations and complaint resolution', 'Police', 'Child protection' and 'Community services'.

Figure 3: Community services complaints and inquiries received



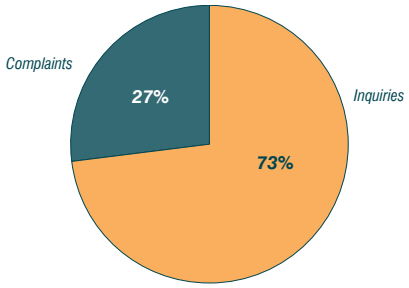
Notes:

1. Complaints about community services received before 1 December 2002 are included in other public sector agencies in figures 1 and 2.

2. The Community Service Commission (CSC) classified complaints differently than the Ombudsman. For this year, we have retained the CSC's classification system.

3. Because of possible duplication it is not possible to make accurate comparisons with complaint statistics from prior years. This will be reviewed for our next annual report.

Figure 4: Community services complaints and inquiries determined



Complaints and inquiries received	02/03
Inquiries	1,228
Complaints	493
Total	1,721

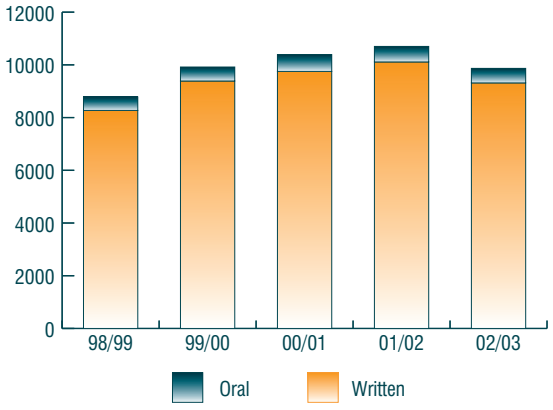
Complaints and inquiries determined	02/03
Inquiries	1,196
Complaints	442
Total	1,638

How we responded

During 2002–2003 we finalised 9,052 formal complaints and notifications (see figure 6).

If a complaint, notification or inquiry can be quickly resolved, it may take only days to finalise. On the other hand, a full-scale investigation can take some time to complete. This is why some of the matters we received during 2002–2003 are still being dealt with and some matters we completed during the year were received before the reporting period.

Figure 5: Complaints received about matters outside our jurisdiction – five year comparison



	98/99	99/00	00/01	01/02	02/03
Written	510	530	639	588	550
Oral	8,271	9,388	9,751	10,111	9,316
Total	8,781	9,918	10,390	10,699	9,866

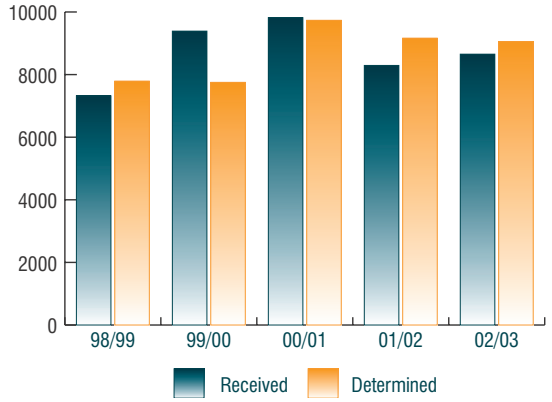
As figure 7 shows, about 48% of complaints we handled in our general jurisdiction were resolved after preliminary inquiries or an informal investigation, less than 9% were outside our jurisdiction and about 43% were not taken any further for a variety of reasons:

- complaints that were premature because the agency concerned had not had a chance to address the matter itself – we advised these complainants to complain to the agency
- complaints where the complainant had a reasonable alternative means of redress
- complaints that were quickly resolved by our staff providing advice or an explanation.

We conducted 16 formal investigations into complaints in our general jurisdiction and made adverse findings in eight of them. We made no adverse findings in three investigations. In the remaining matters, the agency concerned took action that resolved the issues to our satisfaction without the need for a formal report.

This year we directly investigated 29 police complaints and three child abuse notifications, and directly monitored 18 police complaints and 311 child abuse notifications. In the majority of matters notified, we were satisfied that the investigation was conducted properly and more direct intervention was not required.

Figure 6: Written complaints and notifications determined



	01/02	02/03
Child protection	1,499	2,724
Corrections	349	326
Freedom of information	157	145
Local councils	809	791
Other public sector agencies	1,238	1,304
Outside our jurisdiction	611	558
Police	4,501	3,204
Total	9,164	9,052

Special reports to Parliament

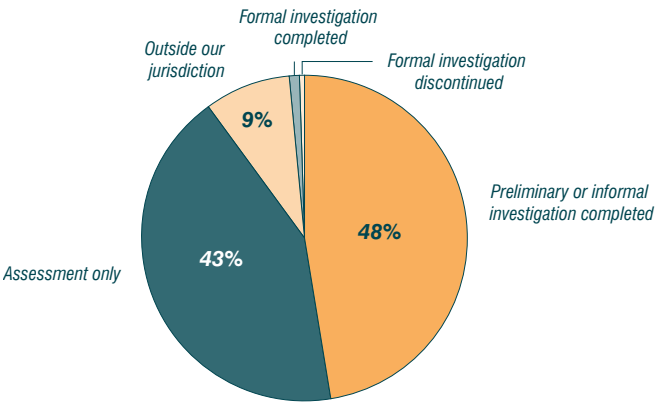
Sometimes our work uncovers a state of affairs that needs to be made public. We are able to make a special report to Parliament if it is in the public interest to do so.

This year we made two special reports to Parliament, both about NSW Police:

- Speedometers and speeding fines: A review of police practice
- Improving the management of complaints: Police complaints and repeat offenders

There was significant media interest in each of those reports. Public debate about some very important issues was stimulated and better informed as a result.

*Figure 7: General complaints determined**

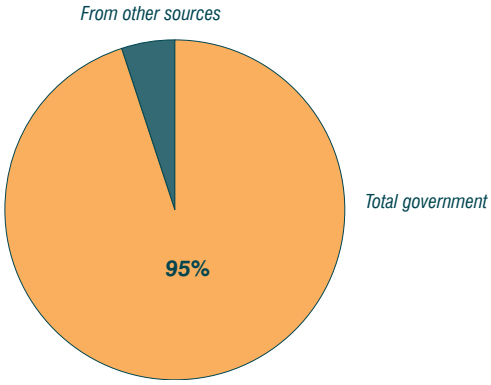


** This figure shows how we determined complaints in our general jurisdiction only. Please see Appendix C for full details.*

Balancing the books

This year we received a total of $16,755 million in funding (see figure 8). Our extra funding was primarily as result of the amalgamation of the former commission.

*Figure 8: Total revenue 2002-2003**



	$
Government	
Recurrent appropriation	13,599,000
Capital appropriation	1,097,000
Acceptance of superannuation and long service leave	1,210,000
Total government	15,906,000
From other sources	849,000
Total	16,755,000

** including capital funding and acceptance of employee entitlements*

Most of our revenue is spent on employee-related expenses. These include salaries, superannuation entitlements, long service leave and payroll tax. In 2002–2003 we spent approximately $11.6 million on employee-related expenses and $3.6 million on the day-to-day running of the office (see figure 9).

Our people

A total of 186 people work for the office. Figure 10 (equivalent full-time staff levels) shows how we have grown over the past five years. We have had to increase our staff because of our expanding jurisdiction and increased workload. Our legislative reviews and child protection functions continue to expand. The large increase in our staffing this year was the result of the amalgamation of the former commission. Most of our staff are employed on a permanent full-time basis. We also have 41 part-time and 47 temporary staff.

Merger of the Community Services Commission

The most significant challenge we faced this year was the merger of the former commission with this office. As reported last year, the NSW Parliament passed the *Community Services Legislation Amendment Act 2002* on 27 June 2002. The effect of this Act was the transfer of the functions of the former commission to the Ombudsman on 1 December 2002. We were also given the following additional responsibilities:

- reviewing deaths of certain children and people with a disability in care

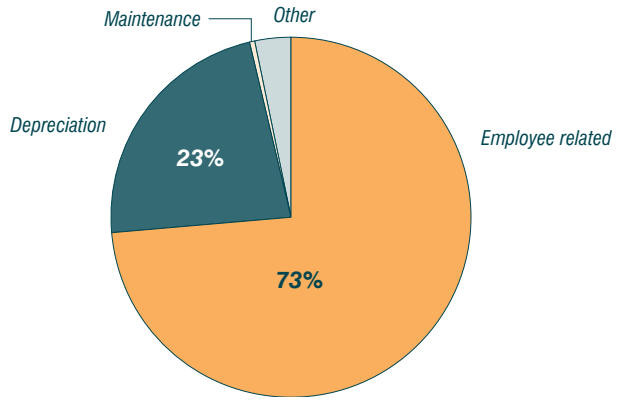
- scrutinising the running of boarding houses through an expanded official community visitor program
- keeping under scrutiny the systems of community service providers for handling complaints about their conduct or provision of services.

The preparation needed to ensure a smooth and successful merger was significant. Our challenge was to bring together two agencies, with their individual priorities, practices and cultures, without compromising the core work of either. We had extensive negotiations and consultations with the former commission and a number of joint working parties were established to review, and where appropriate, integrate aspects of each agency. The working parties looked at issues such as accommodation as well as work practices, employment conditions and other employee policies. We reviewed the IT infrastructure of the former commission as well as their payroll and accounting systems. We published information on the new role of the Ombudsman, targeting relevant community sector agencies.

On the whole the amalgamation itself was smooth, which is to the credit of all staff who worked hard to achieve this outcome. As is often the case in these situations, there were some hiccups in the transitional period. Issues were discussed and resolved as they arose. The staff of the former commission are now established as our community services division.

The impact of the merger on staff of the former commission was without question significant and disruptive. The impact on our office was also significant. Not only did our staff numbers increase by about 40, our jurisdiction expanded further into the private sector and we were given a number of new and distinct functions.

*Figure 9: Total expenses 2002-2003**



	$
Employee related	11,643,000
Depreciation	3,598,000
Maintenance	75,000
Other	514,000
Total	15,830,000

** Audit require recognition of leave at pay increase rates – employee related expense changed.*

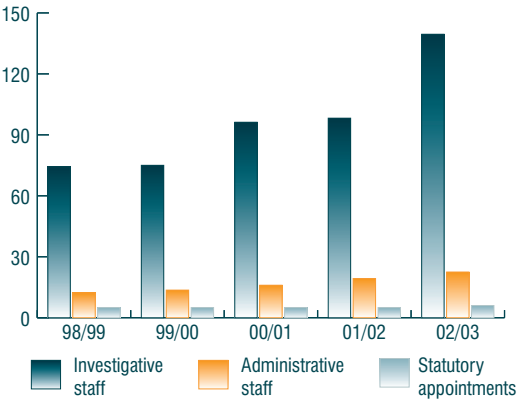
Other significant corporate projects

PCCM

We continued our involvement in the police complaints case management (PCCM) project this year. The project is a major initiative sponsored by the Premier's Department and involving NSW Police, the Police Integrity Commission and the Ombudsman. The aim of the project was to create an integrated database to improve the collection, monitoring and analysis of complaints about police and complaint-related data. The project is substantially complete and systems are in place for the agencies involved to work cooperatively in ensuring that the benefits of the systems are fully realised.

The PCCM was a series of independent projects, such as the development of a case management system - c@ts.i - and the development of a data warehouse –the Police Oversight Data Storage (PODS) - which will improve intelligence gathering on individual officers as well as local area and specialised commands, and information on significant issues.

*Figure 10: Staff levels – five year comparison**



	98/99	99/00	00/01	01/02	02/03
Statutory appointments	5	5	5	5	6
Investigative staff	74.3	75	96.2	98.2	139.5
Administrative staff	12.2	13.6	16	19.3	22.5
Total	91.5	93.6	117.2	122.5	168
Trainees	1	1	1	0	0

** full time equivalent*

Lin Phillips (receptionist) and Wendy Parsons (inquiries officer) assisting with an inquiry at our reception

Document management

Part of the PCCM project was a requirement that we implement a document management system in our police team. Funding was sought and obtained to extend this system throughout the office.

Last year we reported that we had successfully entered into a contract for the supply of an enterprise document management system (EDMS). This year saw considerable development work on the EDMS to customise it to our needs.

We modified the product to suit our record types, including its integration with our existing case management systems, c@ts.i and Resolve. It was piloted by our general team prior to its roll out across the office. The system was accepted in June 2003.

To facilitate the introduction of the EDMS, considerable work was done in reviewing and developing new record management policies and business rules. In addition, a series of training courses was developed and run including training on the system itself as well as technical training for IT and other support staff.

Expected disruptions to business processes turned out to be minimal due to careful project management and a proactive change management strategy. Staff have been quick to adapt to the new system and the enhanced search capabilities of the project have already led to noticeable productivity gains for many staff.

A final sub-project is still underway to integrate the EDMS with the two principal case management systems used by the community services division.

The Premier and the Ombudsman at the 20th Australasian and Pacific Ombudsman Conference in November 2002 at Parliament House

Security

We began a project in 2002 to review and enhance information security management. The purpose of this review was twofold. Firstly, the Premier had announced a government policy requiring all agencies to be compliant with the Australian Standard for Information Management Security (AS7799) by 2003. In addition, all PCCM partners had agreed to review and improve information security. Independent security consultants were engaged by the PCCM project manager to review information security at each agency involved in PCCM.

Our project focused on a number of areas. We looked at our perimeter security and instigated a number of capital programs to improve it. We looked at the security of our information holdings – both physical and electronic. We strengthened our network and invested in new infrastructure hardware and software. We reviewed work practices and introduced a range of policies to assist staff understand their responsibilities and as well as guiding them in their work. Significant training of IT staff occurred and a staff awareness program was developed.

Having achieved substantial compliance with the standard by mid 2002, we decided to pursue full accreditation. SAI Global (Standards Australia) conducted a pre-certification audit of the Ombudsman's Information Security Management Systems in November 2002 and certification was granted on 9 December. The Ombudsman is the first fully accredited agency in Australia, although some sections or divisions of a small number of other agencies had already been accredited. Since our accreditation, three other NSW agencies have also achieved accreditation. The project succeeded through the combined effort of a key group of staff, particularly those in our IT section.

CERTIFIED

TM

Information Security Management System

Lic ISM 20007

Australian Standard logo for information security management accreditation

How we operate

We pride ourselves on the quality of our work and the standard of our service. Our reputation for maintaining high standards in administrative conduct is important because it helps ensure that agencies accept our advice and implement our recommendations. We aim to lead by example and focus on practical outcomes that do the most good for the most people.

The environment in which we operate is never static so we have developed the ability to be flexible and adapt to change. We continually monitor our performance to identify areas for improvement and then work towards making those improvements.

We have found that employing and developing specialist staff is the most effective way of fulfilling our various functions. We also make sure that corporate knowledge is shared and work and management practices are consistent across the individual teams.

This section discusses some of our strategies for meeting the challenges our office faces.

Statement of responsibility

The Ombudsman, senior management and other staff have put in place an internal control process designed to provide reasonable assurance regarding the achievements of the office's objectives. The Ombudsman, Deputy Ombudsman and each Assistant Ombudsman assess these controls.

To the best of my knowledge, the systems of internal control have operated satisfactorily during the year.

Bruce Barbour
Ombudsman

Accountability

Our office is accountable to the public in much the same way as any other NSW public sector agency. We come under the scrutiny of agencies such as the Auditor-General, the Independent Commission Against Corruption, the Privacy Commissioner, the Anti-Discrimination Board, State Records and Treasury.

The PJC

The Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission (commonly known as the PJC) has broad responsibilities for monitoring and reviewing how we exercise our functions. The PJC is made up of parliamentarians from different political parties. This ensures that we are accountable to Parliament, not to the government of the day, and is crucial to maintaining our independence.

The PJC can examine our policies, practices and systems, review our reports and performance measures, examine complaints made about us, and suggest ways in which we could improve how we operate. It cannot review substantive decisions we have made about individual complaints, but it can criticise the process by which those decisions were made.

Giving reasons

Under section 15 of the Ombudsman Act we have to give each complainant reasons for refusing to investigate or conciliate their complaint or for discontinuing an investigation. There are no restrictions on what they do with that information. This is an important accountability mechanism and has helped us establish a public reputation for making fair and well-reasoned decisions. As a result of this reputation, we have greater credibility when we make recommendations to agencies and our recommendations are more likely to be followed. Our need to be accountable actually helps to make us more effective.

Our annual report

Our annual report is a public record of our work for each financial year. It provides Parliament and the community with an opportunity to find out what we have achieved and the way we have achieved it. Although specific investigations and inquiries are generally conducted in private, we may include certain issues or instances of misconduct or maladministration in our annual report if we feel it is in the public interest.

Each year we submit our annual report for judging to the Australasian Annual Report Awards. All NSW public sector agencies are encouraged to do this as a means of promoting better reporting practices. We are pleased to report that the Ombudsman's 2001-2002 annual report won a silver medal.

Corporate planning

Our corporate plan provides broad strategic direction for our work. Each investigative team develops a detailed business plan outlining strategies and activities to support the corporate plan. These differ between the teams because they operate within different and changing environments and face quite specific challenges. Each team's business plan forms the basis of the work plans for individual staff. The teams regularly evaluate their performance against their business plan to see if any improvements or changes need to be made.

The corporate plan is supported by centralised office policies and plans such as the IT strategic plan, the access and awareness plan and the plans underpinning the information and document management projects. We also have consistent performance indicators across the different teams.

We will review our corporate plan in 2003–2004 to take into account the new functions we perform particularly following the merger of the former commission. We will also develop a business plan and performance indicators for the division to ensure its efficiency and effectiveness as well as consistency with the rest of the office.

Performance management

Performance indicators

One of our corporate goals is to be a cohesive and effective organisation. Information about the quantity, quality, timeliness and impact of our work is essential to achieving this goal. Performance benchmarks measuring these factors are established at the corporate, team and individual staff level and workflow statistics are used to inform procedural changes.

Monitoring performance and risk management

We track our performance at two levels — in relation to individual files and in relation to our systems and structures for completing work.

Supervisors are responsible for formally reviewing files monthly or bi-monthly. This enables them to monitor the performance of individual staff members and provide guidance on how files or a particular matter might be better managed.

Timeliness

Data from our case management system is used to monitor turnaround times and identify where there may be backlogs, delays or inefficiencies. For example, we periodically review all files that have been open for more than six months and develop strategies to address any issues that may be causing unnecessary delay.

With many of our complaints and notifications, we need to factor in the time it takes for an agency to provide us with information. This could be answers to inquiries or a response to a draft investigation report. Sometimes an agency's tardiness is the main cause of a delay. However, we do have a responsibility to escalate certain matters in the interest of all parties potentially affected by an investigation, particularly the complainant and the subject of the allegations. We try to reduce the risk that, if a matter takes too long to resolve, all parties may be dissatisfied and it may be too late for any of our recommendations to be implemented.

Accuracy, integrity and good decision-making

The integrity and accuracy of the data we keep is crucial to the effectiveness of our work and our ability to monitor our performance. We periodically conduct internal audits of the recording of information on our case management system to check that it is accurate.

Our assessment of complaints and notifications also needs to be sound and consistent. We have systems for consultation and discussion to ensure that the appropriate decision is made at the outset. We also make sure that if a complainant asks for a review of our decision, a more senior member of staff conducts the review.

We use close supervision and periodic file audits to review the quality and consistency of our work. This helps ensure that the decisions we make are sound and the management of files is efficient and effective.

It is also important that any correspondence and reports we send out are factually accurate and properly reasoned. We have rigorous procedures for supervising, checking and authorising these documents.

Internal structures and systems

Review of team structures

Our internal structures and systems are designed to maximise the sharing of corporate knowledge, provide a cohesive and open environment for staff and use resources in the most effective way.

The community services division was initially established with what was in effect the former commission's structure, less some corporate support staff who had transferred to the corporate support team. A formal review of the division's structure was completed to ensure it was able to deal effectively with its current functions and to respond to the addition of new or expanded responsibilities.

The other focus of the review was to ensure the division's structure was aligned with the broader office to ensure consistency of grades and structures of positions.

The review of our inquiries area was finalised. The team increased to seven full time staff who work under the daily direction and guidance of a senior inquiry officer. A senior investigation officer was transferred to manage an expanded inquiries and resolution team' which also includes reception staff.

Policies and procedures

During the year we made substantial progress on a review of our policies and procedures. A number of new policies were developed, particularly in relation to IT and office security.

Meetings

Our senior staff meet weekly to inform each other about the progress of work, exchange information and discuss issues of concern. Office-wide committees, issues groups and teams meet regularly to discuss current developments, reinforce new policies or management directions and exchange information. We also hold staff meetings once a month.

Intranet, newsletters, bulletins and operations reports

We encourage the exchange of information through the office intranet, the email system and the circulation of periodic newsletters. Monthly operational review reports are prepared for the Ombudsman and contain details about work inputs and outputs and current issues.

The intranet currently gives staff easy access to complaint management information, legislation, precedents, policy and procedure documents of agencies we oversight, a telephone directory and trend analysis reports.

The EDMS significantly improved access to corporate information.

Training and development

The investigation skills training program that we began to develop last year was trialled successfully. We refined a number of individual modules in light of feedback, and are currently working on ensuring the course materials are of a professional standard. Other training that was conducted during the year was primarily focused on EDMS and occupational health and safety. Please see 'Corporate support' for more details.

Relationships with others

Ombudsman offices here and overseas

Like other Australian Ombudsman, our office is part of the International Ombudsman Institute and participates in the activities of the Australasian and Pacific Regional Group. We hosted the 20th Australasian and Pacific Ombudsman Conference in November 2002.

About 40 delegates from countries across the region attended the conference which was opened by the Premier and held at Parliament House. The theme was 'Ombudsman – Future Options and Directions' and useful presentations and discussions canvassed a range of issues to do with the exercise of powers and effective investigation techniques. Ways in which mutual support and assistance might be offered was another theme.

Networking with other Ombudsman's offices gives us the opportunity to learn from their experience, share our own knowledge, provide mutual support and promote the importance of the Ombudsman concept in all jurisdictions.

We continue to be a leader in the field of accountable public administration. We are pleased to support the establishment of Ombudsman's offices in other countries and to make our guidelines and other resources readily available. This year we were visited by the Assistant Secretary General, Office of the Ombudsman of Thailand, Ms Viyada. We also hosted a visit by members of the Supreme and District Courts of Indonesia, and briefed a delegation from the Northern Province Legislature of South Africa.

Other watchdog bodies

The Ombudsman Network Group is a group of the CEOs of most NSW watchdog agencies who meet to exchange information and discuss issues of concern.

The Joint Initiatives Group (JIG) is a network group of staff of watchdog agencies covering a range of jurisdictions. It meets regularly to share information, resources and opportunities for joint activities such as training and community outreach. In 2002-2003 JIG organised an ADR seminar series to encourage discussion and understanding of issues and developments in complaint handling and alternate dispute resolution. Primarily designed for managers and staff working in the area, the seminars will be presented by leading professionals and academics in the field.

We met regularly with the Police Integrity Commission (PIC) to review topical issues, avoid duplication and ensure the most effective use of the resources of both organisations. We also met quarterly with the Inspector General of Corrective Services to discuss emerging issues and coordinate our activities.

Statewide child protection agencies

We are part of the child protection senior officers group that includes representatives from agencies such as the Departments of Health, Education and Training, Community Services and Juvenile Justice, the Attorney General's Department and NSW Police. We meet every six weeks to review issues relating to the protection of children. The group set up a working party to consider the exchange of information across interagency partners. For more details, please see 'Child protection'.

We work closely with the Commission for Children and Young People and are both part of a state wide strategy on child protection.

Agencies within our jurisdiction

It is very important for us to maintain cooperative relationships with the agencies we oversight. A good working relationship allows us to have frank and open discussions about issues and helps to speed up the resolution of both complaints and any systemic concerns that we raise.

We have formal liaison arrangements with senior staff of the Department of Corrective Services, the Department of Juvenile Justice, NSW Police, the different state departments providing services to children (including the Department of Education and Training), and peak bodies representing non-government agencies that provide services to children (such as the Catholic Commission for Employment Relations).

Class or kind agreements

This year we made two significant amendments to our class or kind agreement with NSW Police. For more details, please see 'Police'. We also reviewed our class or kind determinations with the Department of Education and Training and the Catholic Commission for Employment Relations for reporting child abuse allegations. Both parties indicated that they were satisfied with the current scope of our agreements.

Other stakeholders

Maintaining good relationships with community groups, unions and other interest groups is important to us. This year we met with the Police Association of NSW, the Teachers Federation and the Independent Education Union to discuss how our work affects their members.

Our staff made several visits to Goulburn Academy to explain our role to student police officers. We also met with a range of community groups and Aboriginal community representatives to discuss policing issues. Please see 'Police' for more details.

We provided workshops and briefings to board members, managers and staff agencies providing out of home care services for Aboriginal children.

The Deputy Ombudsman, Community Services Division, spoke at a number of conferences and seminars on a range of issues related to the provision of community services. Please see 'Speeches and presentations' for more details.

Other activities

In November 2002 we co-sponsored and organised the fourth in a series of bi-annual symposia with the Institute of Public Administration Australia and ICAC. Nearly 200 participants from a wide range of investigative and mainstream agencies from all states and territories came together to hear over 30 presentations over two days from leading practitioners on latest trends and techniques in investigative practice. A large contingent of overseas Ombudsman and senior staff also attended this symposium as it was run back to back with the APOC conference. The symposium provided a unique opportunity for investigators with varied functions from many jurisdictions to get together to compare approaches and learn from each other.

In addition to giving presentations to groups of people, in 2002-2003 we also conducted six workshops on a fee for service basis to Centrelink. These workshops were on complaint handling and dealing with difficult complainants.

Relationships with complainants

Complaints and compliments

Our policy on complaints and compliments gives us a framework for using customer feedback to continually improve our services. Complaints can help us to identify areas of our service that need improvement or show where expectations of service levels exceed what we can reasonably deliver. Compliments are a useful tool for obtaining feedback on the aspects of our service that we do well.

Figure 11: Complaints about us

Issues	Number
Bias/unfair treatment/tone	12
Confidentiality/privacy related	6
Delays	13
Denial of natural justice	3
Failure to deal appropriately with complaint	18
Lack of feedback/response	13
Limits to jurisdiction	0
Faulty procedures	11
Inaccurate information/wrong decision	11
Poor customer service	9
Other	11
Total issues	107
Total complaints	86
% of all written complaints determined	0.96

Complaints, compliments and suggestions for improvement are recorded and analysed to help us identify areas that we need to improve. When someone complains about our service, we firstly try to address the complainant's dissatisfaction and secondly think about how to prevent similar issues arising in the future.

If necessary, we take some form of remedial action to resolve complaints. In most cases we contact complainants and provide an explanation and further information about our policies and procedures. We have also offered apologies, reviewed workloads giving greater priority to identified files, or reallocated matters for prompt attention. We also review our procedures for dealing with delayed complaints and implement more rigorous procedures.

Figure 12: Complaints about us – outcome

	Number
Unjustified	52
Justified or partly justified	8
Some substance and resolved by remedial action	43
Total complaints resolved	103

This year we received compliments about the quality of our advice and assistance to complainants, and the timeliness of our intervention.

Requests for review of complaint determinations

The Ombudsman Act requires us to give a complainant reasons for our decision to decline to investigate their complaint.

*Figure 13: Request for a review of decision (% of complaints and notifications received)**

	No. of reviews	%
Child protection	2	0.08
Corrections	10	2.98
Freedom of information	8	5.71
Local councils	103	13.31
Other public sector agencies	100	8.38
Outside our jurisdiction	10	1.82
Police	41	1.32
Total	274	3.17

**This table does not include requests for a review of matters dealt with by the Community Services Division*

Unsurprisingly, some complainants do not accept our determination of their case and want to have it reviewed. The basis for a review request usually falls into at least one of these categories.

- A subjective conviction that the available evidence supports an alternative determination more favourable to the complainant.
- Our alleged failure to make sufficient inquiries or properly analyse evidence. This may include claims of bias, corruption or improper discrimination.
- A subjective conviction that their case needs to be investigated.
- Presentation of new evidence either unknown to the complainant when making their complaint or known to, but withheld by, the complainant when making their complaint.
- Pursuit of an agenda to punish an agency or individuals.
- Unrealistic expectations of the service or enforcement an agency can provide.

We are not infallible and have a longstanding 'one review' policy, first set out in our 1995-1996 annual report. The review process is a safety net that is an essential element of complaint handling best practice. Given the resources used by review requests, we think it is important to restate our policy on reviews.

A review request is not allocated to the staff member who handled the original complaint. Wherever possible, a different and more senior staff member reviews the complaint. The reviewer examines all material in the case, including any new evidence produced. Additional inquiries are often made with the complainant or agency concerned. In some cases, the original determination is overturned and an investigation or conciliation undertaken.

If the reviewer's recommendation is not to investigate or conciliate, the file goes to the Ombudsman for consideration and final determination. The Ombudsman Act provides for no merits appeal beyond his decision. If he affirms the original determination, the case is closed. This means a complainant is entitled to one thorough and impartial review, but no more.

We are generally unsympathetic to review requests where the complainant has originally withheld information from us, especially if there is a suggestion that even more evidence could be provided. We expect complainants to lay all their cards (good and bad) on the table at the outset so we can assess their case based on all the available information.

Some complainants refuse to accept any decision by us that does not accord completely with their wishes. They will often demand further reviews until we get the determination 'right', that is agree with them. These demands may involve many phone calls, lots of correspondence and visits to our offices seeking personal interviews.

Sometimes we must cope with verbal abuse and even physical threats to our staff.

In such cases the Ombudsman may notify the complainant that no further phone calls will be accepted or interviews granted about the complaint already reviewed. Correspondence will be received, assessed and filed but only acknowledged if, in our opinion, it raises new issues that warrant action. The Ombudsman takes this last step with the greatest reluctance, but to act differently would be to take resources away from other cases that deserve attention.

Figure 14: Outcomes of request for review of decision

	A1	A2	Resolved	Reopened	Total
Child protection	2	0	0	0	2
Corrections	9	2	0	1	12
Freedom of information	4	1	0	2	7
Local councils	38	61	3	3	105
Other public sector agencies	55	39	2	6	102
Outside our jurisdiction	8	1	0	0	9
Police	39	0	0	0	39
Total	155	104	5	12	276

A1 = original outcome affirmed after the review
A2 = original outcome affirmed after telephone enquiry

The following case illustrates a number of these points.

One complainant this year alleged we had colluded with other agencies to cover up his complaint and that the staff member he dealt with had been obnoxious. A senior investigation officer was asked to examine both allegations. She reviewed all material on file and interviewed the staff member who had originally dealt with the matter.

Complaints about telephone conversation tone are obviously difficult to investigate. In this case there was no indication in the staff member's notes that she had developed any antipathy towards the complainant.

On the other hand, the complainant's manner was consistently aggressive and extreme in his dealings with both the complaints officer and the review officer. Given this, together with the fact that the complaint itself had been dealt with in a diligent and professional way, the Ombudsman concluded there was no evidence to support allegations about the complaints officer's manner.

The complaint itself was about the way an area health service's aged care assessment team (ACAT) had assessed the complainant's mother and the outcome of that assessment.

We had initially declined the complaint because the complainant failed to produce any evidence to support his assertions that the ACAT was corrupt and unprofessional. We also felt that other agencies were better placed to conduct any inquiries warranted.

The complainant began to assert that the Department of the Prime Minister and Cabinet (PM&C) had instructed the Commonwealth Ombudsman to work closely with us to investigate the extensive problems with the ACAT and the Guardianship Tribunal. The review officer then discovered the complainant had approached PM&C, the Commonwealth Department of Health and Ageing and the Commonwealth Ombudsman.

None of these agencies had any expectation of our involvement since they were all, in one way or another, responding to the complaint. This does not mean there was any available evidence of wrong conduct by the ACAT.

The Ombudsman's final letter to the complainant said that agencies agreeing with each other's assessments, particularly when there had also been independent reviews, does not indicate collusion or cover-up. Given the extensive resources of other agencies being expended on the complaint, the Ombudsman considered it was unnecessary for us to make any further inquiries.

Performance Indicator
Request for review of decision

Team	Target	01/02	02/03	No. of reviews	No of complaints determined
Child protection	< 1.0%	0.3%	0.1%	2	2723
General	< 6.0%	5.1%	9.1%	231	2996
Police	< 1.8%	1.4%	1.3%	41	3204

Interpretation

This performance indicator refers to the number of requests for a review of our decision as a proportion of the total matters determined. Separate figures are kept for each of the investigative teams. The police and child protection teams are under the target. The general team is significantly above the benchmark. We are currently reviewing this to ascertain why this increase occurred.

Statistics are not currently kept for complaints dealt with by the Community Services Division.

Investigations and complaint resolution

Although our role has expanded considerably over the years, our traditional function of dealing with complaints from members of the public about government agencies is still an essential part of our day-to-day work. In this section we discuss our investigative work and the work we have done to resolve complaints in the following areas:

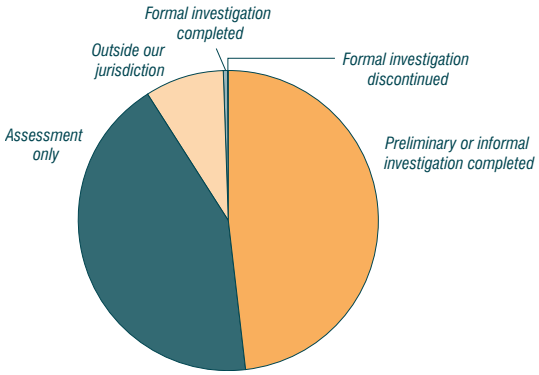
- general complaint work
- local councils
- corrections
- protected disclosures
- freedom of information.

General complaint work

Complaint numbers

In 2002-2003 we received 1280 written complaints and 3,719 oral inquiries about 139 agencies in our general jurisdiction. This is 12% more written complaints and 5% more oral complaints than last year. These figures do not include complaints about local councils and correctional centres or complaints about Freedom of Information. These are discussed separately in this report.

*Figure 15: Complaints received and determined**



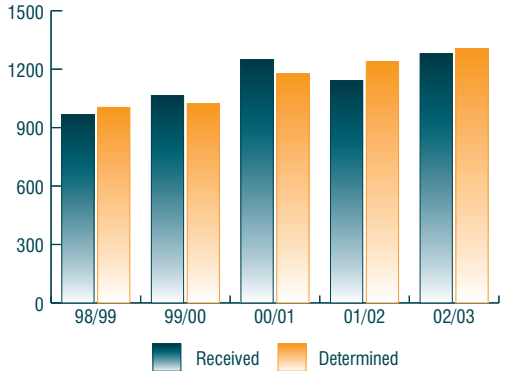
** This figure shows complaints about public sector agencies other than NSW Police, local councils, the Department of Corrective Services, the Corrections Health Service and the Department of Juvenile Justice*

Complaints received	
Written	1280
Oral	3719
Request for review of our decision	100
Total	5099
Complaints determined (written)	
Preliminary or informal investigation completed	628
Assessment only	558
Outside our jurisdiction	111
Formal investigation completed	6
Formal investigation discontinued	1
Total	1304
Current investigations (at 30 June)	
Under preliminary or informal investigation	67
Under formal investigation	5
Total	72

Up until 1 December 2002 when the Community Services Division began operating in our office, our general team also dealt with complaints about the Department of Community Services (DoCS) and the Department of Ageing, Disability and Home Care. These complaints and inquiries are included in the statistics here representing work done, but further breakdowns of those particular complaints are included in the chapter on the work of the Community Services Division. Additional resources were not made available for the work done on community services and this obviously had a significant impact on general team work.

*Figure 16: Written complaints received and determined – five year comparison**

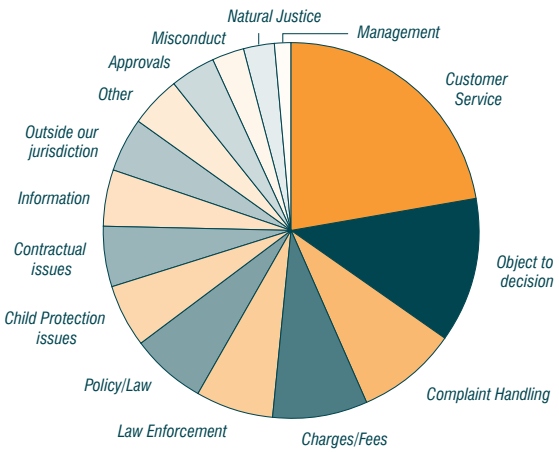
** This figure shows complaints about public sector agencies other than NSW Police, local councils, the Department of Corrective Services, the Corrections Health Service and the Department of Juvenile Justice*



Year	Received	Determined
98/99	967	1004
99/00	1065	1023
00/01	1249	1176
01/02	1140	1238
02/03	1280	1304

In addition, there was a surge in complaints about the Infringement Processing Bureau (IPB) and the State Debt Recovery Office (SDRO). These are discussed in more detail below. Other agencies with significant changes in the numbers of complaints received about them were the Department of Housing –150 complaints (up 19%) and the State Rail Authority (SRA) – 43 complaints (down 26%). Last year's annual report recorded our assistance to the SRA in establishing a central complaints unit, written guidelines and an enhanced case management system. While caution is needed, we

*Figure 17: The subject of complaints**



** This figure shows complaints about public sector agencies other than NSW Police, local councils, the Department of Corrective Services, the Corrections Health Service and the Department of Juvenile Justice.*

	Written	Oral	Total
Approvals	80	114	194
Charges/Fees	110	298	408
Child Protection issues	81	189	270
Complaint Handling	156	278	434
Contractual Issues	58	202	260
Customer Service	238	875	1113
Information	90	153	243
Law Enforcement	140	194	334
Management	19	52	71
Misconduct	34	104	138
Natural Justice	14	119	133
Object To Decision	58	565	623
Other	33	187	220
Outside our jurisdiction	85	148	233
Policy/Law	84	241	325
Total	1280	3719	4999

hope this substantial drop in complaints about the SRA is a reflection of these improvements to their internal complaint handling.

The rise in complaints about universities over the previous three years (from 34 to 56) slowed, with 60 complaints received this year. However, the higher than average rate of both protected disclosures and requests for review of our decisions concerning university complaints (and hence the work involved in handling them) continued. Please see case study 1.

What we do and how we do it

Everyone has the right to complain to our office about the conduct of a public sector agency. These agencies exist to serve the public and the public has a legal right to complain to us about the way an agency is functioning. We have the power to investigate a variety of conduct that is unlawful, unreasonable, inappropriate or otherwise wrong.

Generally complaints should be made in writing, but we do accept oral complaints in special cases. This could be when the complainant describes an emergency situation that needs urgent attention or it is very difficult for the complainant to put the complaint in writing because of, for example, their level of literacy or a disability. The complaint also needs to be sufficiently serious to warrant a preliminary investigation.

When we receive a complaint, the first thing we do is assess whether it is within our jurisdiction. If it is outside our jurisdiction, we try to refer the complainant to another agency that might be able to handle it or give them advice about other options.

We may decide not to pursue other matters because it would not be in the public interest for us to do so. For example, some complaints can be more effectively dealt with directly by the agency concerned or another body or the complainant may have a reasonable alternative way of resolving the complaint.

Sometimes the complaint is minor or too old, or finding a practical solution to the grievance is unrealistic. In many cases, the matter can be resolved by giving the complainant advice or an explanation. If we decide to decline a complaint, we always give the complainant reasons for our decision.

We try to resolve individual complaints wherever possible and appropriate, but our overriding principle is that we act in the public interest. We do not act as advocates for complainants. This means that if a complaint raises systemic matters, we focus on bringing those concerns to the attention of the agency and persuading them to improve their systems rather than just trying to resolve the complainant's individual grievance. Please see case study 2.

We made preliminary inquiries or informal investigations into 628 out of the 1,304 complaints finalised this year that were within jurisdiction. These preliminary inquiries often involve numerous phone calls and letters as well as meetings and negotiations with staff from the agency concerned.

Sometimes our inquiries show there is little or no evidence of any wrong conduct or that pursuing the matter would not produce any practical outcome in the public interest. In these cases, we conclude the matter and close the file. On the other hand, if we are not satisfied with the agency's response, particularly if they have failed to address our concerns about serious or systemic issues, we may escalate the matter and use our formal investigative powers.

Case study 1

We received a protected disclosure suggesting a professor had submitted a research grant application to his faculty research committee that was based largely on work reported in a student's honours thesis. There was no acknowledgement of the student in the application. Another professor had recognised the application's similarity to the thesis. He formally complained to the Deputy Vice-Chancellor (DVC) about the applicant's apparent plagiarism and fraud in seeking funds for work already largely done by the student. He included extracts showing the very close similarity of parts of the application and the thesis. Before the application, the applicant, the student and the student's thesis supervisor had produced a conference paper that was, in effect, a boiled down version of the thesis. The applicant and the supervisor had presented this paper, which named the student as first author, at conferences in Auckland and Verona. The applicant was seeking publication of the joint paper in an academic journal.

The DVC responded to the complaint by seeking an explanation from the applicant. The applicant phoned the student (now working in another city) and gave a misleading account of why he was seeking a letter of support. The student believed the application had been in relation to securing publication of the joint paper. The applicant dictated a letter addressed to himself that the student signed and then faxed back to him. That letter referred to the student's name being included in the joint paper, praised the applicant's inclusive approach to research and noted the student was honoured to be part of the applicant's continuing research program. The supervisor (the applicant's former PhD student) faxed a letter of support to the applicant in broadly similar terms to that from the student.

The DVC accepted at face value the two letters of support and the applicant's explanation that the joint paper absolved him from any suggestion of plagiarism and that the application was a substantial extension and consolidation of the student's work. The DVC subsequently conceded to us he did not examine the extracts supplied by the complainant.

When we began our investigation, the applicant said he had never seen the student's thesis. This assertion presents the strongest possible defence to a plagiarism allegation. He maintained that position during our hearings using Royal Commission powers where he, the DVC and the student were examined. The application proposed to process data obtained using a lengthy econometric equation published in a 1999 Journal of Finance paper. The student's thesis data had been processed using this same equation. The applicant said the equation in his application had been taken directly from the 1999 paper. Unfortunately for the applicant, in reproducing the equation in his thesis the student had made a number of inconspicuous changes (mainly by reversing the subscripts of certain terms). The equation in the application was identical in all respects to the equation in the thesis (and to that in the joint paper that was derived from the thesis). While its econometric effect was the same, the application equation was not identical to and could not have come directly from the 1999 paper. In addition, it was clear that at least some of the unacknowledged student's work would form part of the project applied for.

We found the applicant's conduct was wrong in failing to acknowledge in the application the honours student's work. This individual case raised important general and often vexed academic issues of attribution and misuse of the work of others. The Minister of Education and Training has now circulated our recommendations to all universities in NSW.

The recommendations were that each university adopt and publish a policy to:

- ensure the proper attribution of prior work in all research grant applications and research publications by all members of the university
- protect students and junior staff from improper or inequitable use of their academic work by more senior staff.

Our investigation also revealed a request to the DVC to destroy what was clearly an official document relevant to his investigation. The DVC commendably did not act on the request. We had uncovered a similar request in an investigation we had conducted into another university two and a half years ago. As a result, the then Minister circulated all NSW universities with our recommendation to review their record keeping policies to ensure they complied with the State Records Act and to institute appropriate training and monitoring programs. This latest destruction request prompted us to recommend the Minister again circulate our previous request about record keeping policies.

Case study 2

A Legal Centre complained about the State Transit Authority's apparent failure to investigate a passenger's allegation that a bus driver assaulted him. The passenger rang the 13 15 00 Your Say Line the day after the incident. After three months he had heard nothing. He claimed he made follow up calls during this time but to no avail.

We contacted the STA who claimed they had received the complaint by email from the Your Say Line but had not read it until they heard from us. They have since taken action to ensure that such an oversight could not happen again.

Having read the email, the STA appointed a depot manager as internal investigator. Ordinarily we would have waited for the investigator's report before determining the need for further action. However we soon became concerned about the investigator's conduct. The passenger alleged the investigator was trying to arrange a meeting off-site between him and the driver. We could see no useful investigative purpose for such a meeting, particularly off-site. We started a formal investigation into the STA's handling of the complaint.

Our investigation found that the internal investigator had not planned his investigation, had not located key evidence (including video evidence from the bus), and had failed to keep adequate records of interviews and phone calls relating to the investigation. His investigation had also not followed the STA's disciplinary policy and guidelines.

The internal investigator concluded it was necessary to take minor disciplinary action against the driver and some corrective action. To compound the problems with the investigation itself, the investigator failed to implement the disciplinary action against the driver and did not advise the passenger or his solicitor about the investigation outcome.

We provided our provisional findings and recommendations to the STA and the investigator. After considering these, the STA told us they were already reviewing their disciplinary procedures and improving their current guidelines for staff who handle complaints and investigations.

In our final investigation report we found that the STA's conduct was unreasonable. They had failed to act on the complaint for three months and then failed to ensure the complaint was adequately investigated and the conclusions implemented. We also found that the investigator's handling of the complaint was unreasonable for the same reasons.

We recommended that the STA produce specific complaint handling guidelines and training for their staff on the expected standards and processes for handling and investigating complaints. Their revised disciplinary policy should reflect those complaint handling guidelines and address issues that had arisen during our investigation.

We also recommended the STA only allocate complaints alleging serious misconduct to experienced investigators with the training, skills and resources to conduct thorough investigations.

In April 2003, the STA told us they had prepared new procedures and started training for complaint and grievance handling. They've also retained an independent expert to review their disciplinary procedures.

Our investigation process

If we use our formal powers and initiate an investigation, we can require agencies to provide us with information and documents. We can also exercise 'Royal Commission' powers that allow us to summon and examine any person on oath and require witnesses to produce documents or relevant items.

During a formal investigation, information will sometimes come to light or an agency will take some action that resolves the matter to our satisfaction. Sometimes circumstances change and we may decide it is no longer in the public interest to continue to use our resources to pursue a matter.

If this happens, we discontinue the investigation. We can suspend our inquiries or investigations at any time while we attempt to conciliate a matter.

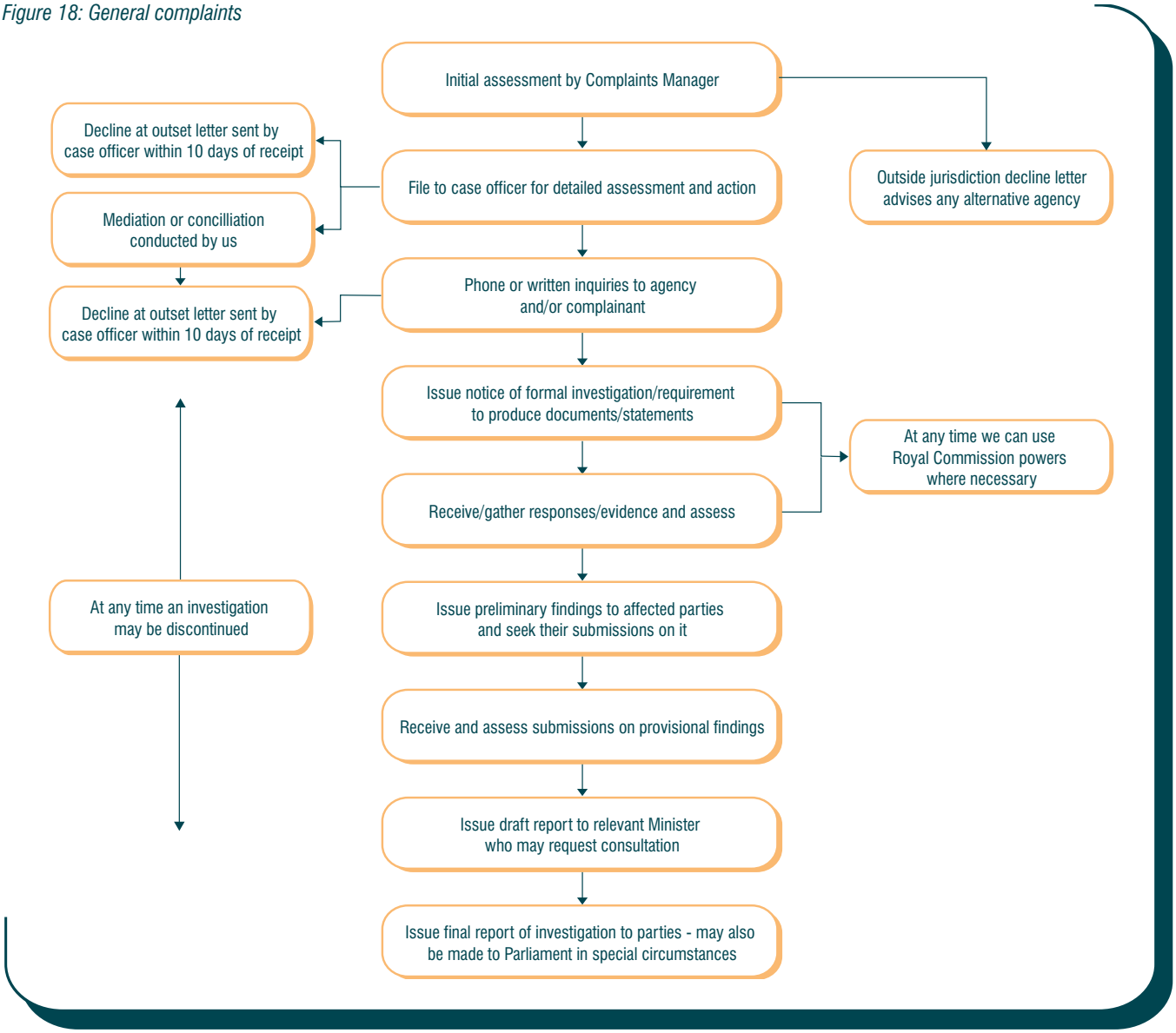
We are careful to afford procedural fairness to all relevant parties. Before we make any comment or finding that is adverse to any party, we give them an opportunity to present their side of the story.

This involves preparing a document we call our 'preliminary findings and recommendations' which is given to any individual or agency about whom we propose to make adverse comments or findings. We consider their response to ensure our final report is fair, accurate and takes into account their views.

The next stage of a formal investigation is a draft report to the Minister responsible for the agency concerned. This report may contain findings of wrong conduct and recommendations for change. We do not issue a final report until the Minister has had an opportunity to consult with us on the draft report. This gives us the opportunity to work with the Minister and the head of the agency to make sure our recommendations are practical, workable and helpful. Occasionally we will table the report in Parliament if we feel this is in the public interest.

After we make a report final, we monitor how the agency complies with our recommendations.

Figure 18: General complaints



Conflict of interests

A key issue in the most serious of this year's complaints was conflict of interests. In recent years, there has been growing public and media attention given to examples of conflicts of interests in business, politics, the public service and even religious organisations. Despite this we continue to encounter individuals, often in very senior positions, who when confronted assert their inability to recognise the most unambiguous examples of actual or perceived conflicts of interests tainting their conduct.

Nearly all public sector agencies have a code of conduct that includes some guidance on avoiding or managing conflict of interests. We believe that the more senior the person, the greater the responsibility on them to be aware of conflicts of interests and set an example by strictly abiding by all the provisions of their agency's code of conduct. Case study 3 details our investigation of the conduct of a chief executive officer, a matter that was very disturbing because of the person's seniority and experience. Case study 5, involving a wife dealing with contracts connected to her husband, might have been thought to be such an obvious conflict of interests that it must be an isolated example. Sadly, it is not. We are currently completing our assessment of a similar complaint about a couple where one partner working in a government agency is alleged to be involved in awarding contracts to her university academic partner.

Because insiders are often best placed to recognise conduct affected by conflicts of interests, it is not surprising that these three cases came to us as complaints that were protected disclosures. Encouraging and supporting whistleblowers is one of the best ways to discourage or detect those who are willing to tolerate the conduct of themselves or their colleagues that involves unacknowledged or inadequately managed conflicts of interests.

For more details about this issue, please see our 'Good conduct and administrative practice guidelines' and our Fact Sheet no. 3 'Conflict of Interests' which is available from our website.

Performance Indicator
Time taken to assess complaints

Target	01/02	02/03
90% within 48 hours	91.14%	89.35%

Interpretation

Our general team aims to assess 90% of complaints it receives within 48 hours.

This year we were slightly under our target.

Refusing to give reasons

We consider that it is extremely important to give reasons for our decisions and we try to ensure all public sector agencies do likewise. Please see section 5 of our 'Good conduct and administrative practice – guidelines for state and local government'. Providing reasons for a decision is good administrative practice for any decision maker. It helps the affected parties to understand the decision and why it was made. Please see case study 4. Clear reasons will inform any consideration about appealing the decision if such a process is available.

While it is generally desirable to give full reasons, there are occasions when this must be balanced against other interests such as privacy, security or potential detrimental effect on ongoing investigations. Complaints about the conduct of individual members of staff can fall into these categories. Agencies may be constrained in releasing full information about the outcome of a complaint about the conduct of an individual staff member if this would unreasonably affect that person's privacy.

This year we received a complaint from the neighbour of a public sector employee. The neighbour relationship was acrimonious and had resulted in several court appearances for minor matters. The neighbour complained the public sector employee was appearing in court during work time. The agency's investigation found this allegation unsubstantiated and advised the neighbour of that result, but refused to give reasons for their decision.

Another case involved a complaint about conflict of interests by a member of staff from the Department of Housing. A man complained that the staff member had arranged public housing assistance for his estranged wife after the staff member had become friends with her. The matter was complicated by serious allegations made against the man by his wife. The department simply advised the complainant that its investigation had been completed, again refusing to tell him the reason for its decision.

In both cases the complainants then contacted us. Our role in these matters is to satisfy ourselves that the agency has handled the complaint properly and its refusal to provide more information to the complainant is reasonable.

We acknowledge that the complainant may find it frustrating if we do not provide more detail about the reasons behind the decision, but for these types of matters they simply have to rely on our judgement, impartiality and integrity as an independent watchdog.

In both examples we considered the investigations conducted by the agencies were appropriate and the decision not to provide more detailed reasons or information was justifiable on privacy grounds.

Case study 3

In January 2003 we received a protected disclosure alleging that Mr Chris Puplick, as both President of the Anti-Discrimination Board (ADB) and Privacy Commissioner, had dealt with several cases in which he had a conflict of interests through friendship with the complainants. We began an investigation during which we obtained case files and relevant policy and procedure documents from both agencies. We interviewed the staff involved and exercised our royal commission powers to obtain documents from other organisations and hold hearings.

The substantial allegation against Mr Puplick was his involvement in a complaint made by a close friend. This person made complaints to both ADB and Privacy NSW in 2000. Mr Puplick had a close friendship with this man and lent and gave him substantial monies. On a day when he lunched with Mr Puplick, this person submitted his complaints. He alleged discrimination and breach of his privacy by his employer. That evening Mr Puplick emailed him at his work address, saying in part: "Hello again Bunny … Your two matters have been assigned by me to appropriate officers and I'll let you know who and when you may expect to hear in due course. I have instructed that they get some priority." Mr Puplick testified that this promise of priority was false advice, given to reassure 'Bunny' who was very troubled at the time. Also, and despite his denials, the evidence pointed to Mr Puplick having provided assistance in the preparation of at least some of Bunny's complaint documents. Mr Puplick at no stage declared a conflict of interests in dealing with his friend's complaints. He continued to loan him money, lunch with him and travel with him. He directly inquired with staff dealing with the complaints as to their progress. As both ADB President and Privacy Commissioner he signed out, and in one case substantially amended, correspondence prepared by case officers to the employer. As Privacy Commissioner, Mr Puplick wrote to his friend and the employer advising that he had made a finding that the employer had breached Bunny's privacy.

The man accepted settlement of his ADB complaint with a net sum of more than $6,000. On that same day Mr Puplick lent him $11,000. In the year following the receipt of settlement monies, Mr Puplick was repaid some of the debt. A condition of the settlement was that the privacy complaint be withdrawn. In testifying, one of Privacy NSW's staff stated that 'I got a feeling that our processes might be a little abused, that in fact the lodging of a complaint with Privacy NSW might be a means to effecting an outcome, in this case in the arena of the ADB'.

We found that Mr Puplick's conduct in this matter was unreasonable and unjust and sending the email was foolish. His role in the complaints was unfair to the employer who could rightly apprehend bias on Mr Puplick's part. It was also unfair to staff at ADB and Privacy NSW who were kept in the dark about Mr Puplick's relationship with the complainant.

There were other complaints where Mr Puplick had a clear conflict of interests. He involved himself in these complaints and either did not declare his conflict, or only did so when prompted by concerned staff. Some conflicts were inevitable, such as when there were complaints to Privacy NSW about the ADB. There were other serious cases of unacknowledged conflicts arising from Mr Puplick also being Chairman of the Central Sydney Area Health Service (CSAHS). In one case a union sought an opinion from Mr Puplick as Privacy Commissioner on how a proposed CSAHS policy would impact on employees' privacy. A CSAHS officer drafted the response and emailed it to Mr Puplick's personal assistant to put it on Privacy NSW letterhead. Mr Puplick signed the letter to the union in his role as Privacy Commissioner.

Our investigation found that Mr Puplick had a poor grasp of the concept of conflict of interests and had repeatedly failed to recognise or manage both actual and perceived conflicts arising from his various professional roles and friendships. He had also ignored the requirements of various codes of conduct. The investigation also focussed on the problems that can arise from one person being both ADB President and Privacy Commissioner and the co-location of the staff of both those organisations.

We found that staff of one organisation had access to complaints and files of the other organisation. We also found that senior managers on the ADB discussed discrimination complaints at meetings where the Deputy Privacy Commissioner was present. These actions were, ironically, contrary to relevant privacy principles as well as legal requirements.

We identified poor complaint handling practices in the ADB, especially gross delays in dealing with many complaints. From a review of a snapshot sample of complaints during the month before and the month after the lodgement of Bunny's complaint, we identified one complaint that was not actioned until over 800 days after it was received. Three others took more than 400 days. In May 2000, over 200 ADB complaints were in a backlog. The Attorney General has accepted our recommendation for an independent and thorough review of complaint handling at the ADB.

Mr Puplick submitted his resignation after receiving our preliminary report. Our final report of 22 May 2003 made ten recommendations to the Attorney General. He has accepted all ten. Some of the key recommendations were that:

- one person should not be both ADB President and Privacy Commissioner
- there should be a review of the co-location arrangements of the ADB and Privacy NSW offices
- the President should be empowered to delegate all his functions except that of delegation
- the Attorney General should consult with the Minster for Health about the need to investigate Mr Puplick's conduct as CSAHS Chairman - Mr Puplick subsequently resigned that office.

Since our final report, a newspaper has reported that Mr Puplick actively involved himself in drafting Bunny's complaint to the ADB, relying on a draft complaint document not provided to us with notes allegedly written by Mr Puplick. Because we were concerned that these media reports may be at odds with information provided by Mr Puplick in sworn evidence and written submissions, we have referred our investigation to the Director of Public Prosecutions and the Independent Commission Against Corruption for their consideration.

Case study 4

A commuter complained to us about the process used to assess route changes as part of the Newcastle Bus Plan. The plan was the first major review of Newcastle bus routes in more than a decade. It was designed to address falling patronage which the STA attributed to the bus system failing to accommodate significant changes in employment, residential development, shopping and leisure activities.

We met with STA staff to discuss how they make and record decisions about route changes. We found that the staff had extensive corporate knowledge and well developed work practices to assist them to make a decision about changes to a bus route. We were concerned though that these practices were not documented in an operational policy or guidelines. Such documentation would help the STA to ensure consistency in their decision-making.

We were also concerned that, although the decision itself was recorded, the reasons for the decisions were not always recorded. For accountability, it is important that the reasons for making discretionary decisions are clearly recorded. It is particularly important to record the reasons for decisions about modifying, deleting or introducing bus routes as they can have significant financial and social impacts. Records of reasons would also be useful reference tools for the STA when considering any future need to change those same routes.

We raised these concerns with the STA and they have since told us they now record the reasons for such decisions and are in the process of developing operational guidelines.

Redress and compensation

If detriment is caused by maladministration, responsible agencies have a moral responsibility to act fairly and reasonably towards the affected person, whether or not they have a legal entitlement to redress.

The guiding principle adopted by most Ombudsman throughout the world is that, wherever possible, people detrimentally affected by maladministration should be put back in the position that they would have been in had the maladministration not occurred. Case study 10 is an example of this. If this is not practicable, other options should be considered. These options may include mitigating the adverse consequences, giving apologies, undertaking to make system improvements or instituting disciplinary action and compensation. If detriment can be readily quantified in financial terms, compensation is generally the core of an appropriate response.

The *Ombudsman Act* contains provisions that not only enable the Ombudsman to recommend payments of compensation, but also empower relevant public sector staff to pay that compensation if the recommendation is accepted.

For more information, please see our 'Guidelines for redress for detriment arising out of maladministration'. This is available from our website.

Case study 7 is one example where we recommended that an ex gratia payment be made to compensate the complainant for the time and expense he incurred in pursuing his quite justified complaint.

We also believe it is essential that agencies develop policies to help staff assess claims for compensation and ex gratia payments. In this way some consistency can be brought to such decisions.

Quite properly, we are not in a position to require agencies to pay compensation or make ex gratia payments. However we can insist on the proper assessment of the available evidence in support of a claim. Please see case study 8.

State Debt Recovery Office and the Infringement Processing Bureau

Last year we experienced a sharp rise in complaints about both the State Debt Recovery Office (SDRO) and the Infringement Processing Bureau (IPB). To cope with these increases, and a corresponding escalation in phone inquiries about these agencies, we are producing a fact sheet for those who seek our assistance that details the timeframes, appeal rights and consequences of all stages of the fine collection and enforcement system. Case study 9 gives examples of the range of issues we have dealt with during the year.

While dealing with individual complaints, we identified more general problems with the IPB's policies, procedures and practices.

Case study 5

We received two protected disclosures about a husband and wife who worked respectively for a university and a major government department. The university did work for the department through a series of million dollar contracts. The wife was a senior member of staff in the department's section that initiated and managed the contracts. The husband gained a senior position in the university unit that fulfilled the contracts. The husband and wife used different surnames.

Our complainants alleged the wife used her position to assist the promotion of her husband. His appointment and a series of his promotions coincided with the award of the section's contracts to the unit. In addition, the wife used a staff member who reported to her to raise false complaints against a senior member of staff in the university unit who was a rival to her husband for promotion. Among other allegations was that the wife gave the husband confidential information concerning contracts and other operations of the department.

The situation was complicated by the fact that the wife had belatedly declared her husband's position to her managers and had taken steps that appeared to distance her from the letting of contracts for which her husband's unit competed. However it appeared that following her declaration, the department took no effective steps to ensure that the wife was unable to use her confidential knowledge and her subordinates to assist her husband's advancement.

Our preliminary inquiries gathered substantial documentary evidence and we interviewed various concerned members of staff. We then sought a meeting with the department's head of Internal Audit. We set out our concerns, noting that a formal investigation by us would be impeded by our lack of jurisdiction to pursue employment related issues. Internal Audit agreed to launch an investigation themselves and provide us with their report. We gave them copies of all the evidence we had gathered – except for those few items that might identify the whistleblowers. Internal Audit showed how seriously they took the case by employing an external investigator, in addition to their own investigators. At the time of writing, the investigation was close to completion. It has already prompted a review of how the department's senior staff should handle issues about conflicts of interests.

Case study 6

A gambler complained to us believing he had won a Lotto prize because the winning ticket appeared to have been registered in his name. In fact, the newsagent who sold the ticket had neglected to remove the complainant's registration details from the machine before selling a winning ticket to another person who retained his ticket and claimed the prize.

Our inquiries found that while NSW Lotteries had correctly determined the prizewinner, it had not given the complainant an adequate explanation of why the other person's claim had been honoured. NSW Lotteries told us they were introducing new software to lessen the possibility of such a situation arising again. This software would give a set of prompts to newsagents and other ticket sellers to switch off registration details at the end of a transaction.

The complainant, who had not retained what he believed was his winning ticket, also claimed an incentive for registration was that registered players did not need to keep their tickets to claim a prize. Our informal inquiries with several newsagents confirmed our complainant may well have been led to believe this. In fact, Lotto game rules explicitly state that entrants must keep their ticket to claim a prize.

Following our inquiries, NSW Lotteries used its weekly newsletter to remind ticket sellers that the public should not be misinformed about the relevant rule ie that to secure a prize, possession of a winning ticket can be essential even for registered players.

Our concerns include several legal issues. One involved section 42 of the *Fines Act* - whether IPB is referring matters to SDRO before properly considering the criteria in this section (the most important being that the fine payment had not been made before issuing the referral). We had already raised this issue with IPB, but their response suggested further inquiries were needed.

Other issues relate to excessive delays in processing (allowing matters to mature beyond the statutory period thus causing IPB to cancel infringement notices that should be enforced) and denying individuals access to the legal system and to a consistent and reliable fine enforcement regime.

Some other systemic issues we identified relate to service issues such as:

- excessive delays - telephone waiting times, responses to written appeals, refunding payments, updating receipt of information onto IPB's computer system
- the quality of information provided to individuals - confusing recorded telephone advice, incorrect advice, multiple reminder notices for the one offence
- flawed decision making when reviewing appeals
- problems with pay by phone and internet
- denial of receipt of correspondence
- the general quality of IPB's letters.

When we raised our concerns, IPB indicated that their relocation from Parramatta to Maitland and the implementation of a new computer system had caused some technical problems. They also told us that, as a result of an increase in complaints, they had adopted a more lenient approach.

Although IPB has made some attempt to address individual issues, we believe that the broader issues require us to make further inquiries.

In recent months, SDRO's attempt to collect very old unpaid fines has also attracted significant public attention. Members of Parliament and some media have claimed SDRO is seeking to recover monies that have either already been paid, from the wrong person, sometimes even from dead people.

We have raised many of these matters with the SDRO in the past and they did take some action at the time. We are pleased to note advice from the SDRO that they have introduced new procedures to resolve complaints about historical matters. We will continue to monitor this situation to ensure the efficacy of the new procedures.

Case study 7

In April 2003, we finalised an investigation of a fisherman's complaint about NSW Fisheries. Our report recommended the department make an ex gratia compensation payment to the complainant, essentially because it had wrongly placed departmental policy above the requirements of relevant legislation to the disadvantage of the complainant.

The complainant had applied to the department for an "endorsement" to fish in a particular area. He also applied for the "validation" of his "catch history" - that is, the department's recognition that he had caught a certain quantity of fish over a number of years. The extent of the complainant's validated catch history was potentially critical to whether he was entitled to particular fishing endorsements. As part of his catch history application, the complainant claimed he was entitled to 25% of the catch recorded in another fisherman's name. The basis for this claim was that he had been an equal partner with the other fisherman and two other people while working on the fisherman's boat.

Departmental policy was that it would only recognise a shared fishing arrangement if there was a signed agreement to that effect between the parties. The other fisherman was only prepared to allocate 10% of his boat's catch to the complainant. Since the complainant could not provide a signed entitlement to 25% of the boat's recorded catch, the department was not prepared to accept the complainant's claim in determining his catch history or fishing endorsements. However, the department advised the complainant that he could seek a review of their decision through a review panel established by the Minister. The complainant subsequently sought such a review.

The relevant legislation required the panel to review the department's decision and provide the Minister with a report. The Minister could then adopt the panel's decision or refer the matter back to the panel for further consideration. The panel heard evidence from the complainant and the other fisherman and decided that the complainant was entitled to 25% of the other fisherman's recorded catch history. However the panel also said it "did not have any statutory authority to give any direction or recommendation and has undertaken the exercise for the convenience of the Director [of the department] in order to try to assist him in the discharge of his responsibilities". When nothing subsequently happened, the complainant's solicitor asked the Director whether he had adopted the review panel's decision. The Director replied that, in accordance with the department's policy, he would not do so without a signed agreement. The solicitor subsequently lodged his complaint with the Ombudsman

After preliminary inquiries, we decided to formally investigate the conduct of both the department and the review panel. We asked for relevant departmental files and answers to various questions. We were particularly concerned about the interpretation by the department and the panel of the regulation governing the exercise of the panel's functions, and expressed a provisional view that this interpretation was incorrect. This prompted the department to seek advice from the Crown Solicitor. In November 2002, the Crown Solicitor confirmed our view that the department and the review panel had been mistaken in interpreting the regulation governing the panel's functions, and that the review panel was required to make a report on the matter for the Minister's consideration. The panel had in fact prepared a report for the Minister - however, the Director had not supplied the report to the Minister on the basis that 'existing policy does not need to be referred to the Minister'.

The department's action abrogated the very purpose of the review panel which was created in legislation to help the Minister deal with such disputes. Our report pointed out that the practical effect of the Director's decision was to deprive the complainant of the opportunity for the Minister to consider the matter. We therefore recommended that the department should make an ex gratia payment to the complainant to compensate him for the time and expense he had wasted in pursuing a review of his catch history through the review panel. We also recommended compensation for the "bother and inconvenience" of having to make a complaint to the Ombudsman. The department accepted our recommendations and paid a substantial sum to the complainant.

Case study 8

In September 2002, we finalised an investigation prompted by the Attorney General's refusal to make an ex gratia compensation payment to a complainant. We examined the adequacy of the advice given to the Attorney General by his department, and whether he had or may have been misled by this advice. The compensation request arose from the complainant's conviction for maintaining an escaped prisoner, resulting in a 10 months periodic detention sentence. He appealed his conviction but was refused bail pending the outcome. By the time the appeal was actually heard, the complainant had already served his sentence. The Court of Criminal Appeal quashed the complainant's conviction, primarily on the ground of insufficient evidence to support the jury's verdict. The court was also critical of the fact that some unduly prejudicial evidence had been admitted at the complainant's trial, noting that the Director of Public Prosecutions (DPP) should not have sought admission of that evidence.

The complainant then sought compensation from the Attorney General for the "financial and emotional trauma" he had suffered. The Attorney General refused this request in 1996. In following years, the complainant, his solicitor, his local Member of Parliament and a barrister sought reconsideration of the Attorney General's decision, without success.

In 2001, the complainant told us about the involvement of the Attorney General's department in the matter. He criticised the adequacy of the department's assessments of the various requests for compensation and consequent briefings to the Attorney General. We had previously prompted the department to provide the complainant with copies of these documents under Freedom of Information legislation.

After extensive preliminary inquiries with the department, we initiated a formal investigation. This involved careful analysis of the department's documents and its answers to our questions about the adequacy of its assessments and briefings. We were particularly concerned about the weight the department had given to advice from the DPP that, in his opinion, the prosecution of the complainant "was correctly brought and carried out". As noted above, the Court of Criminal Appeal had criticised the DPP for seeking the admission of unduly prejudicial evidence at the complainant's trial. The department's own guidelines for ex gratia payments indicated that compensation could be paid where a conviction had been quashed and there was "clear evidence of fault or error in the manner in which the prosecution was conducted".

Our final investigation report noted that the Attorney General "should be confident that any advice provided by the department is sound and complete and gives a full and accurate picture of the relevant issues". We found that, in this case, the department's original assessment of the complainant's request for compensation was inadequate and had the potential to mislead the Attorney General. In addition, the department had provided deficient interpretations of the material at hand when the Attorney General was required to respond to further representations about the matter. We were particularly critical of their failure to properly assess the significance of the Court of Criminal Appeal's observations. We recommended that the Attorney General should seek further "independent" advice and reconsider the complainant's compensation request. The Attorney General accepted this and obtained advice from the Solicitor General. After considering this advice and reviewing further evidence, the Attorney General ultimately decided in June 2003 that an ex gratia payment to the complainant was not justified.

Our report also noted that although the Attorney General's department had some 'guidelines' for considering applications for ex gratia payments, these were not in an identified policy document. We pointed out that such a document would be helpful to staff, promote better decision-making, and assist the public to understand how discretionary decisions about compensation payments were made. We therefore recommended the department develop a formal policy on assessing applications for ex gratia payments. This recommendation has been accepted and we are awaiting confirmation that they have implemented an appropriate policy.

Case study 9

- A car belonging to a non-English speaking woman was stolen and, while stolen, was involved in 18 separate traffic offences. Although the woman had reported the theft, there was a gap in police records for part of the time the vehicle was missing. We were able to assist the complainant to prove to the Infringement Processing Bureau (IPB) that the car had been stolen at the relevant time and the fines were withdrawn.
- A man complained about a fine being referred to the State Debt Recovery Office (SDRO) for enforcement action when he had elected to have the matter heard at court. It turned out that the referral had been an administrative error. The fine was withdrawn from the SDRO and the man received a summons to a court hearing.
- Another man who wished to dispute a fine he received was unable to do so because the IPB failed to process his court election. As the matter had become statute-barred by the time we inquired about the man's complaint, the IPB withdrew the fine altogether.
- A complainant elected to have a fine heard at court. Instead, the matter was referred to the SDRO. She sought an application form for annulment of the fine but was sent the incorrect form. The SDRO apologised and gave her the correct form.
- When people send payments to the IPB after fines have been referred to the SDRO, the IPB should refund the fine monies to the payers. Unfortunately, this process can be slow and refunds to some people have been delayed up to several months. Where an emergency indicated a complainant should be refunded quickly, we asked the IPB to make repayment a priority while the SDRO agreed to suspend further enforcement action until the repayment was made.
- A man complained about being penalised for late payment of fines. He had attempted to pay the fines on the due date, but the phone payment system was inoperative that day. Assuming the fines would be automatically transferred to the SDRO on the following day, the man did not attempt to pay after the due date. Although the fines were not transferred for some days, because of the failure of the phone payment system on the due date, the IPB agreed to withdraw these fines from the SDRO and accept late payment.
- A clerical error by the IPB resulted in them replying to representations about a matter that a man did not wish to contest, and failing to respond to his concerns about a matter he did wish to contest. When we told the IPB of the mistake, they decided not to pursue the fine the man had wanted to contest.
- A Perth man vacationing overseas loaned his vehicle to a man who generated a fine for a NSW traffic offence. Although the vehicle driver signed a statutory declaration accepting responsibility for the fine, communication difficulties resulted in the matter being referred to the SDRO. These cases can generally be resolved by applying to the SDRO for annulment of a penalty notice enforcement order under sections 48-52 of the *Fines Act 1996*. However because the complainant lived in Perth, the opportunity to take this matter to a NSW local court was not a viable solution. The IPB therefore agreed to withdraw the matter from the SDRO, accept late payment, and consider transferring liability for the fine to the vehicle's actual driver.
- The IPB failed to respond to representations a South Australian made about a traffic infringement notice before referring the matter to the SDRO. When we prompted the IPB to review the case, rather than require the man to attend a NSW court to exercise his right to a hearing, they decided to withdraw the fine.
- A hire car company received a number of fines attaching to vehicles they had disposed of before the offences. Despite representations to the IPB, these fines were sent to the SDRO. When we identified this administrative error, the IPB withdrew each of the disputed fines.

Case study 10

A migrant nurse complained that the Far West Area Health Service (FWAHS) did not honour its undertaking to sponsor her application for permanent residency. Documents suggested FWAHS led her to believe it would support her permanent residency application once in Australia. Based on this apparent assurance, the complainant sold her house in South Africa and moved her family here. The complainant had attempted to resolve the problem directly with FWAHS. She felt she had exhausted all available avenues because her case fell outside the jurisdiction of all the agencies she had been referred to.

Our initial inquiries suggested, and we later confirmed that, FWAHS had no clear policy on permanent residency sponsorship. We were told that if a nurse working on a sponsored visa wrote to the human resource manager after 12 months service and sought permanent residence sponsorship, the request would generally be granted. We were told that sometimes, when nurses fulfilled their temporary visa commitments and sought permanent residency (usually due to a desire to remain in the area), FWAHS supported permanent residency applications. Recruitment and retention of staff is a significant challenge for FWAHS given the remoteness of the area. Sponsoring skilled worker category nurses was a strategy for providing stability of services by virtue of their visa's duration. FWAHS told us it was prepared to support our complainant's permanent residency application after three years satisfactory service.

We felt the complainant was inadequately advised of this three year requirement at the outset. Also, she was never given a formal response to her request. We were also concerned that the complainant appeared to receive conflicting information about what she could expect once in Australia. FWAHS acknowledged the misunderstanding and undertook to process sponsorship for permanent residency for the complainant.

Performance Indicator
Average time taken to determine complaints

Target	01/02	02/03
7.1 weeks	7.1	5.17

Interpretation

Our general team aims to take on average 7.1 weeks to finalise complaints (not including those about freedom of information). This year we finalised complaints two weeks earlier than our target.

Performance Indicator
Reports recommending changes to law, policy or procedure

Target	01/02	02/03
80%	81.0%	92.3%

Interpretation

We aim to include in 80% our final investigation reports recommendations for improvement. This year we included recommendations in over 92% of our reports, which was above our target.

Performance Indicator
Complaints resolved through the provision of advice or constructive action by public sector agency (including freedom of information complaints)

Target	01/02	02/03
65%	66%	64%

Interpretation

This performance indicator refers to the percentage of general team complaints that were:

- declined at the outset or after preliminary inquiries by providing the complainant with information or advice on applicable law and procedures, or suggestions of how to resolve the complaint with the agency concerned
- resolved to our satisfaction by the agency following our preliminary inquiries or other intervention
- formally conciliated

The result is slightly under our target.

Performance indicator
Recommendations implemented

Target	01/02	02/03
100%	91%	100%

Interpretation

We aim to have all recommendations that we make at the end of our formal investigations implemented.

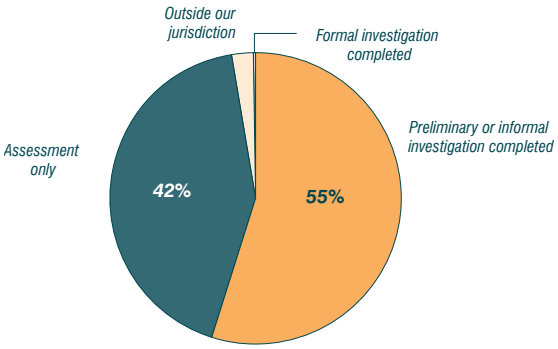
This year all of the recommendations made by the general team were implemented.

Local government

Introduction

The number of complaints about councils in 2002-2003 was similar to the previous year. Customer service issues such as poor complaint handling, failure to notify or consult and failure to reply to correspondence together with objections to development and problems about enforcement continue to be the most common cause of complaint.

*Figure 19: Local councils complaints received and determined**



* This figure shows complaints determined (written)

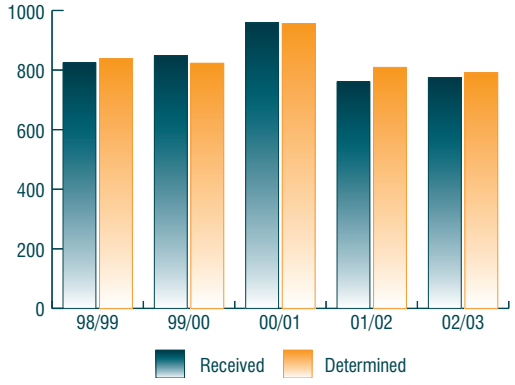
Complaints received	
Written	774
Oral	2,226
Request for review of our decision	103
Total	3,103
Complaints determined (written)	
Preliminary or informal investigation completed	434
Assessment only	336
Outside our jurisdiction	19
Formal investigation completed	2
Formal investigation discontinued	0
Total	791
Current investigations (at 30 June)	
Under preliminary or informal investigation	57
Under formal investigation	3
Total	60

There was a 23% overall rise in complaints about development issues this year. A small number of these complaints were about refusal of development applications (DAs) or objections to consent conditions where the complainants had clear rights of appeal to the Land and Environment Court.

The Ombudsman has no jurisdiction to investigate such matters unless there are special circumstances.

The majority of development complaints concerned objections from neighbours to developments on adjoining properties and complaints about unsatisfactory DA processing. Unfortunately, in many of these cases, there is little scope for review because the developments have already begun and only the court can overturn the approval decision. The rights of adjoining owners to be notified of development applications and given the opportunity to lodge objections have been seriously eroded over the past decade.

Figure 20: Local council complaints received and determined – five year comparison



	Received	Determined
98/99	824	838
99/00	848	823
00/01	959	956
01/02	760	809
02/03	774	791

During the 1980s, many councils began notifying adjoining owners of building applications as part of their standard assessment process following a number of reports by the Ombudsman, some celebrated legal cases and later amendments to the law. More recent amendments to the *Environmental Planning and Assessment Act* made in the interests of simplifying the development process have meant that, in the majority of development applications, notification obligations are now matters of discretion for many councils.

Significant increases in medium density housing in the Sydney region in particular have contributed to a growing disquiet among many citizens. They feel they are being cut out of a development assessment process that often results in significant detrimental impact on their lifestyle and amenity. Such unrest is being expressed in increased community and political action over development issues. A number of councils have responded in innovative ways. Some have introduced mediation services to facilitate compromises in plans the subject of neighbour objections before they are formally assessed. Others have introduced independent assessment panels to remove such decisions as far as possible from the political realm. In the interests of natural justice, we continue to believe that councils should consult adjoining neighbours on development applications wherever possible.

A copy of 'Enforcement Guidelines for Councils' was provided to each council free of charge.

Councils as model citizens

We take the view that public sector agencies should be model citizens in the same way that government policy states they should be model litigants. The public are entitled to rely on them doing the right thing. This includes performing their functions in a responsible and transparent way. If any wrong or improper conduct is uncovered, agencies should accept responsibility and try to address any problems that the wrong conduct has caused.

During the year, a ratepayer made a claim on a council for water damage to their property. The damage had been caused by defective work by a contractor who the council had engaged to replace a footpath. The council put the claim into the hands of their public liability insurer and sought legal advice.

The council's insurer advised the ratepayer to pursue the contractor – and council did not dispute this even though it appears to have known that the company no longer existed. Although the legal advice obtained by the council was that council was liable for the damage, the lawyers recommended that liability not be accepted and a strategy of 'wait and see' be adopted. Council accepted this advice. Notwithstanding the apparent conflict of interests, the solicitors appeared to be acting for both the insurer and the council in the matter.

The ratepayer complained to us because no action was being taken on his claim. We made inquiries with the council and received some information from them. We subsequently received requests from council's solicitors that we return certain documents which they said were subject to legal professional privilege. They also asked us not to speak directly with council staff about the matter any further. We refused these requests. They requested again. We refused again. We also noted that, while it may have been in the interests of the insurer, it was not in the interests of council to refuse to speak with us about the matter. We gave council a copy of our letter to their solicitors and we heard nothing further. A follow-up phone call to council elicited the information that they had instructed their solicitors to settle the matter. In doing so, council made no admission of liability. We checked with the complainant who was happy with the settlement.

In our view, it was not appropriate for the council to adopt the advice of their solicitors in this case. By doing so, they demonstrated a disregard for the interests of the ratepayer and an irresponsible approach to accepting responsibility for a legal liability. The interests of an insurer are not necessarily those of a public agency. There are overarching responsibilities to act ethically which go beyond commercial advantage or business practicality.

The ratepayer in this case was put to the inconvenience of organising the remedial works and then dealing with the insurer for over 12 months before being recompensed for their expenses. In circumstances where liability should not have been in question, it is unacceptable for a public agency to behave in this manner.

Figure 21: Nature of local council complaints

Issue	Written	Oral	Total
Building (not after 1/7/98)	0	5	5
Community services	11	19	30
Corporate/Customer services	231	422	653
Development	127	561	688
Enforcement	112	274	386
Engineering services	86	137	223
Environmental service	44	176	220
Management	6	18	24
Misconduct	42	103	145
Non-jurisdictional issues	15	29	44
Object to decision	38	174	212
Rates charges & fees	43	175	218
Strategic planning	12	28	40
Uncategorised	6	105	111
Other	1	0	1
Total	774	2,226	3,000

Suspension of councillors

Many councils continue to face problems in dealing with instances of misconduct by councillors. Last year we highlighted difficulties for councils investigating breaches of their codes of conduct without denying procedural fairness. An investigation this year highlighted deficiencies in the sanctions available to councils when such breaches occur.

Queanbeyan City Council's recent history has been marked by considerable conflict among councillors. They attempted to strengthen their code to deter misconduct, apparently out of concern that the sanctions in the previous code were not onerous enough to compel compliance or to address the types of behaviour that arose from the conflicts. They incorporated new sanctions for breaches of the code that enabled them to suspend a councillor for a period nominated by resolution and to reduce their annual fee proportionately for any period during which they were suspended. While council had never imposed these sanctions, the complainants argued they were beyond council's power to impose.

We found that council did not have the power to impose these types of sanctions or to reduce the councillor's annual fee. The sanctions should therefore not have been incorporated into the code of conduct. We also considered the power of suspension to be so broadly framed as to allow council to impose a permanent suspension. This potentially could allow a majority to effectively negate the election of individual councillors. We found the two sanctions to be unreasonable and recommended that council amend their code of conduct to remove them.

During the course of the investigation, we became aware of two other councils with similar histories of conflict that had considered incorporating similar sanctions into their codes of conduct. Neither council subsequently did so, but the cases did suggest that councils felt a need for a 'sin bin' mechanism to deal with serious misconduct by councillors.

We recommended that the Department of Local Government issue a circular to councils to clarify sanction powers. We also recommended that the Minister for Local Government take steps to initiate amendments to the *Local Government Act* to empower an independent person or body to suspend councillors for serious and/or repeated misbehaviour, including serious and repeated breaches of a council's code of conduct. The Minister advised he was considering proposals that would address the issues raised by councillor misbehaviour without unduly limiting the significant level of autonomy councils are granted in carrying out their functions. We look forward to these amendments, as do many councils.

Non-pecuniary conflicts of interests

Uncertainty amongst both staff and councillors about how to identify and deal with non-pecuniary conflicts of interests continues to lead to a number of complaints to the Ombudsman. This is particularly a problem for councillors who

Case study 11

Residents of Lake Macquarie City Council complained of council's failure to take action against their neighbours who had excavated next to a retaining wall. The excavation had caused the wall's collapse and significant erosion on their property. Building a suitable retaining wall was a condition of council's development consent.

In response to our inquiries, the council immediately visited the site. They told us they would issue a notice of intention to serve an order under the *Environmental Planning and Assessment Act 1979* and the owners of the property would be required to rebuild the wall and maintain its integrity.

Case study 12

A number of Sutherland Shire Council residents raised concerns that council had not enforced a condition of consent relating to a residential block of town houses.

Residents had lodged objections to the development because of the traffic hazards they believed it would create. Council had addressed these by including a condition requiring the developer to provide a traffic refuge on the feeder road. Unfortunately, the private certifier issued an occupation certificate before the refuge was constructed. Some years later, as the traffic increased, the residents wrote to council. Council told them it would pursue the construction of the refuge with the developer. After several months of apparent inaction, and no response from council to numerous letters from residents, one irate neighbour complained to us.

Our inquiries showed that council had made several unsuccessful attempts to get the developer to complete the refuge. Because an occupation certificate had been issued and the townhouses were already sold, there was little more council could do to enforce the condition. However since private certifiers have become involved in large projects, council has had a policy of requiring developers to pay large bonds. This enables council to complete work required under conditions of consent at the developer's expense - if an occupation certificate has been issued without the work having been completed.

Council had already decided to use the bond money to construct the refuge. However, they had not responded to the residents' letters because they believed that the local member, who had also been receiving letters from residents, would keep them informed. Council acknowledged that this was poor customer service and agreed to write to the complainants explaining the situation.

Case study 13

We received a complaint about Kempsey Shire Council levying a search or retrieval fee for a copy of an approval granted the previous year. The complainant's house had been burgled and some important documents had been taken. He went to council to request a copy of council's septic tank approval and was informed that the copy would cost $38.50. We made inquiries with the council and were told that the charge was in accordance with the schedule of search charges in its fees and charges policy.

We wrote to the general manager and had discussions with senior staff on the provisions of s.12 of the *Local Government Act.* Section 12(1) lists the documents that must be available for public inspection. The list includes 'records of approvals granted'. The inspection right includes the right to take away a copy for free or council may apply 'reasonable copying charges'. We took the view that the 'search or retrieval fee' did not conform with the provisions of section 12 or its intentions.

Council reviewed its fees and charges policy and amended the section relating to search fees to exclude charges for documents covered by section 12. They also refunded the amount of the search charge to the complainant.

often have a broad but ill-defined range of options available to them under most councils' codes of conduct for dealing with such conflict.

This year we completed an investigation of a complaint alleging that a councillor of Newcastle City Council participated in a decision by council's Development Approvals Committee (DAC) to reject the complainants' DA, despite being personal friends with one of the objectors. The complainants lodged a DA with council for renovations to their house. A number of their neighbours objected to their proposed plans. Over a period of nine months they amended the plans five times and participated in two mediations in an unsuccessful attempt to address their neighbours' concerns. In that time the proposal was also considered and deferred by the DAC so the complainants could reconsider their plans. The complainants alleged council staff and councillors told them their DA was 'political' and that committee members were 'hot on this one'. The complainants also alleged they were told that two of their objecting neighbours were members of the same branch of the ALP as one of the councillors and were close personal friends with her.

Before the DAC reconsidered their DA, the complainants complained to the general manager that the councillor had a conflict of interests and expressed concern she would be participating in the consideration of their DA. The general manager responded advising that responsibility for declaring an interest lay with the councillor. At the meeting that followed, the councillor made no declaration of interest and the DAC resolved to reject the DA.

After they complained to us, the complainants sought a review of the decision under section 82A of the *Environmental Planning and Assessment Act* submitting further revised plans. These plans were subsequently approved. We found no evidence to suggest the councillor had dealt with the DA on anything but legitimate planning grounds. However, the question of whether the councillor had a conflict of interests turned on the nature and depth of her relationship with the objectors. Given its intangible nature, this was difficult to determine. Our investigation disclosed no evidence that the relationship was anything but that of casual acquaintances. We therefore considered that any personal or private interest she had in relation to the DA was at best marginal and therefore unlikely to have given rise to a conflict of interests as defined under council's code of conduct. Even if it were accepted that her relationship with the objectors did give rise to such a conflict, we did not consider it was such as to preclude her from participating in the consideration of the DA under the code.

We agreed with the general manager's advice to the complainants that responsibility for a declaration of interest lay with the councillor. However, as this case demonstrates, non-pecuniary conflicts of interests are often far from clear-cut. It can be difficult for councillors to determine whether they have a conflict of interests and what course of action they are required to take in meeting their obligations under the *Local Government Act* and their code of conduct.

Case study 14

A resident of Liverpool City Council complained about the way council had dealt with her DA to operate a beauty salon from her home and its failure to respond to her inquiries about its progress.

The complainant submitted her DA in January 2002. Council requested more information in April and again in June to allow the application to be properly assessed. By August, when the complainant had heard nothing from council, she assumed there was a problem and decided to cancel the DA and seek a refund of the $942 application fee. She contacted council for the refund and was told that approval had already been given in May and that council was therefore unable to refund her fee. The complainant could not understand why council had asked her for further details in June if it had already approved the DA in May. In September, she wrote to the general manager to complain but by January 2003 had received no reply.

Our inquiries showed that the planning officer involved had been taken ill and had left the incomplete file and a draft letter of approval on her desk. The complainant's letter of complaint addressed to the general manager was also on the file awaiting action. The file had sat on the officer's desk unattended for six months until we contacted council. Council agreed that this represented a serious failure of its file management practices and its customer service. At our suggestion, council agreed to refund the DA fee.

Case study 15

A resident of Ku-ring-gai Municipal Council complained about the delay in processing his application to remove a tree from his property. He had applied, under s.82A of the *Environmental Planning and Assessment Act,* for a review of council's initial decision to refuse his application. Two years later, council finally completed the review and confirmed the initial refusal. They did not apologise for the two year delay. They also neglected to inform the complainant that he could appeal council's decision to the Land and Environment Court. We examined council's overall turnaround times for tree removal applications and review requests. These suggested the delay in determining the complainant's s.82A review was not typical. We asked council to write to the complainant to explain the reasons for the delay and to apologise for it.

Council maintained that the complainant had no right of appeal on a review. They believed the only avenue of appeal open to him would be to make a fresh application. If that was refused he could then appeal that decision to the court. We disagreed with this view and asked council to seek legal advice. This advice confirmed our view that the complainant did have a right of appeal in relation to council's review determination under s.97 of the *Environmental Planning and Assessment Act.* Council subsequently informed the complainant of his rights.

Case study 16

An absentee landowner discovered that Mid Coast County Council had constructed a sewerage pumping station that encroached on her property. She had received no prior notification and had not given consent. Council failed to respond to her several approaches about compensation for these works. We contacted council and they confirmed that they had encroached on the complainant's property in error. They told us they had not made a final decision on compensation but had requested a property valuation from the State Valuation Office. We asked whether the valuation report was based on the value before or after the work had been done on the property. As a result, council sent the valuation back for additional information.

In response to our inquiries, council issued a written apology to the complainant about the encroachment and their delay in responding. They also provided a copy of a valuation report with both before and after works valuations. Based on these valuations the council offered to compensate the complainant, giving her the option to sell all or part of the affected property.

To assist councillors we suggested that Newcastle City Council establish an ethics panel consisting of the general manager, the mayor and an appropriately qualified member of staff such as an internal solicitor or auditor. We also suggested council amend its code of conduct to enable councillors to refer to the panel questions of whether they have a conflict of interests and, if so, what course of action they should take. Decisions by the panel would be made in writing and include reasons. Their decisions would not be binding on a councillor, just something they should take into consideration when deciding whether to declare an interest in relation to a matter. However, to ensure transparency and accountability, the panel's decision would be published in the business papers relating to the matter in which the alleged conflict has arisen. The panel's decision could also be a relevant consideration (as would any failure by a councillor to refer a matter to the panel for advice) in subsequently dealing with any allegation that a councillor has breached the *Local Government Act* or code of conduct by failing to declare the interest.

We recognised however the potential for the panel to cause undue delay to matters due to come before council if a referral was used as an excuse to defer discussion. It is also only a suitable mechanism for considering conflicts of interests that are declared in advance. We therefore also recommended that council establish alternate procedures for dealing with matters referred to the panel as a matter of urgency.

While this precise model may not necessarily be appropriate for all councils, a number of councils are now experimenting with such models. The general manager of Newcastle City Council advised that our investigation helped councillors and staff to have a better understanding of the issue and disclosure of conflicts have been more frequent as a result.

Transparency in the application of development bonuses

An MP wrote to us concerned about the public consultation process for the redevelopment of the St Margaret's Hospital site at Surry Hills and, in particular, South Sydney City Council's decision to grant bonus floor space. Council granted bonus floor space in return for the provision of community and public open space and a public art program. The MP alleged the approval granted a floor space ratio (FSR) that greatly exceeded the FSR and bonus originally proposed and notified. She questioned the value of public consultation in setting development standards if these are exceeded through negotiations between developers and councils.

Council's bonus floor space policy is based on its Development Control Plan 1997 which it adopted with the concurrence of the then Department of Urban Affairs and Planning. The DCP makes bonus floor space available subject to the provision of 'material public and community benefits'. These benefits may include the dedication of publicly accessible space, through-links, street closures and public art.

The public need met by the developer had been previously identified by council. Furthermore, the subsequent DA was

Case study 17

We received a complaint from a cyclist about the problems he had had trying to get some maintenance work done on a pedestrian underpass to Gardeners Road.

A number of agencies were involved in the construction and maintenance of the underpass. The complainant initially approached the RTA about removing graffiti from the walls and repairing the lighting in the tunnel. The RTA referred him to Botany Bay City Council. They referred him to South Sydney City Council who referred him back to the RTA. In total frustration he wrote to us.

The underpass had a complex history and its maintenance had been the subject of some dispute between the RTA, Botany Bay City Council and Randwick City Council in the past.

In 1968 Botany Bay City Council had agreed to contribute one third of the cost of its construction and then the full cost of its maintenance. However, this information had been lost from council's corporate memory and was now only available from the RTA. In 1969 Randwick City Council offered to assist with maintenance of the tunnel. South Sydney City Council later became involved when there was an exchange of small areas of land between it and Randwick City Council.

The RTA sent us documents setting out past arrangements for maintenance. We sent these to the councils and arranged for Botany Bay and South Sydney City Councils to meet to negotiate arrangements for current and future clean ups.

Case study 18

A councillor complained about the way the general manager dealt with her complaint about another councillor who she suspected of impropriety in claiming travel allowances. There turned out to be no substance to the original allegation.

However the councillor claimed that, after orally reporting the matter to the general manager, council's director of corporate services subsequently discussed the matter with her during a morning tea with other councillors and staff in a small crowded room. He did so within earshot of the councillor against whom she had made the allegations.

All parties appeared to agree that the director's actions were nothing more than an innocent but clumsy attempt to make conversation with the councillor. Everyone however, including the director, agreed that his actions were inappropriate.

The complaint also raised a number of issues about the adequacy of council's internal reporting systems for protected disclosures. It also became clear that council had neglected to identify its internal reporting policy in its summary of affairs as required under section 14(3)(a) of the *Freedom of Information Act*.

As a result of our inquiries, council reviewed its internal reporting policy and adopted a revised policy based on the model one in our *Protected Disclosures Guidelines*.

The revised policy was circulated to councillors. We suggested it should also be circulated among staff. Council also agreed to consider providing information sessions on the policy for councillors and staff.

As the nominated disclosure officers, both the general manager and director acknowledged that all such issues raised by councillors should be actioned as formal complaints. Council now has forms to complete to raise matters under the internal reporting policy and will include the policy in its future summaries of affairs.

approved by council on the basis that it was consistent with the performance criteria for height, bulk, FSR and urban design in the applicable Local Environmental Plan and DCP. It therefore seemed that this was not a case of council having approved a development, that would have otherwise been inappropriate, on the basis that the developer had agreed to meet a public need.

Our inquiries also showed that council went through a proper notification process in relation to the original Masterplan for the project, the amended Masterplan and the DA for the site. The combined FSR subsequently approved was publicly notified at the amended Masterplan stage. There was also no evidence to suggest that council failed to appropriately consider objections in making decisions about the proposal.

Our inquiries of the then Planning NSW suggested that the practice of granting development bonuses in return for a material public benefit is not uncommon. It seems this may have developed as a practical way of securing public benefits that could not otherwise have been obtained through the development consent process.

However we shared the complainant's concerns about the transparency and accountability of such bonus schemes. Of particular concern is the potential for abuse of such schemes to approve developments that would otherwise be unacceptable on the basis of the provision of 'sham' public benefits. We therefore asked Planning NSW to consider developing best practice guidelines for councils to help them exercise their discretion in granting bonuses in return for public benefits. We suggested that these guidelines advise councils to:

- Prepare, with public consultation, a social plan identifying in advance public needs that may be met through a bonus scheme.
- Identify the scope of any bonuses available to developers in their DCPs to prevent councils from granting bonuses on an ad hoc basis. Councils are required to follow a statutory public consultation process in preparing DCPs.
- Apply normal assessment processes to developments potentially benefiting from bonuses. This would ensure that developments that would not normally be considered to be appropriate on a merits assessment are not approved simply because a public need is being met by the developer.

To ensure greater accountability and provide checks on any abuses, we also suggested Planning NSW consider taking steps to make developments benefiting from bonuses subject to similar statutory notification requirements as designated developments.

Planning NSW told us that they would consider these matters when developing broader guidelines on flexibility provisions in the planning system.

Tree removal applications

Procedures governing the removal of trees have featured prominently and regularly in the media.

The legislation allows councils considerable scope in the way they administer tree removal applications. They can adopt tree preservation orders (TPO) under clause 8 of the Environmental Plan and Assessment Model Provisions 1980 or they can regulate applications directly under their local environmental plan (LEP).

We understand that applications for the removal of trees under either a TPO or an LEP are DAs for the purposes of Part 4 of the *Environmental Planning and Assessment Act*. This means that:

- the applications would be subject to a council's notification policy
- applicants would have a right of review under section 82A and a right of appeal to the Land and Environment Court under section 97, and
- council would be obliged to notify the applicant of these rights under clause 100(1)(j) of the regulation.

However in the course of dealing with the complaint referred to in case study 15, our inquiries with Ku-ring-gai Council and a number of staff of what was then Planning NSW suggested this view was not universally held. We decided to survey the practices of several other councils and found a wide variation in practices in relation to such applications. For example at some of the councils we spoke to, a tree preservation officer assesses and determines tree removal applications. If dissatisfied the applicant may request a review of the decision and another tree preservation officer will conduct a fresh assessment. If the original decision is affirmed, the matter is closed. Those councils had never considered the question of whether applicants had the right to appeal.

Legal advice subsequently obtained by Ku-ring-gai Council supported our original view.

The confusion and wide variations in practice we encountered prompted us to write to Planning NSW. We suggested that councils might benefit from some guidance as to whether applications for removal of trees are applications for development consent under Part 4 and whether the relevant appeal and review mechanisms apply. This will assist councils to ensure they comply with their statutory obligations in dealing with tree removal applications and to decide whether their notification policies apply.

Dealing with difficult complainants

Councils often write to us for advice on particular issues or ask us to review their draft policies.

The issue councils most commonly seek our advice on is how to deal with difficult complainants.

We recognise that just as councils have certain obligations to the communities they service, members of the community wishing to complain to their council have responsibilities too. These include:

- communicating with council staff in an appropriate manner
- giving councils all relevant information about their complaint at the outset
- not making excessive and unreasonable demands on the resources of councils.

Our publications, '*Dealing with Difficult Complainants*' and '*Better Service and Communication Guidelines for Local Government*', outline limits councils can reasonably impose on complainants who are unwilling to accept their responsibilities. Increasingly, councils are adopting difficult complainants policies based on the principles set out in those publications. Although this is a positive development, it is important that councils remember that any restrictions they impose should not be inconsistent with any statutory and other legal obligations they owe to residents. Case studies 19 and 21 illustrate the need to ensure restrictions comply with the requirements of procedural fairness and do not prevent a council from meeting its broader customer service obligations.

Serious flooding as the result of inadequate drainage – see case study 20 for details

In imposing restrictions, councils also need to make sure they continue to comply with their statutory obligations. A council once wrote to us seeking our 'assistance to provide the means whereby permanent action' could be taken to prevent a resident from disrupting council meetings. The council previously dealt with this conduct by adjourning its meeting until the police attended to remove him. However on one occasion the council did not adjourn the meeting and the resident continued to scream over the top of councillors throughout the meeting.

We advised that, except for being able to close a council meeting to deal with disorderly conduct at a particular meeting, the current *Local Government Act* does not allow councils to prevent members of the public from attending council meetings. Also, we would not support any proposed amendment to the Act or the Meetings Regulation to allow a

Case Study 19

A long-term patron of a council owned caravan park complained he had been banned from using it without being given proper reasons.

He had complained to council after he was unable to secure a site large enough for his caravan, a four-wheel drive, a boat and an annexe. He claimed this was the result of his earlier complaints about the park managers. Four senior council staff attempted to deal with the dispute.

During this time, the caravan park managers told council they felt threatened by the complainant. Council advised the complainant of this and told him not to contact them directly again. The complainant did contact the managers and this added to their perception that he was acting in a threatening manner. As a result, council told the complainant he was no longer welcome at the caravan park.

The complainant subsequently complained to council about the decision to ban him from using the caravan park. Another more senior council member of staff reviewed the matter and confirmed the decision.

We considered council's decision was not an unreasonable one. However, we suggested that if council is considering banning a person from a facility, restricting access or withdrawing its services it should adopt a formal approach that ensured it observed the principles of procedural fairness. Council agreed to develop new procedures aimed at incorporating procedural fairness principles. In this case, they wrote to the complainant giving him an opportunity to argue his case against the ban.

Case study 20

A resident of a villa unit development wrote to us about a serious flooding problem the residents were having. The units had been built on an old orchard that used to be a natural watercourse for runoff from surrounding properties. He was concerned about the failure of Lake Macquarie City Council to ensure that the drainage system was adequate to cope with the runoff from the watercourse in the uphill property. The pipes were not connected to the villa development drainage pipes but ended in a pit that overflowed during heavy rain. A number of dramatic photographs were included with the complaint that clearly showed the extent of the problem. Council had inspected the site in 2000 but said the installation was adequate and denied the existence of stormwater pipes running into the pit.

Our inquiries found that the Department of Community Services owned the uphill property and that stormwater from this and other nearby properties discharged into a natural watercourse on the block below on which the units had been built. The department had piped the watercourse across their land to protect their disabled clients but the developer of the units had initially filled in the part of the watercourse that crossed his land. The department informed us that localised flooding occurred as a result and that they had advised council that a pipe between the two properties would be required to fix the problem. Council however had not taken that advice but had relied on the certification provided by the private certifier. Also, the drainage system constructed deviated from the plans approved by council and there was no record that council approval had been sought or given for the variations.

After our written inquiries, council carried out its own investigations and decided that it might have some responsibility in the matter. Council offered to carry out the work to connect the two drainage systems to eliminate flooding and to attempt to negotiate an agreement with the private certifier and the Department of Community Services to assist with the cost of the work.

Council was successful in its negotiations and told us that the work would be done at no expense to the villa unit owners. This was a very pleasing result and council is to be congratulated on the way it finally dealt with the problem.

council or any other body to prevent members of the public from attending its meetings on any ongoing basis. In our view, this would be contrary to the objects of the *Local Government Act* and strike at the heart of open and participatory local government.

The current provisions of the Meetings Regulation for dealing with disorderly conduct by members of the public provide a reasonable balance between ensuring openness and public participation in the conduct of council business and the need to maintain order at council meetings. In this particular case, we suggested the council use rangers or security personnel to eject the person if they disrupted future council meetings.

Section 12 of the *Local Government Act* is a provision that is much abused by difficult complainants. Under section 12, subject to certain limited exemptions, councils are required to make their documents available for inspection free of charge. We recently dealt with a complaint in which the complainant had written to a council around 180 times in an 18 month period requesting various documents and information under section 12. The council continued to meet the complainant's ongoing requests despite the demands this placed on its resources.

Although councils are obliged to deal with requests to inspect documents under section 12, there is nothing in that section that prevents council from trying to manage those requests in a way that minimises the impact on its resources. Limiting a person to a reasonable number of requests within a defined period of time may do this. Alternatively, the council may restrict contact to regular meetings with a single nominated member of staff at which complaints and requests for documents are dealt with. The complainant would be required to submit requests to inspect documents in advance of such meetings.

Finally, we consider it to be good practice for a council to regularly review any restrictions imposed. Circumstances and behaviour may change over time. For example, one council's difficult complainants policy required regular review of any restrictions placed on a person. After one review, the council lifted their restrictions because of the complainant's improved behaviour.

Auditing a complaint management system

The general manager of Warringah Council asked us to audit their complaint management systems. This was part of a general strategy to improve complaint management following adverse media the previous year. Our audit included asking council to complete a detailed questionnaire, reviewing their policies and procedures and other relevant documents, and conducting interviews with key senior staff. We also observed the operation of their customer service centre and case management systems.

We found a number of disparate systems in operation across council's various divisions. Not all service units had complaint procedure manuals available and none of the existing unit complaint policies were sufficiently comprehensive.

Little effort had been made to make council's complaint systems visible and accessible. There were also no corporate performance standards for investigating or replying to complaints. Council's existing systems to record and monitor complaints were seriously deficient. Complaint data was not regularly reported to the executive management team or used to improve service delivery in the council, although corrective action had obviously been taken on individual matters. During the audit, council's executive management team adopted a new interim complaints management policy and guidelines. A training and implementation strategy was being developed to support the roll out of the policy, due to become operational on 1 September 2003. Additional resources allocated for better complaint management included the appointment of a complaints administrator and an internal ombudsman, and the development of a workflow module in its Dataworks document management system to record and partly automate the processing of complaints.

Our audit report not only provided a snapshot of council's practices but also gave us an opportunity to make a series of recommendations designed to fine tune council's new policies and practices. We hope that Warringah Council, which is now under administration, can successfully implement these plans.

Mystery shopper audit: Baulkham Hills Shire Council

For a number of years we have been conducting customer service audits of a range of NSW state and local government agencies. The level of complaints about corporate or customer service in councils continues to be significant. Obviously, the community is expecting much improved levels of service from its local councils. This year we used our 'mystery shopper' methodology – where we pose as ordinary citizens making enquiries - to test the performance of Baulkham Hills Shire Council.

Our audit was intended to provide a snapshot of council's general standard of customer service, not an in depth evaluation of their organisational performance. It was conducted during April and May 2003 and involved 70 separate customer/agency interactions – 30 telephone calls, 10 face-to-face contacts, 10 letters and 20 emails.

Telephone

All 30 telephone calls by mystery shoppers were made to the council's main telephone number. They were mainly basic customer requests and problems that would normally be received by the council and should have been relatively simple to answer.

The phone was never engaged and rang, on average, 3.57 times before being answered. When answered the caller was greeted with the name of the council in all cases, with the staff member's name in nearly half of cases and an appropriate greeting such as 'How can I help you?' or 'How can I be of assistance?' in all but one case.

Our mystery shoppers rated the courtesy of the initial contact person as either pleasantly courteous or exceptionally friendly in 80% of cases and noted that staff generally seemed interested in their requests. It was pleasing to note that in all 30 cases the council was able to answer the questions raised by our mystery callers by either providing the information directly or referring the caller to a relevant external organisation and providing contact details.

Comments from our mystery shoppers were generally very positive and provided an image of council staff as being friendly, professional, knowledgeable and helpful.

Face to face service

Ten mystery shoppers visited the council over a two-week period. Each person was allocated a topic which involved asking for information about the council and its services and functions. The courtesy of the customer contact staff was generally rated as either business like or pleasantly courteous. Only one encounter was negative, with the person being rated as 'disinterested / unhelpful'. On two occasions the staff member could not answer our mystery shopper's questions but referred them to another person in council.

Correspondence

This part of the audit was done in a controlled fashion so that the council received the letters on the next working day after posting.

Eight responses were received to the 10 letters sent. These eight responses were received within six to 31 days, with an average of 15 days.

Two responses consisted of printed material and a 'with compliments' slip. The six other responses were appropriately written and provided the information requested. They included the name and title of the person signing the letter and, in five cases, a contact phone number for further details.

Email

Council has a very detailed and informative web page with an email link to lodge enquiries with council electronically. Council's general email address is also included on its standard letterhead. Whether or not it is realistic, the general public's expectation is that emails will receive a much quicker response than standard 'snail mail' letters. Generally, the council met this expectation well with a few exceptions.

Over a period of approximately two weeks, we sent 20 emails requesting information or advice from council. Only 17 responses were received. This was a little surprising given that the topics the emails covered were not complex and it should have been possible for a response to be provided within a reasonable timeframe.

Case study 21

A complainant wrote to us about restrictions placed on his access to Bankstown City Council by its general manager. The general manager had written to the complainant advising him that, in view of the large number of frivolous complaints made over a two year period - 31 letters of complaint and 55 phone contacts, he had advised staff to acknowledge his complaints but not enter into any further communication with him.

We do not consider it unreasonable for a council, where residents continue to make repeated and unreasonable demands on its resources in relation to issues that have already been addressed, to stop corresponding with them on these issues.

Having reviewed the circumstances and copies of the complainant's correspondence with council, we did not consider the decision to restrict his access to be an unreasonable one. However, we had concerns with the nature and breadth of the restrictions imposed. They had the potential to prevent council from dealing appropriately with any future complaint the man made about new and legitimate issues. We suggested the general manager consider reviewing the nature of the restrictions imposed on this person.

The general manager told us that the complainant's behaviour had deteriorated since he had sent the letter and that he was now threatening and abusing council staff.

We acknowledged the difficulty in managing such conduct and agreed there were no easy solutions. We suggested that council should adopt a difficult complainants policy to at least bring transparency and consistency to the process.

Case study 22

Baulkham Hills Shire Council complained to us about a valuation done by the Valuer General for the purpose of issuing a determination of compensation notice as a result of a compulsory acquisition by the council under the *Land Acquisition (Just Terms Compensation) Act*.

The council claimed the valuation was defective due to errors of fact, faulty assumptions and failure to consider relevant matters. They also claimed it was not valid because of a conflict of interests on the part of the contracted valuer. Comments by the regional valuer had led council to believe the Valuer General's delegate had also failed to properly monitor and review the recommended valuation before issuing the determination.

During our inquiries, the former landowner lodged an appeal in the Land and Environment Court against the level of the determination. This provided a means of redress for council to challenge the adequacy of the valuation in court. Information provided by both the Valuer General and the general manager of Land and Property NSW about the valuation process satisfied the council that its concerns about the initial determination were no longer an issue. In the circumstances, no further action on the complaint was needed.

The case, however, highlights a serious anomaly in the *Land Acquisition (Just Terms Compensation) Act*. Acquiring authorities are bound to pay compensation determined by the Valuer General's valuation. The Act grants former landowners an automatic right to challenge the amount of compensation in the Land and Environment Court.

If acquiring authorities dispute the valuation, as in this case where council had advice from senior counsel saying it was wrong, they have no right of appeal. The Act unfairly favours one party and needs to be reviewed to ensure fairness for all.

The average response time for 14 of the emails was 3.4 days. The average response time for the remaining three replies, which were the subject of follow-up emails sent by our mystery shoppers, was 24.6 days. The responses received provided the information requested and generally presented the council in a good light.

Summary

In general, the interaction between council and our mystery shoppers conveyed a very positive impression of council as an effective and courteous organisation in its dealings with its customers.

Council was pleased with the results of our audit and responded very positively. The audit highlighted the efforts that had been made to improve customer service levels and they welcomed our comments in the few areas where some improvement could be made.

Sheila O'Donovan, training and community liaison officer and Wayne Kosh, investigation officer in our FOI unit.

Corrections

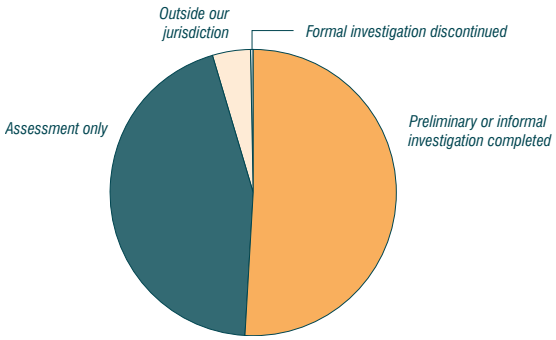
There has been considerable debate in Parliament this year about the role of the Ombudsman in dealing with prison complaints. Much of the information on which the debate was based appears to have been put forward by people with a variety of interests. Unfortunately much of it was also misinformed.

We have been dealing with complaints from inmates for 28 years. We have jurisdiction to investigate complaints about the Department of Corrective Services, the Corrections Health Service, Australasian Correctional Management, the private company that runs Junee Correctional Centre, and any other private provider who may provide correctional management services in the future. Over the years we have developed a significant depth of understanding of the complexities of the correctional system, the effect of prison life on inmates, and where reforms are most necessary. We have the power to investigate systems issues and make recommendations for wide sweeping reforms, such as establishing rights of appeal against segregation directions. We also have the power to investigate the conduct of individual officers and we regularly do so. For example, we make inquiries about discretionary decisions by officers at every level of the department to ensure that discretion is used appropriately. Please see case study 23.

The full suite of our investigation powers can be used in such investigations, and when necessary, we do use them. There is little doubt that simply because we have these powers the department is respectful of our input. However, without that intervention being based on clear, practical and achievable recommendations there is also no doubt that the department would resist more strongly.

In the last few years, we have worked hard to develop positive relationships with corrective services staff. This enables us to deal quickly and efficiently with the majority of complaints. One of the tenets of best practice complaint handling is that the complainant, the person or agency complained about and the public interest is best served by complaints being resolved at the lowest possible level. It is far more efficient for us to provide informal advice on how a complaint should be resolved and know that the department will respond positively than have to undertake a more formal investigation. Our relationship with the department has also provided opportunities for us to work with them providing rigorous and independent advice aimed at improving their policies and procedures.

Figure 22: Corrections complaints received and determined



Complaints received	
Written	336
Correctional centres, DCS and ACM	299
Juvenile justice centres and DJJ	22
Corrections Health Service	15
Oral	3,133
Correctional centres, DCS and ACM	2,585
Juvenile justice centres and DJJ	254
Corrections Health Service	292
Request for review of our decision	10
Inspector General of Corrective Services	2
Total	3,479

Complaints determined (written)	
Preliminary or informal investigation completed	166
Assessment only	145
Outside our jurisdiction	14
Formal investigation completed	0
Formal investigation discontinued	1
Total	326

Current investigations (at 30 June)	
Under preliminary or informal investigation	44
Under formal investigation	3
Total	47

**This figure shows complaints about the Departments of Corrective Services and Juvenile Justice, the Corrections Health Service and Australasian Correctional Management Pty Ltd (operating the private facility Junee Correctional Centre)*

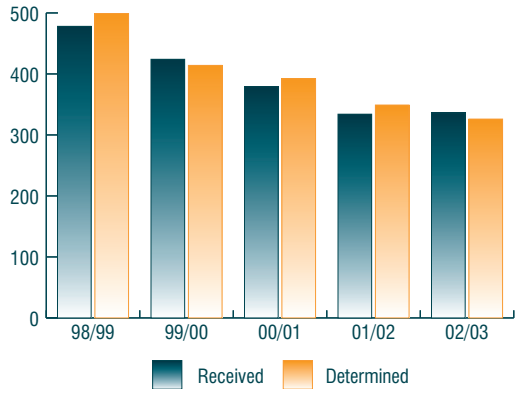
Our relationship with the Inspector General of Corrective Services

During 2002-2003, we continued to meet with the Inspector General and his staff to discuss issues and to attempt to avoid duplicating work. We regularly exchanged information on complaints and inquiries. Despite our best efforts, it was obvious that our respective roles were not sufficiently clear to inmates to avoid duplication. That, together with a number of inmates who were obviously 'agency shopping' in order to get the response they wanted, meant that approximately 15% of all the complaints we received were also made to the Inspector General. This has also sometimes meant that both agencies approached the individual correctional centre or head office in relation to the same matter, a situation that wastes everyone's time and resources.

At the time of writing, it has become clear that the office of Inspector General of Corrective Services will not continue. However it is important that we report on this aspect of our work this year.

In July 2002, we spoke to official visitors at their conference in Sydney. Many of the official visitors at the conference found it useful to hear about the role of the Ombudsman in the corrections area as well as in other areas such as NSW Police. These visitors play an important role in visiting centres regularly and resolving problems. They provide us with useful information as well as referring to us the more intractable complaints. We have also referred inmates to them when the problems seemed amenable to their intervention.

Figure 23: Corrections complaints (written) received and determined – five year comparison



	Received	Determined
98/99	478	499
99/00	424	414
00/01	379	392
01/02	334	349
02/03	336	326

**This figure shows complaints about the Departments of Corrective Services and Juvenile Justice, the Corrections Health Service and Australasian Correctional Management Pty Ltd (operating the private facility Junee Correctional Centre)*

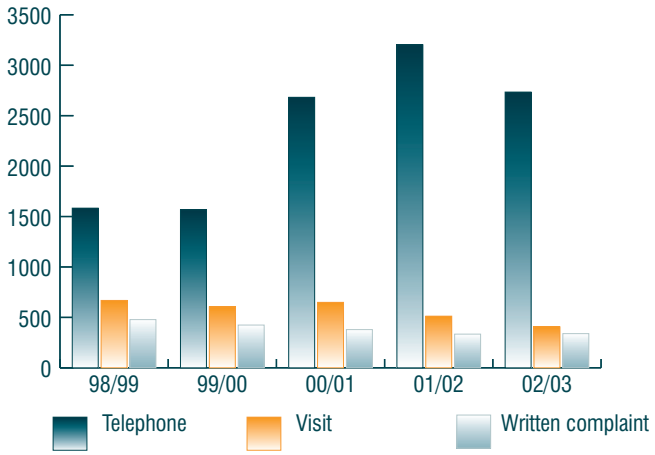
Trends in complaints

Over the past five years there has been a steady reduction in the number of formal written complaints received from inmates. This has coincided with a dramatic increase in the number of telephone calls we receive from inmates.

The number of calls dropped slightly this year as did the number of complaints taken on our visits to correctional centres.

The main areas of complaint concerned matters affecting the daily lives of inmates – daily routines such as time out of cells, lost property, unfair discipline and problems with transfers between centres. Many of these issues, such as property not being transported with an inmate from one centre to another, may seem simply irritating. But in the reduced circumstances in which inmates live, the loss of shoes, education materials, cassettes or food stuffs bought with a wage of less than $20 can become major sources of distress and anger unless they are quickly returned or their owner compensated.

Figure 24: How inmates contacted us – a five year comparison



	98/99	99/00	00/01	01/02	02/03
Visit	668	604	649	512	406
Written complaint	478	424	379	334	339
Telephone	1,583	1,567	2,682	3,203	2,734

While we assist with such problems where necessary, we have increasingly encouraged inmates to try and resolve their problems locally before we become involved. Not only does this allow us to direct our limited resources to the investigation and resolution of deeper problems, but it also puts responsibility back where it belongs – with correctional staff.

Our observations suggest that the majority of staff now working in the system have generally become more responsive to the needs and rights of those in their custody.

Case study 23

We conducted a formal investigation into the application of the department's policy on 'restricting and prohibiting visits to inmates and correctional centres'.

Each year the department imposes about 450 visitor sanctions under this policy. Visitor sanctions are administrative decisions made in response to a visitor committing a breach of the *Summary Offences Act 1988* or the Crimes (Administration of Sentences) Regulation 2001. They restrict or prohibit a person's visiting privileges to an inmate, a correctional centre or all NSW correctional centres. They are imposed for a variety of reasons including offensive behaviour and trafficking of contraband into correctional centres. Such conduct is viewed as serious because it can threaten the safety of staff, inmates and other visitors as well as a correctional centre's security, good order and discipline.

Although police can prosecute visitors for criminal conduct such as trafficking drugs, the department's role is to apply a reasonable sanction. They consider the seriousness of the visitor's action and the risk it presents as well as the effect on an inmate's family. This is a difficult area of administration for DCS as the denial of visitation rights can have a profound and negative impact on an inmate's ability to maintain relationships with family and friends. DCS generally views family relationships as a positive factor in an inmate's rehabilitation and so their maintenance is encouraged. It is also one of the few areas where the department's jurisdiction extends to members of the public.

It is the department's practice to tell individuals that they intend to deny access to correctional centres and that they may contact us about the decision. Only a relatively small number of affected people take up this option, compared to the number receiving sanctions. If there is evidence to support a complainant's dissatisfaction with the department's internal review, we generally make inquiries. The department then explains its decision on each case. Most of the decisions we have reviewed in the past were individually justifiable or provided insufficient evidence of maladministration to warrant further inquiry.

However, over a period of time, we became concerned about the department's use of its discretion in applying visitor sanctions. Our concern was that, although guided by a policy encouraging the use of discretion, the department appeared to apply only a limited range of visitor sanctions and often imposed the maximum recommended penalty.

The policy we investigated sets out a process for considering and applying a sanction against a visitor who has:

- introduced or attempted to introduce weapons, drugs, syringes and other contraband into correctional centres
- behaved in an abusive and aggressive manner on or at a correctional centre
- behaved in an offensive, unseemly, indecent or improper manner on or at a correctional centre.

The policy requires decision-makers to consider certain matters when contemplating a sanction. These include the type of conduct, the visitor's history, any police involvement and the visitor's intention. A sliding scale of sanctions is then used to determine the length and type of visitor sanction that may be applied. These sanctions are a caution, a restriction to non-contact visits, or a prohibition from visiting an inmate, a correctional centre or all NSW correctional centres. They usually last for periods of up to 24 months.

Our investigation, to date, has been primarily an audit. We obtained copies of all records related to visitor incidents that occurred in November 2001 and January, March, May, July and September 2002. We developed a database around a checklist based on factual details and good administrative practice. We then reviewed 227 decisions and analysed the data to identify any patterns or trends. We also reviewed the related policy and the new policy the department implemented after the start of this investigation and re-analysed the complaints we received during 2001 and 2002.

We believe an audit of this size provides a sufficient range and number of incidents to provide an adequate picture of the department's administration and application of its policy. It also enables us to identify current practice and assess whether it properly reflects the law, the policy and is a reasonable application of the discretionary parts of the visitor sanction process.

At the time of writing, we are assessing the response of DCS to our preliminary findings and recommendations.

Case study 24

During a visit to Grafton Correctional Centre we spoke to a female inmate who had been transferred to Grafton to attend court. Grafton has a women's unit, the June Baker Centre, but we saw the woman in the special management unit. She complained about being in segregation and her limited access to the telephone. Her cell card indicated that she was on segregation, but when we checked segregation and protective custody directions we could not find one for this inmate.

We asked the then governor about her status. He told us she had recently arrived for court but there had been problems when she had been in the June Baker Centre before. He had decided not to let her stay there this time because she was potentially a risk to the good order and security of the centre. While we understood the governor's dilemma, it also appeared that she was being unlawfully segregated while he decided what to do. Before we left the centre, the governor told us he had considered the overall risk and had directed the woman be moved to the June Baker Centre.

Case study 25

When we went to John Morony Correctional Centre in December 2002, we spoke with a group of inmates in 'E unit' - the segregation and protection unit. Some of the inmates told us they had been waiting for many months to be transferred to Cooma Correctional Centre. We were concerned that the delay might be affecting their case management and their access to programs. After we contacted DCS, most of the inmates were moved to Cooma without further delay. We then began an investigation into case management in E unit.

Case study 26

We were contacted on behalf of a forensic patient at Long Bay Hospital. The patient was upset because he had been in protection for six months and couldn't spend much time out of his cell. He had asked to come off protection, but his request wasn't approved. We contacted Long Bay Hospital and he was removed from protective custody. We also asked for copies of the papers relating to his protection but found that a direction had never been made. While the executive staff at the hospital agreed to review their administration of protective custody, we thought it appropriate to raise our concerns about the general issue of protection at Long Bay Hospital with the Commissioner.

Case study 27

An inmate complained to us that the Commissioner had rejected a recommendation that he have his escape risk category removed and be given a minimum C1 classification that would allow him to progress through the system. Our complainant was confused because he felt he had met all of the relevant criteria and the Escape Review Committee had recommended the change. He was most upset that he had not been given any reasons for the decision. We raised the issue with the Commissioner who gave us his reasons for not approving the recommendation. We considered that the Commissioner had reasonable grounds for reaching the decision he did and we advised the complainant of this.

Communicating with the Department of Corrective Services (DCS)

We continue to meet regularly with senior DCS staff including the Commissioner. These meetings are a good opportunity to discuss specific issues of concern and to keep up to date with general changes in the correctional system.

DCS provides us with a copy of its daily synopsis, a document that sets out all incidents that took place in the previous 24 hours in the correctional system. We find the synopsis helps us to respond to inquiries from inmates about matters like lockdowns. It also gives us a good idea of how the system is running at any given time.

We generally have a good working relationship with the department, but there are times when the flow of information could be improved. Sometimes, we only become aware of issues after we receive a number of inquiries from inmates. For example, changes to classification guidelines and movements within centres involving a number of inmates usually cause stress and inmates call us for clarification. Often these issues can be dealt with by providing explanations and advice about new procedures that is not always adequately provided by the centres themselves. This is one example of how we can function as a safety valve for inmate dissatisfaction that, unless addressed immediately, can often escalate into more serious disputes.

When Junee Correctional Centre relocated two units of inmates, DCS recommended they tell us before it happened. We were therefore prepared for any inquiries about the re-organisation. In contrast, when a relocation of inmates at Goulburn X wing happened, DCS didn't tell us and we weren't able to provide immediate advice to inmates when they called to complain.

Segregation

We gave an update in last year's report on an investigation we had finalised about the unlawful segregation of an inmate. We reported that the department had proposed the *Crimes (Administration of Sentences) Act* be amended to clarify whether or not a direction to 'extend' segregation could be made after the original direction had expired. We were surprised on 18 September 2002 to get a phone call from DCS advising that a Bill to amend the segregation and protective custody provisions of the Act had been introduced and was at second reading stage. We were more concerned after we read the Bill. The proposed amendments totally change the basic framework for segregation and protective custody directions. We expressed our disappointment to the then Minister, and to the department, about the lack of consultation and set out our concerns about the provisions of the Bill. Since the legislation was passed, we have turned our attention to working with DCS to develop appropriate policies and procedures.

It is no longer necessary for each segregation and protective custody direction to be reviewed and formally extended at relevant times. The amendments mean that such directions now remain in effect until revoked. Over the years we have investigated on many occasions the department's failure to administer a scheme for segregation and protection that had clearly legislated parameters. Please see case study 24. The new legislative scheme does not have these inbuilt protections and it is absolutely essential that policies and procedures are developed that ensure its administration is transparent and accountable.

Figure 25: Nature of correctional centre complaints

Issue	Written	Oral	Total Complaint
Buy-ups	9	89	98
Case management	17	76	93
Child abuse related	0	1	1
Classification	21	185	206
Community programs	0	4	4
Court cells	0	3	3
Daily routine	33	353	386
Day/other leave/works release	6	52	58
Fail ensure safety	8	31	39
Food and diet	2	38	40
Information	7	38	45
Legal problems	3	48	51
Mail	6	51	57
Medical	7	58	65
Natural justice	0	1	1
Officer misconduct	35	194	229
Periodic/home detention	4	21	25
Probation and parole	8	47	55
Property	36	326	362
Records/administration	20	172	192
Security	7	30	37
Segregation	7	72	79
Transfers	21	205	226
Unfair discipline	1	90	91
Visits	21	160	181
Work and education	7	99	106
Other	6	134	140
Outside our jurisdiction	7	7	14
Total*	299	2585	2884

** Also received two oral enquiries regarding the Inspector General of Corrective Services*

Court cells

During 2002-2003 we were concerned about the amount of time some people were spending in DCS managed court and police cells before being transferred to a correctional centre. We inspected some of the cell complexes, spoke with staff and met with senior officers to see if they could work out a way to deal with the problem. Soon after we raised the issue, the Senior Assistant Commissioner Inmate and Custodial Services told us about new approaches adopted to reduce to 72 hours the maximum time people would spend in court or police cells under DCS control. Subsequent monitoring showed a reduction in the number of cases where inmates were kept in court cells for long periods and the 72-hour maximum target is now usually met. We were pleased to see such a significant improvement in the department's practice without the need for a formal investigation.

The Corrective Services Support Line

In 2001 we discussed with the Commissioner strategies to deal with the escalating number of calls inmates were making to us about minor matters. In response, he proposed an internal telephone inquiry system. Inmates would ring the Corrective Services Support Line (CSSL), a departmental unit in his office that would deal with inquiries and provide basic information on a range of topics. The Commissioner hoped this would reduce the number of inmate enquiries to external oversight bodies such as the Ombudsman and the Inspector General of Corrective Services.

We supported this proposal. We also believed the data collected could provide the department with a performance management tool to help it identify particular problems in centres or specific units, and then take action to resolve these problems.

We provided the steering committee with advice about complaint handling and copies of non-confidential information from our database to help them identify the specific issues that inmates complain about. We were also involved in a number of meetings with inmate development committees to gauge their response to the proposal.

The department decided to pilot the CSSL for 12 months and then evaluate its operations. The pilot started at the Metropolitan Remand and Reception Centre in January 2003 and was extended to Lithgow Correctional Centre in April and Mulawa Correctional Centre in May 2003. The plan is to include Parklea Correctional Centre in the near future.

A Memorandum of Understanding about the CSSL pilot scheme was negotiated between the Ombudsman, the Commissioner of Corrective Services and the InspectorGeneral of Corrective Services. The MOU clearly sets out the responsibilities of senior DCS officers. It also provides for a limited exchange of information between us and CSSL, focusing on numbers of inquiries from participating centres. The department would like to see the CSSL manage all inmate inquiries. However, some inmates are likely to always be sceptical about complaining to the department about the department and its staff.

While the MOU includes an undertaking that both the Ombudsman and the Inspector General would encourage inmates to use the department's internal processes, we maintain our statutory right and power to inquire into any matter at our discretion.

Early indications are that the same numbers of inquiries are being made but, as the department hoped, we seem to be receiving fewer of those calls. We will closely monitor the pilot scheme, particularly how complaints and inquiries are handled and any effect on the capacity and willingness of inmates to raise their concerns.

Case study 28

During 2002 an inmate had an elbow reconstruction and the surgeon recommended physiotherapy as part of his rehabilitation. This was supposed to be noted in his medical file. He complained to us that nurses in the correctional centre were refusing him the treatment. The inmate's elbow was put in plaster after the operation and the plaster was to be replaced when it became worn. He told us a doctor at the correctional centre had noted it needed replacing but that the nurses refused to take it off. The inmate's medical file did not record with any certainty what had previously happened with his medical management.

CHS arranged physiotherapy treatment and referral to an orthopaedic surgeon the day after we notified them of the complaint. The case was also referred to the CHS Quality Council so relevant managers and directors could develop procedures for improved follow up care. CHS told us they had also started a medical records audit aimed at improving documentation and clinical record keeping, and a review of diagnostic procedures for post-operative care and peer review of cases.

Case study 29

We received a lot of complaints about buy ups from inmates at the Metropolitan Special Programs Centre (MSPC) at the Long Bay complex. Many inmates were upset they were not getting items they had ordered and paid for, and also about delays generally in receiving their purchases. We spent time speaking with the logistics manager of the complex and the administration manager of the MSPC about how to deal with the complaints. We gave them details of individual matters and they were investigated. We also met with DCS staff about the process inmates should follow to get problems sorted out. As a result, staff at Long Bay revised the complaint process for buy ups generally and for the delivery of goods by the contractor. Over a six-month period the buy up situation at the MSPC improved and individual matters were resolved.

Case study 30

A female inmate was upset because she had to travel from Mulawa to a court cell complex the day before a court appearance and had to sleep in her court clothes or just her underwear. The woman was due to go back to court the following week and was worried the same thing would happen to her. We made inquiries and were told a policy was introduced for inmates travelling to certain court cell complexes to wear their court clothes and be issued with 'greens' (correctional centre clothes) when they got to the cells. They are then able to re-dress in their court clothes before attending court. Our complainant had not been given her greens at the cell complex because they had none in storage. After our call, this was fixed. We checked to ensure the woman was given her greens when she returned for court the following week.

Case study 31

An inmate at Junee Correctional Centre requested protective custody. Early that afternoon he was taken to the protection area without returning to his cell. He was given his property the next day and his portable CD player was missing. He tried to have the matter fixed locally using an inmate application form, including details about who he thought might have taken the CD player.

We made inquiries and were told that it was likely the inmate had lent his CD player to another inmate (which is not allowed) so he would not be compensated for the loss. Our further inquiries showed that staff in the unit where the inmate usually lived had not been told for some hours that he had been moved to another area. His cell property had therefore not been secured before the other inmates returned to the unit at the end of the day. This meant it was entirely possible that his CD player had been stolen.

Junee Correctional Centre management reconsidered its original decision and agreed to pay compensation to the inmate.

Our visits to centres

The easy telephone access that inmates now have to our office has reduced the need for us to make regular visits to all centres for complaint taking. We visit some centres twice each year and other centres less often. Our decision about which centres we will include in our annual visit program is partly influenced by the inquiries and complaints we receive. When we plan our visit program we also consider other things such as the opening of new units or the start of new programs that our staff might not have seen before. This year our staff made 25 visits to 18 correctional centres. Our visits are flexible and we try to inspect the centre, respond to inmate inquiries and examine key records while we are there. Sometimes our visits alert us to things we might not otherwise hear about. Please see case study 25 for an example.

We visited the new secure unit at the Prince of Wales Hospital for the first time this year. We looked at the facilities and talked with staff of the unit about the daily routine for inmate patients. Visits like this are especially helpful in responding to inquiries in areas like the secure unit, where conditions might be different from what inmates are used to in centres.

In last year's annual report we said we would monitor the department's proposals for improving Mulawa's induction unit. When we visited Mulawa in January 2003, construction had started on individual exercise yards attached to the segregation cells. We were surprised when we were told the unit was at that time being run by SERT officers. SERT are specialist response officers and we were worried about their ability to provide an appropriate environment for women in the unit as it is usually their first point of contact with the correctional system. Many of the women are stressed and unwell and there is a high potential for self-harm. We were told the unit would be run by SERT officers while new standard operational procedures were being prepared and until appropriate staff were recruited and trained. At the time of our visit, a new governor had only recently taken up her role at Mulawa so we arranged to meet with her again after she had spent more time in the position.

We went back to Mulawa in May 2003 and the induction unit had become the Reception, Assessment, Programming, Planning Unit (RAPP unit). The new name better describes the purpose of the unit. New unit staff had been selected and were being trained, the segregation yards were built and other works were under way.

Protective custody

Substantial changes to the legislation governing segregation and protective custody were made during the year. We plan to monitor the department's implementation of the new segregation and protective custody procedures. We also have had some concerns about special management area placements (SMAP) and have noticed some staff seem confused about the differences between SMAP and protective custody. DCS defines SMAP as a placement for inmates of similar needs.

The purpose of SMAP is to protect vulnerable and fearful inmates without limiting their access to programs and education, among other things. A SMAP placement can be made without a formal direction - an inmate's participation is simply entered on the department's offender management database (OMS). At the moment, there are no specific procedures covering SMAP although we understand the department is currently developing relevant procedures. Special management programs should not involve the isolation of the inmate. This is not always the case and we have previously identified occasions when the use of 'special management programs' for inmates has amounted to little more than segregation without the legal protection.

One case we dealt with this year included protection, segregation and SMAP issues. It came to our notice when an inmate wrote to us complaining about lost property. He added that he had been 'stuck in segro' at Junee Correctional Centre. Our inquiries revealed he had been kept on protection in segregation conditions for 25 days in total, the last 11 days without a lawful direction. Junee Correctional Centre's records for the last 11 days did not help us understand the legal basis on which the inmate was being kept in isolation or whether he was receiving his access to daily exercise in the open air. Various sources suggested he was on segregation, protection or a special management program or a combination of these.

We began an investigation because we were concerned at the absence of a lawful direction to allow for the isolation of the inmate, the quality of the record keeping about his daily routine including his access to daily exercise, and the adequacy of the information relied upon by the centre to place him on protection in the first place.

We also wrote to the Commissioner for Corrective Services because we were concerned that Junee Correctional Centre staff had provided inaccurate advice to the department's inisterial Liaison Unit about the inmate's placement during this period. We sought to clarify how DCS checked that Junee

The sign outside the entrance to Long Bay Correctional Complex

staff were applying segregation and protection properly and where its special management areas were located. DCS advised us that it does not check every direction but does conduct random audits on a regular basis. It advised that all of Junee Correctional Centre had been considered suitable for the special management programs as it had previously been entirely a protection centre. This has since changed.

We issued Australasian Correctional Management (ACM) with a document outlining our investigator's preliminary findings and recommendations. It was clear that staff at Junee Correctional Centre had been motivated to ensure that the inmate was not harmed by others. Our preliminary recommendations were that Junee staff develop local procedures to monitor the placement of inmates on protection and segregation. We also recommended that they develop local procedures about placing an inmate on a special management program, give inmates reasons for placing them on the program and advise them about their appeal rights.

ACM has agreed to implement all the recommendations. We did not make any recommendations about developing local orders for seeking an extension of segregation and protective custody directions because of the recent changes to the legislation.

Decisions and reasons

The *Crimes (Administration of Sentences) Act* and Regulation require the Commissioner of Corrective Services to exercise discretion when making many decisions affecting inmates. This includes responding to recommendations by the Serious Offenders Review Council about inmate classification, security rating and for certain inmates to participate in programs such as external leave. We received a number of complaints during the year from inmates that decisions had been made by the Commissioner without any reasons being given. These decisions had the potential to impact on an inmate's program pathway.

We wrote to the Commissioner and met with him about one case. While we understand that the Commissioner is not required to give reasons for many decisions, we confirmed our belief that the giving of reasons is simply good administrative practice. In addition, it seems likely inmates who are recommended for a change of classification, transfer or program may not be inclined to continue with their case plan if they are not given reasons when recommendations are not approved. The Commissioner undertook to be more forthcoming with reasons for such decisions. He told us the department was working on new guidelines in a number of areas of classification and case management. He expected the new guidelines would assist him to be able to give reasons for many more of his decisions.

We realise that, in the interests of security, there are some instances where the Commissioner will not be able to give full details of his reasons for certain classification and placement decisions. We have arranged with the Commissioner that if an inmate complains to us about not being given reasons for a decision, we will scrutinise the Commissioner's reasons without providing detailed information to inmates. In such cases, inmates will have to rely on our independence and integrity. Please see case study 27.

Corrections Health Service

To speed up the resolution of health related inmate complaints and inquiries, we contact the Corrections Health Service (CHS) via email. This system continues to work well - we are able to get quick responses to matters and to provide that information to the complainant. It also gives CHS a good overall picture of the number and type of issues raised with us about health services.

We were invited to attend a CHS Quality Council meeting after CHS recognised that 30% of all inquiries and complaints they receive are referred by us. We were pleased to talk to CHS about our role in complaint taking and about ways our inquiry process could be improved.

Figure 26: Nature of complaints about the Corrections Health Service

Issue	Written	Oral	Total Complaint
Food and diet	0	1	1
Information	1	2	3
Medical	14	284	298
Other	0	1	1
Outside our jurisdiction	0	3	3
Records/administration	0	1	1
Total	15	292	307

Last year we reported that we had established an arrangement with CHS that we would write to the nursing unit manager at the clinic of each correctional centre when we are going to visit the centre. The arrangement also covered procedures for us to obtain any medical information necessary for us to assess an inmate's complaint. These procedures are working well. We have had no problems with clinic staff responding to our inquiries during our visits to correctional centres this year.

Please see case study 28 for an example of a complaint about the Corrections Health Service.

Case study 32

An inmate complained to us that the department had not properly investigated his claim that he had a positive urinalysis result for morphine because he was taking prescribed medication. The repercussions for the inmate were serious – he was removed from the works release program and his classification was increased. The inmate submitted medical evidence to show his test results could have been interpreted differently. When he first asked for a review, the Commissioner told him the decision would stand.

We made inquiries and the department further researched the inmate's claims. The investigation showed the test results were incorrectly interpreted because the interpreting officer was given wrong advice about the complainant's medication. The department agreed no action should have been taken against the inmate based on the urinalysis result. The complainant's records were amended and the department agreed to give staff more training on interpreting urinalysis results.

Department of Juvenile Justice

Visiting centres

During 2002-2003, we continued our program of visits to all full-time juvenile justice centres. These general visits are used to meet staff, inspect facilities and records, and talk to detainees. The visits serve at least two purposes. We get a good snapshot of how a centre is functioning plus we make ourselves available to detainees who might not telephone the office to talk about issues that are occurring.

This year we made 14 visits to inspect and take complaints, most centres being visited twice. Two of those that were not visited for a second time were audited by our child protection team (see the section on child protection for more information) and the third, Yasmar, was the subject of extensive inquiries as a result of issues raised during the first visit. Please see case study 33.

We try to resolve any issues that arise during the day with the manager. Usually we leave a list of issues that need attention and ask that responses be provided as soon as possible after the visit. This system has worked well for several years. This year we had difficulty getting responses from some managers once we had left the centre.

Although we do have extensive powers of investigation, we are reluctant to use these when informal exchanges of information are likely to solve the complaint. Having raised this with the Director Operations, we not only obtained the information we needed but hopefully encouraged centre managers to be more helpful.

Clarifying our role

We also worked with the department to clarify the role and purpose of the Ombudsman's office. There was some confusion about our two distinct roles - one for child protection issues and the other our complaint handling role.

We agreed to have regular liaison meetings with staff from the department's central support office to make sure the work of these two different teams is clearly understood. We have only had one meeting so far, so it is difficult to say what impact this will have on our interactions with juvenile justice centre staff. We have also met with centre managers to clarify how we operate to resolve complaints.

The department also asked us to comment on procedures they were developing. These included the centre operations manual, classification/case management and the urinalysis program procedures. We also provided information for their procedures for dealing with us when we visit centres and request information.

Case study 33

During a routine visit to Yasmar Juvenile Justice Centre in November 2002, we undertook a review of unit logbooks. The logbook for one unit indicated that over a period of three days a detainee had been held in the unit by herself. We asked the centre manager for the legal or operational basis for this placement but she could not tell us.

We then wrote to the Director General asking on what basis a detainee could be placed in a unit by themselves and whether the department had sought legal advice about such placements. We also noted that a staff member who was still the subject of a child protection investigation was rostered to work in this unit with the detainee by himself. We asked if a risk assessment had been done to determine the appropriateness of this rostering arrangement.

The Director General advised that he was seeking clarification from the department's legal officer as to whether the placement was permitted. He did advise us that the detainee had been placed by herself due to health and medical issues. We were further advised that such a placement was consistent with clause 7(5) of the Children (Detention Centres) Regulation 2000. This provision allows for the isolation of detainees if they are suffering from an infectious medical condition and there is a risk of other detainees becoming infected with the condition. It also applies if a detainee has a medical condition that is sufficiently serious to require their isolation.

Finally, the Director General advised us that no risk assessment of the worker had been done. He told us that the investigation had not been finalised but the 'preliminary outcome' suggested that there was insufficient evidence to support the allegation. He also noted that the centre in question has a procedure that states that no individual staff member may open the door of any detainee's room during night shift.

Having reviewed all the available evidence, it seemed to us that the detainee in question had been segregated. There was no evidence that the detainee was suffering from any type of medical condition necessitating her isolation, so clause 7 of the regulation did not apply.

Section 19 of the *Children (Detention Centres) Act 1987* provides for the segregation of detainees and stipulates the maximum time in segregation for detainees is three hours in 24, unless the Director General's approval for six hours has been obtained. So not only was clause 7 of the Regulation irrelevant but, because she was held in isolation for three days, section 19 of the Act had been breached.

In response to further questions from us, the Director General acknowledged that the placement of the detainee was inconsistent with the relevant legislation.

We found the lack of a risk assessment on the sole worker supervising the young woman insufficient. While we understand that staff are instructed not to enter a detainee's room alone, having a policy does not guarantee it is followed.

Risk assessments should be done for any workers who are the subject of either child abuse allegations or allegations of abuse against any detainee. In this instance, not only may the detainee have been at risk of abuse by the staff member, but the staff member may have been at risk of having a false allegation made against him. A procedure that requires centre managers to assess potential risk when placing workers on duty is in the best interests of both detainees and staff.

The Director General advised us that the centre manager and management team would develop a procedure to ensure that risk assessments are done in future.

Record keeping

The most common issue identified from our visits to centres was the quality of the records kept. Far too often we still find mistakes in the writing up of misbehaviour sheets, segregation and confinement records and use of force records. Sufficient and correct documentation is not only a legal requirement, but it enables situations that arise to be properly reviewed. In at least one centre, staff were unable to locate records such as the current confinement register.

Two specific issues we raised in a number of centres were the need for clearer and more detailed reports about the use of force and better information about checks on detainees in confinement or segregation. Too often it looks as if the checks are written in the book without an actual check on the detainee. This was evident in one form we saw where the staff member had to cross out the last half dozen entries as they would have been made after the detainee had been released.

In those centres where managers check the paperwork regularly we saw comments indicating problems and the need for correct entries. The records in these centres were usually of a higher standard. We continue to raise each individual matter identified during our reviews but it is disappointing to see the same problems recurring. We now provide copies of our visit feedback sheets to the Director Operations so we hope to make more progress on this issue in the future.

Figure 27: Nature of Juvenile Justice Complaints

Issue	Written	Oral	Total Complaint
Case management	2	5	7
Child abuse related	0	5	5
Daily routine	0	64	64
Day/other leave/works release	0	7	7
Fail ensure safety	0	4	4
Food and diet	0	16	16
Information	0	1	1
LegalpProblems	0	1	1
Mail	0	1	1
Medical	0	9	9
Officer misconduct	9	39	48
Other	1	21	22
Outside our jurisdiction	4	4	8
Probation/parole	1	2	3
Property	0	8	8
Records/administration	1	2	3
Security	2	4	6
Segregation	0	3	3
Transfers	0	13	13
Unfair discipline	1	29	30
Visits	1	7	8
Work and education	0	9	9
Total	22	254	276

Staffing matters

It seems from our visits that the upheaval and uncertainty caused by the restructure of centre staffing is beginning to settle. The Council on the Cost and Quality of Government (COCQOG) restructure is now in place, recruitment is finalised and the new structure is gradually being bedded down.

During the year, the Corrections Health Service took over responsibility for providing medical and nursing services to juvenile justice centres. In most centres this appears to have been a smooth transition, with only a few settling in issues.

Telephones

An increasing number of detainees are ringing us to complain. During the year the department installed the Arunta telephone system in its juvenile justice centres. This is the system adopted some years ago by the Department of Corrective Services. Some of the instructions for using the Arunta system are too complex and we have suggested that centre staff make them clearer.

Calls to the Ombudsman are paid for by the department and are not included in the seven calls allocated to each detainee each week. We were concerned to discover that at Cobham JJC detainees' access to ring our office had been removed for about a month. The centre management had been told this was because the Ombudsman had complained about receiving nuisance calls. This was absolutely untrue – in fact the statistics show that we only received six calls from detainees at Cobham. During the same visit, in response to our suggestion, a sign was put up next to each Arunta telephone clearly stating how the detainee could ring our office or make any other free call on the system.

At many centres, the Arunta system is switched off for most of the day. We were told this was so detainees did not leave school or programs to make telephone calls. Given that telephone inquiries to our office should be made before 4pm, we were concerned that this would unreasonably limit access to us. However centre staff told us that a detainee could ask a unit coordinator to make a call to us even when the system was shut down. The numbers of calls we have had indicate that there has been no widespread problem and there have been no complaints about this issue from detainees.

Protected disclosures

Protected disclosures encourage public sector staff to blow the whistle on agency misconduct and mismanagement. The intention of the *Protected Disclosures Act 1994* (the PD Act) is that complainants making allegations about serious issues are protected against detrimental action or reprisals resulting from making the disclosure. Insiders are best placed to notice misconduct and mismanagement by colleagues or their employer, so whistleblower protection is an important means of ensuring complaints can be made without fear of retaliation.

The NSW Ombudsman is one of five watchdog bodies to whom protected disclosures can be made. The others are the Independent Commission against Corruption, the Auditor-General, the Police Integrity Commission (and the PIC Inspector), and the Director General of the Department of Local Government. Representatives of most of these agencies, plus the Premier's Department and NSW Police, sit on the Protected Disclosures Act Implementation Steering Committee to monitor how agencies are implementing the PD Act.

The Ombudsman's main roles in relation to protected disclosures are:

- Complaint handling - we deal with disclosures about maladministration, allegations about reprisals being made against whistleblowers for making a protected disclosure, and problems agencies may have with implementing the PD Act.
- Advice - we provide advice to public sector staff thinking of making a disclosure or to staff who are responsible for implementing the PD Act.
- Training - we offer training to agencies about their responsibilities under the PD Act.
- Monitoring and improvement - we work with other watchdog bodies to develop guidelines on interpreting and implementing the PD Act.

Our 2001-2002 Annual Report included a detailed outline of our role as well as information on how to make complaints. Please see pp. 66-71 of that report.

Complaint handling

In 2002-2003, we received 133 protected disclosures - 58 oral disclosures and 75 written disclosures. This is an increase on last year's figures (see Figure 28 for five year comparison). A large number of these were complaints about universities and several protected disclosures by university staff were investigated during the year.

We conducted three formal investigations in 2002-2003, all of which resulted in findings of wrong conduct and the Ombudsman making recommendations about changes to policy or procedure. For more details, please see case studies 1 and 3 in 'General complaint work'. We have also conducted several informal investigations – please see case studies 34, 35 and 36 in this section.

Conflicts of interests have been at the forefront of issues raised in protected disclosures this year. For example, our investigation into allegations made against the President of the Anti-Discrimination Board and the Privacy Commissioner showed that he had a poor grasp of the concept of a conflict of interests and had repeatedly failed to recognise or manage both actual and perceived conflicts arising from his various professional roles and friendships. He had also therefore ignored the requirements of the codes of conduct of these agencies. For more details, please see case study 3 in 'General complaint work'.

Protected disclosures, like other complaints, can bring about much-needed changes in government services. For example in case study 34 on the closure of Gullama, the Department of Community Service's Aboriginal service centre in Redfern, our investigation resulted in work being done to preserve the integrity of child protection information handled by the centre.

In addition, DoCS has made considerable improvements to its recruitment processes and support for Aboriginal staff. In case study 36, our inquiries led to the Department of Ageing, Disability and Home Care implementing better

asset management systems and a new policy governing computer usage.

There is the potential for the PD Act to be used illegitimately to, for example, make a disclosure to avoid disciplinary action. We want to encourage genuine whistleblowers but, at the same time, ensure that agencies have clear guidelines in place to reduce the possibility that protected disclosures could be misused. Guidelines in themselves, however, are not enough – it is vital that agencies also provide induction and refresher training on protected disclosures to all their staff.

We have begun an investigation into how complaints made by police officers with a genuine grievance against other officers are handled internally by NSW Police.

The project is considering various aspects of the complaint handling process including:

- how these complaints are assessed and allocated
- the appropriateness of investigation strategies used and outcomes reached
- the timeliness of investigations
- the tools used to measure complainant satisfaction.

Figure 28: Protected disclosures received – five year comparison

	98/99	99/00	00/01	01/02	02/03
Oral	87	65	56	34	58
Written	113	78	97	75	75
Total	200	143	153	109	133

Prerequisites for a disclosure to be protected

During the year we became aware of a number of agencies that were confused about the prerequisites for a disclosure to be protected under the PD Act. Representatives of some agencies believed it was important that complainants nominate that they had made a protected disclosure.

It is, in fact, irrelevant whether the complainant or the person they inform is aware that the complaint is a protected disclosure. If the disclosure meets the requirements of the PD Act – that is, it is not made frivolously or vexatiously or in an attempt to avoid disciplinary action, does not question the merits of government policy, has been made to the appropriate authority or person, and shows or tends to show conduct specified in the PD Act – then the protections and obligations of the Act will apply.

In case study 36, the department's focus on the issue of confidentiality occurred at the expense of protecting the complainant.

Case study 34

We received a protected disclosure about the closure of Gullama, an Aboriginal service centre in Redfern. The Department of Community Services established the unit in 1976 to provide advocacy as well as advice and support for staff working on child protection matters involving Aboriginal families. In 1994, staff of the unit began to take a primary role in child protection casework. There were ongoing difficulties at the centre with casework practices, administration and workers' time management. Some of these difficulties were due to workload and/or inadequate supervision.

In April 2000, after the stabbing of a young child whose parents were clients of Gullama, the department's former Director General decided to remove the unit's child protection function, integrate the staff into the Eastern Sydney Community Service Centre (CSC) and redefine the role of Gullama. The complaint we received was about how the closure had been managed. The issues raised included what steps had been taken to ensure that case files were complete and reallocated, what training was provided to staff being reintegrated into the Eastern Suburbs CSC, how culturally appropriate casework practices were to be maintained and the future of Gullama.

Initially we did not disclose the complainant's identity when we wrote to DoCS. When DoCS was unable to find documentation relating to one of the complainant's main concerns, we asked the complainant if we could identify her as we could not make further inquiries without doing so.

In particular, we could not give the department copies of a review the complainant had conducted of the now missing documentation. She agreed to this disclosure and we were then able to conduct an audit aimed at cross checking information provided by the complainant with electronic records and Gullama files relocated to Eastern Suburbs CSC. As a result of our inquiries the DoCS Client Information Service database (CIS) was updated, files were completed and reallocated, and all cases still marked as belonging to Gullama were reviewed and brought up to date.

DoCS has replaced Gullama with an Aboriginal family preservation service. This will be a home based program for Indigenous families in crisis whose children are at risk of being taken away for protective reasons. DoCS is also working on improving the recruitment, training, support and mentoring of Aboriginal staff and has established an Aboriginal Services Branch.

The branch will help Aboriginal and non-Aboriginal staff to improve service delivery to Indigenous clients. They will also work directly with other agencies and DoCS staff to address child protection and early intervention issues for Aboriginal families.

We acknowledged the complainant's contribution to the important and necessary work that had been done as a result of her protected disclosure.

Case study 35

We received a protected disclosure about management practices in a Department of Housing branch office. The whistleblower alleged some staff were using other staff members' computer usernames and passwords to make payments to contractors. There was no allegation of corrupt conduct but, had there been, this practice would have made it very difficult to identify those responsible.

The department responded promptly to our inquiries. They acted to ensure that staff who did not have sufficient delegation to approve payments to contractors could not do so, and staff who could make these payments had the necessary access.

Confidentiality

The PD Act contains important confidentiality requirements. When a complaint is classified as a protected disclosure, the complainant's identity must be kept confidential unless:

- the complainant allows their identity to be made public
- procedural fairness requires the information to be revealed
- proceeding with the investigation depends on the complainant being identified
- it is in the public interest to reveal the information.

In the Gullama case, for example, we did not identify the complainant when we initially wrote to DoCS. However later on, the investigation could not progress without her identity being revealed. Luckily she agreed to this disclosure. In another case involving allegations that a police officer had corrupt motives in extending the date of his medical retirement, we were able to refer the protected disclosure to NSW Police for investigation without any need to identify the complainant.

The requirement of confidentiality can, however, be a double-edged sword. On the one hand, it may offer the best protection for complainants against reprisals. On the other hand, a defendant in proceedings for detrimental action, victimisation or tort can use it as a defence. For example, in a case involving the prosecution of a police officer for alleged detrimental action, the defendant was able to show that the whistleblower's identity had not been disclosed to the police or its investigators. As a result, there was no way to prove that detrimental action taken by the defendant against the whistleblower was in reprisal for the complaint he made.

The requirement that confidentiality be maintained does not address the fact that people within an agency often know exactly who made the disclosure. For example, the whistleblower may have somehow communicated their intention to complain before making the disclosure or have previously raised the issue in the workplace. They may be the most likely person to have made the disclosure given the nature of their work or their knowledge of or involvement in the matter or related issues.

Another problem is that people who are aware that a disclosure has been made can wrongly guess the identity of a whistleblower and then mistakenly harass a person who has had no involvement in the matter.

We have found one remedy for cases in which it is impractical to maintain confidentiality. After gaining the complainant's permission to disclose their identity, we have on occasion approached the agency's CEO early in the process. We have told the CEO that a disclosure has been made and who the complainant is. We then inform the CEO that we will hold him or her responsible for ensuring that no detrimental action is taken against the whistleblower. From our experience, this approach has resulted in senior management making sure that appropriate protections are in place.

Case study 36

An employee of the Department of Ageing, Disability and Home Care complained to us about how the department handled a protected disclosure she'd made about staff at a group home accessing pornography via one of the home's computers.

The department believed that because the computer was privately owned it was not covered by the department's internal computer use policy. The complainant insisted that the department had purchased the computer and provided a copy of the receipt.

The department maintained that the receipt she provided did not refer to the computer in question and, despite considerable time spent tracking down a receipt that would prove ownership, no definitive proof was found.

The department used its view that the computer was privately owned to argue that the complaint was not a protected disclosure. They also asserted that as the incident had been investigated as a management issue before the complainant approached the Ombudsman and the department's Professional Conduct Unit and was therefore considered to be public knowledge, there was nothing further to be gained by treating the complaint as a protected disclosure.

We pointed out to the department that the PD Act is not simply intended to protect the complainant's identity – it also protects the complainant from any victimisation, harassment or other reprisals stemming from making a complaint. Because the department had refused to accept the complaint as a protected disclosure, the complainant's rights under the Act had in effect been denied.

As a result of our inquiries, the department agreed that the complaint should have been accepted as a protected disclosure and apologised to the complainant. In addition, they assured us that new accounting measures were now in place for group homes to ensure proper future tracking of all assets.

The department has also put in place a policy covering the use of all computers on departmental property.

Lindy Annakin, a senior investigation officer in our general team and editor of this year's Annual Report.

Training and review

During the year, we presented six training sessions for senior managers at agencies including the Motor Accidents Authority, State Rail Authority and Transgrid.

Our advice was also in demand across the country. For example, the Deputy Ombudsman was invited to Western Australia to brief senior bureaucrats (including the WA Ombudsman) on the practical implementation of the *Public Interest Disclosure Act 2002*, their equivalent to our PD Act.

We also offered an internship to a postgraduate student who will review all Australian and New Zealand Acts offering whistleblower protection. We will then make recommendations to the Joint Parliamentary Committee on the Ombudsman and the PIC about potential amendments to the NSW Act.

Working with the steering committee

The Protected Disclosures Act Implementation Steering Committee (the steering committee), chaired by the Deputy Ombudsman, met four times during 2002-2003. The Strategic Plan 2002-2005 and Work Plan 2003-2004 were both approved. The steering committee conducted training and produced and distributed fact sheets on protected disclosures for state and local government agencies. They also recommended legislative change so that the PD Act is reviewed every five years instead of every two years.

Following recommendations made by the steering committee, the *Local Government Act* and *Protected Disclosures Act* were amended to clarify the definition of an 'officer of a council'. The definition now explicitly includes disclosures about the conduct of a council, a delegate of a council, a councillor, and a staff member of a council. The PD Act was also amended to extend protection to public sector staff making allegations about staff from another agency.

Examples where public sector staff may observe the behaviour of those employed by another agency during their day-to-day work include Joint Investigation Response Teams (involving both police and DoCS staff), Business Link, the Department of Public Works and Services, and the Central Corporate Services Unit. This unit looks after human services, financial services, IT, facilities and records management, procurement, and research and development needs for government departments.

The steering committee made a submission to Standards Australia on their draft Australian Standard, *Whistle blowing systems for organisations*, published in June 2003. The standard is for both public and private organisations which creates potential difficulties because the corporate governance and accountability frameworks for the public and private sectors are very different.

The committee congratulated Standards Australia for taking this step and asked that the standard explicitly state that it did not replace or override the PD Act or any other standards of greater scope that apply to public sector agencies.

Kim Swan, legal officer and Galina Laurie, project officer.

A change of name

In last year's Annual Report, we mentioned a possible name change for the PD Act. The suggestion was to rename it the 'Public Interest Disclosures Act' to better reflect the Act's intent that protected disclosures are in the public interest and to reduce the tendency for staff to confuse personal grievances with protected disclosures.

We asked state and local government agencies for their views on the name change but, despite lively debate, a poor return rate provided inconclusive results. The issue is therefore currently on hold.

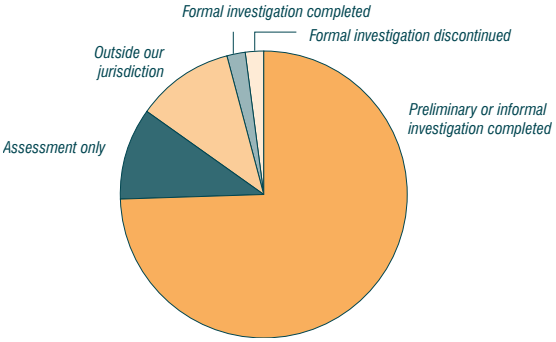
Freedom of information

Our role

We have a role under the *Freedom of Information Act 1989* (the FOI Act) to review the conduct of public sector agencies in relation to Freedom of Information (FOI) applications. These applications are made by members of the public wanting to access information or amend records of personal information held by the agencies.

We review how agencies handle FOI applications and the merits of the decisions they make. We also provide guidance and assistance to agencies about their FOI decisions and processes.

Figure 29: FOI complaints received and determined



Complaints received	
Oral	367
Written	140
Review	8
Total	515

Complaints determined (written)	
Preliminary or informal investigation completed	108
Assessment only	15
Outside our jurisdiction	16
Formal investigation completed	3
Formal investigation discontinued	3
Total	145

Current Investigations (at 30 June)	
Under formal investigation	0
Under preliminary or informal investigation	17
Total	17

We deal with FOI matters impartially and independently and try to help all NSW public sector agencies conduct their FOI work in a fair, reasonable and accountable way. This is an area that can become highly politicised. Members of various interest groups and political parties consistently use the FOI Act to obtain information from government agencies. We do not perform our functions to facilitate political purposes. Our sole purpose is to make sure that agencies comply with the provisions of the FOI Act and its underlying philosophy of accountable government.

FOI complaints

This year we managed to finalise more complaints than we received for the third year running. This helped us deal with our previous backlog of complaints. We also increased the number of matters that have been completed to our satisfaction. This usually means that the agency agrees to release the documents we believe should be released or they agree to take some other positive action to address the particular problem we have identified.

During 2002-2003, in over 80% of matters where we raised issues with agencies, the complaints were either resolved to our satisfaction (52.5%) or finalised on the basis that there was no or insufficient evidence of wrong conduct (27.5%).

Formal investigations

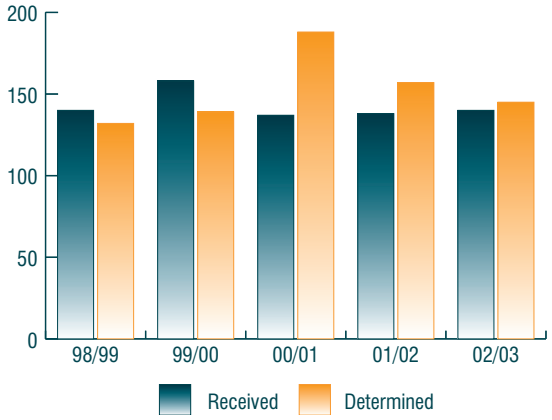
We initiated six formal investigations in 2002-2003. We discontinued three of these after the underlying issue had been resolved and issued final reports on the others.

Nature of complaints

Although the majority of complaints we received this year were about agencies refusing access to documents, the actual number of complaints about this issue has gone down from 95 to 73 over the last four years. People also complained about a range of other matters including incorrect procedures (29), concealing documents (12) and claims that documents are not held (8).

We also received complaints from third parties about proposals by agencies to release documents about their personal or business affairs (8).

Figure 30: FOI complaints (written) received and determined – five year comparison



	98/99	99/00	00/01	01/02	02/03
Received	140	158	137	138	140
Determined	132	139	188	157	145

Implementation of the FOI Act by agencies

In our 2000-2001 annual report, we indicated that it was unlikely we would be able to carry out any further audits or reviews of FOI annual reporting because of resource constraints. However, in its December 2002 report entitled 'First Report on the Inquiry into Access to Information', the Committee on the Office of the Ombudsman and the Police Integrity Commission recommended that:

> *'… the Ombudsman's annual audit of compliance with FOI annual reporting requirements should continue and adequate resources should be made available by the Government for this purpose.'* (recommendation 1)

Given the importance of such audits, and the interest from the public and our parliamentary committee, we decided to resume our audits of FOI annual reporting and conducted an audit of agency annual reports for 2001-2002. The results of this audit and our review are available on our website www.ombo.nsw.gov.au.

Our most recent audit of FOI reporting by agencies has shown that, while the numbers of FOI applications reported to have been made to audited agencies has increased significantly since 1995-1996 (by at least 15%), the percentage of applications that are approved in full has decreased significantly (by approximately 17%) over the same period. In 1995-1996 audited agencies reported fully disclosing documents in over 80% of matters but by 2001-2002 this had fallen to only 63.5%. Most of this change is due to an increase in the percentage of matters where only partial access was granted to the requested documents. The percentage of matters refused in full remained largely the same.

We also found that agency compliance with mandatory 'summary of affairs' reporting requirements in June 2003 was at its lowest since our audits began in June 1997.

What is the Ombudsman's FOI jurisdiction?

One of the issues that has arisen this year is whether we have jurisdiction to investigate a matter if the applicant has not previously sought an internal review.

We have always considered that there is no provision in the FOI Act that prevents us from exercising powers under the *Ombudsman Act* in relation to a matter that may also fall under the FOI Act. Examples include:

- the general FOI related conduct of an agency - as opposed to specific decisions on applications for information
- the course of conduct or the general approach adopted by an agency arising from a number of FOI decisions
- decisions to allow access to a certain category or type of information as distinct from access to specific documents.

We have received senior counsel's advice that, when dealing with issues associated with public agencies and the FOI applications made to them, our powers and jurisdictions from both the *FOI Act* and the *Ombudsman Act* co-exist. They are not inconsistent and should not be interpreted in a way that unduly restricts the obligations and traditional functions of the Ombudsman. Also, the restriction under the FOI Act relating to internal reviews does not prevent us from conducting preliminary inquiries under the *Ombudsman Act* - these are not 'investigations' under the *FOI Act*.

Figure 31: Nature of FOI complaints

Issue	Written	Oral	Total Complaint
Abuse/rudeness	0	1	1
Access refused	73	41	114
Admin wrong conduct	0	1	1
Agency enquiry	0	86	86
Amendments	2	6	8
Charges	3	10	13
Child abuse related	0	1	1
Documents not held	8	5	13
Documents concealed	12	8	20
Documents destroyed	1	1	2
Documents lost	2	0	2
General FOI	0	74	74
Information	0	3	3
Outside our jurisdiction	2	3	5
Other misconduct	0	2	2
Pre-application enquiry	0	66	66
Pre-internal review enquiry	0	39	39
Third party objection	8	4	12
Wrong procedure	29	16	45
Total	140	367	507

Is the motive of a FOI applicant relevant?

Courts and tribunals often refer to a release of documents under FOI as being to 'the world at large'. This recognises an agency's lack of control over a document once it is released under FOI. However this does not mean that agencies cannot consider the motive, particular interest or identity of an applicant in appropriate circumstances. It has been found in a variety of cases in the Administrative Decisions Tribunal (ADT) and elsewhere that the motive of a FOI applicant can be a relevant consideration in assessing exemptions for documents. The identity and particular interests of the applicant can also be relevant if, for example, the application is for documents that contain medical or psychiatric information about the applicant, there is a public interest in the applicant having access to documents (they have a 'right to know' as opposed to mere curiosity), or if disclosure of material about the personal affairs of a third party would be unreasonable.

Amending records

In 2002, the NSW Court of Appeal made a decision that has implications for record keeping in NSW (*Crewdson v Central Sydney Area Health Service [2002]* NSWCA 345).

An employee of a large government agency was dismissed after the agency received a medical opinion from another agency stating that he was unfit to continue work. He became involved in industrial proceedings and made an application under the FOI Act to amend and delete the medical opinion because he considered it to be wrong. The agency refused to amend it.

The employee appealed to the ADT. The tribunal disagreed with the agency and considered the medical opinion to be misleading. The tribunal ordered that it be deleted and permanently removed. This decision was overturned on appeal by the Appeal Panel of the ADT. They determined that the medical opinion was not misleading and should therefore remain on the record. The Appeal Panel believed that although deletion was an option available under the FOI Act, it was only appropriate in extreme cases.

The FOI applicant then took his case to the NSW Court of Appeal which also rejected his claim. The court held that the FOI Act was concerned with the accuracy of official records and not with the merits or legality of any official action recorded. It did not provide a vehicle for the collateral review of the merits or validity of official action. The court noted that, in circumstances where an expert opinion had been accurately recorded but was later thought to be incorrect at the time it was made, the proper course would be to add a notation that the opinion had been withdrawn rather than remove the original opinion. Deleting the information would falsify the records and attempt to rewrite history.

We see this issue from time to time in the complaints we receive and will continue to monitor it in the future.

Case study 37

In 2001 the Minister for Education and Training announced that he proposed to close Hunters Hill High School at the end of 2002. The Hunters Hill High School P&C Association began a public campaign against this decision. The P&C also applied under the FOI Act to the Department of Education and Training for various documents about the department's actions and its consultation with the community and certain interest groups about the proposal to close the school.

Although the department's determinations did give the P&C access to various documents, the P&C complained to us that it was suspicious that not all documents it had requested had been identified in the department's determination. This suspicion was based on the department's advice that it did not have documents 'containing records of meetings and consultations [with many parties] to discuss the future of secondary schools in the Ryde District'.

It took the department some months to respond in writing to our inquiries. After assessing their response, we began a formal investigation. This investigation canvassed a number of issues including delays by the department in dealing with the P&C's applications and their failure to identify relevant documents, consult with the P&C to clarify the scope of their application or give reasons for claimed exemptions.

It subsequently emerged that the department had failed to identify all the documents that were subject to the P&C's FOI application. In addition, very senior officials of the department had attended 39 meetings in 2000 and 2001, at which the future of the school was most likely discussed, without making or keeping records of those meetings.

Shortly after we had sent our preliminary report to the department for comment, the then Minister for Education and Training announced that he had reversed the decision to close Hunters Hill High School. This decision was widely reported in the media. In making his decision not to close the school the minister cited the criticisms we made of the department in our preliminary report.

In our final report about this investigation, we recommended the department release documents showing the Valuer General's valuation of the Hunters Hill School site. We suggested that details of two confidential meetings about the decision to close the school should be released. We also recommended that the department remind all their staff of the need to comply with relevant provisions of the *State Records Act,* particularly the requirement for public officials to properly and thoroughly record their decisions and activities. The department complied with all of our recommendations, including drafting new FOI procedures to make sure it dealt with FOI applications on a more professional basis in future.

The Hunters Hill High School P&C had also applied to The Cabinet Office under FOI for all documents relating to the decision to close the school. They released various documents but determined that most of the requested documents were exempt. We considered that documents relating to the minister's decision to close the school should have been released to the P&C as this matter had been finalised and disclosure would not therefore be contrary to the public interest.

We put this view to The Cabinet Office and they redetermined the matter and released the documents to the P&C. Other documents remained exempt as they did not relate to Hunters Hill High School.

Case study 38

We recommended that Broken Hill Council release correspondence and reports relating to an ICAC inquiry. Not only was the recommendation adopted, but council also released a significant amount of additional material relating to the inquiry. The result was greater transparency about why neither the ICAC nor the council upheld the original complaint.

Record keeping

It is a fundamental principle of good administrative practice that public sector staff make and keep full and accurate records of their official activities. Good record keeping improves accountability and provides for transparent decision making.

The *State Records Act* obliges public sector agencies to make and keep full and accurate records of their activities (s.12(1)). Staff should help their agencies to meet this obligation by creating and maintaining full and accurate records of the work they do and the decisions they make, including the reasons for those decisions.

Unfortunately, our experience is that record keeping is often seriously deficient. Please see case study 37.

Reviewing FOI policies and procedures

Last year we reported on an investigation we had started into the FOI processes of the Department of Community Services (DoCS). This began after we became aware that there might be systemic problems in DoCS' FOI processing and recordkeeping practices.

The Ombudsman's special report to Parliament in April 2002, 'DoCS – Critical Issues', identified some of these problems. In the course of our investigation there were a number of significant changes within DoCS and to relevant government policy. We therefore asked DoCS for a progress report on the problems identified. They advised us that they had taken the following action.

- A review and assessment of the DoCS FOI unit had been completed in April 2003. They had now employed additional FOI staff and started to rectify problematic internal processes. They had made improvements in meeting statutory deadlines and were planning a comprehensive internal communication strategy to increase staff awareness of FOI issues.
- Special attention had been paid to the consistency and standardisation of policies and procedures to inform staff practice. A standard file cover had been developed for statewide introduction and a new client information system is to be implemented later in 2003.
- A new records management system is to be developed and implemented by Businesslink, a cross-agency initiative that includes DoCS. Funds for a scoping study and system specification were included in the initial package for Businesslink.

As a result of this evidence of progress in key areas of concern, we discontinued our investigation. However our final letter to DoCS made it clear that we have a continuing interest in these vital areas and may consider making further inquiries in the future.

Case study 39

An FOI application was made to the Environment Protection Authority (EPA) for all documents relating to the EPA's liaison with the Roads & Traffic Authority (RTA) about sewerage disposal problems in 1998 and 1999 at a rest stop for drivers on the Hume Highway near Gunning. The EPA gave access to numerous documents but advised it could find no documents detailing its contact with the RTA in 1998 or 1999.

The complainant alleged the EPA had lost or was concealing documents relating to a major environmental problem at the site and that the failure to produce documents concealed improper conduct by the EPA and the RTA. We established that the EPA did contact the RTA in the late 1990s about sewerage problems at the site although it could find no records.

The EPA advised us that records may either not have been made at the time or may have subsequently been destroyed. However, they advised us that the environmental problems were minor and the liaison between the RTA and the EPA had not been extensive. We reminded the EPA of their record keeping requirements under relevant legislation, including the *State Records Act*.

Case study 40

The Rail Infrastructure Corporation (RIC) refused to give a journalist applicant access to a risk assessment report on Sydney's underground rail tunnels. RIC also refused to give the applicant detailed reasons for its refusal of access, considering the reasons to also be exempt.

We met with representatives of RIC and put our preliminary view that most of the report was not exempt and that none of the reasons were exempt. This matter was resolved by the following compromise.

Although access was still refused, RIC arranged a number of meetings where the journalist was given detailed explanations for RIC's point of view, the background to the report, access to the director general as well as the opportunity to ask questions, view the report and take notes.

Case study 41

An employee of the Rail Infrastructure Corporation (RIC) applied under FOI for a consultant's report about a confrontation involving himself and some of his colleagues. RIC determined that the report should be exempt without giving reasons.

We wrote to RIC asking for a copy of the report together with supporting reasons why all or part of the document should not be provided to the employee. After a considerable delay, RIC advised that it had decided to release the report with the exemption of the names of two of his colleagues.

Even though the complaint was resolved, we raised our concerns with the CEO of RIC about their delays and other deficiencies in handling this matter.

Case study 42

A journalist applied to the State Rail Authority (SRA) for all documents about the '10 worst' commuter rail services in NSW and efforts to improve them. In refusing access, the SRA argued that processing the application would involve an unreasonable diversion of resources. However the SRA had not given the journalist any opportunity to narrow his application.

When we began our external review, the SRA agreed to meet with the applicant to resolve the matter. This led to a narrowing of the application to 'top level' material only which was then released.

Resolution of complaints

Our focus with FOI complaints is on resolution wherever this is possible and appropriate. We often make suggestions to agencies on how they might resolve FOI matters that are subject to our review. If our inquiries indicate that processes or decisions were incorrect, we usually suggest ways for the agency to remedy mistakes and change determinations. We may make informal suggestions verbally or in writing, or formally under the FOI Act. This allows an agency to redetermine an application in accordance with a suggestion by the Ombudsman. If an agency follows our suggestions we will generally consider the external review to be complete.

NSW Police

We commend the general level of performance by NSW Police this year in their approach to external reviews and particularly their significant efforts and activities to resolve FOI complaints. Case study 46 includes several examples of work done in this area.

Police rosters

Overall numbers of police and their allocation to particular stations, local area commands and regions is an issue of continuing interest to MPs, the media and members of the public.

In case study 53 in our 2001-2002 annual report, we gave details of our investigation into NSW Police's refusal of access to police rosters.

During the course of the investigation, certain members of NSW Police and the Police Association raised concerns about police officer safety. However, in response to our inquiries, NSW Police confirmed that it had no evidence of any security problems as a result of the previous practice of releasing rosters in full. There was also no evidence that, at any time before April 2001, any complaints or concerns had been raised by the police FOI Unit or front line police about their release.

We discontinued our investigation in October 2002 after the then Minister for Police proposed making police rosters available through Police Accountability Community Team (PACT) meetings - this had been announced in Parliament on 25 September 2002. We were pleased that this alternative approach had been adopted.

The PACT proposal appears to be a reasonable and practical way to achieve greater transparency in relation to police rosters and recognise the genuine public interest in this issue without exacerbating the concerns raised about police officer safety.

Case study 43

A woman complained about the decision of South East Sydney Area Health Service (SESAHS) to disclose under FOI a copy of a letter she had written to a SESAHS care provider about the standard of care being provided to her mother.

We found that the release of the letter would have involved an unreasonable disclosure of the woman's personal affairs. The frank expression of the woman's views should have been exempt even though much of the rest of the letter was merely factual.

We suggested to the SESAHS that some information be deleted and the letter then be disclosed, subject to a deferral to allow the woman the opportunity to appeal to the ADT. The SESAHS accepted and implemented this suggestion.

Case study 44

The complainant in this matter was studying cattle and sheep production courses. She claimed that there had been changes to the courses based on improper reasons and applied under FOI for relevant documents.

The Department of Education & Training exempted certain material as it claimed they were internal working documents. However all final decisions had occurred well over a year before the department determined this FOI application.

The department's exemptions not only served no good purpose but also made reference to a decision made in the 1980s by the Federal Administrative Appeals Tribunal. This decision has been strongly criticised in numerous judicial and administrative decisions as being contrary to the public interest. After receiving our comments and criticism, the department reviewed the matter and released all the documents.

Case study 45

A legal firm wrote to us with a FOI complaint relating to documents involving Uralla Shire Council's purchase of a property for $1.3 million for a purpose that did not eventuate. They argued that this meant the council was left with a 'useless' property.

The legal firm made an FOI application for access to documents about the purchase and access to the contract for the council's general manager. They received a letter from another legal firm representing the council which advised that they would be dealing with the FOI application and requested disclosure of the identity of the applicant.

Soon after, the applicant firm received another letter from the council's legal firm asking for an advance deposit of approximately $2,500 for processing costs. Some of these costs were calculated on the basis of $60 per hour (the FOI Act only allows $30 per hour).

We wrote to the council pointing out that a private legal firm could not determine the application on the council's behalf and highlighted the flaws in the firm's advice.

The council's firm contacted us and asked whether they could try and negotiate with our complainant to resolve the matter. The negotiations led to all relevant documents being released, including the general manager's contract.

FOI manual

In 1998 we agreed to produce a joint FOI procedure manual with the Premier's Department that would combine our respective publications.

We undertook to combine and update the material based on ADT decisions and our work since the original publications. We completed the bulk of this work by late 2001. After a series of delays, we are hopeful the FOI manual will be finalised and published before the end of 2003.

The manual will be available in electronic form on the Premier's Department website at *www.premiers.nsw.gov.au* or on our website. It will also be available in hard copy from this office and the Premier's Department.

Case study 46

- A complainant claimed that a FOI application had involved significant processing delays and failed to identify many documents. Following our intervention, the police located and made determinations concerning more than 1,200 additional documents and disclosed previously exempt material.
- A complainant believed that another person had been wrongly convicted of a serious crime and that a 'missing' report about a physical assault in 1988 might prove he was in police custody at the time the crime was committed. At our request the police made further searches, provided thorough descriptions of all the searches previously conducted and detailed the document types used in 1988 and the relevant destruction schedules. They spoke to those officers still serving who had been involved in the investigation of the physical assault. No documents were found, but the police actions allowed the complainant to conclude with some certainty that this was an unproductive avenue of inquiry.
- A complainant provided ample evidence of the existence of certain documents disputed by police in a FOI determination. The complainant also argued that the police should apologise for what she claimed were inappropriate remarks and an incorrect and insulting comment in their FOI determination. As a result of our preliminary inquiries, the police conducted extensive searches. They confirmed that the documents did in fact exist, but they did not hold them. To resolve the matter the police sought the documents from the District Court and passed them on to the complainant. They also expressed regret for the comments to which the complainant objected.
- A solicitor was acting for a family who had lodged a complaint alleging that one of their relatives had been assaulted by police. The complaint was under investigation but had been severely delayed. The solicitor had been told by police that witnesses had been interviewed but the witnesses told him this had not happened. He therefore applied under FOI for the investigation report. The police FOI determination advised him the report was exempt as the investigation was ongoing.

  We then wrote to the police asking for a copy of the report. We were advised that the local area command had not compiled the report but it would now be written on an urgent basis. It turned out that the local area command had misled the police FOI Unit by not telling them the report had not actually been written. In a conciliatory gesture, the police offered to waive the application fee for the report. The Ombudsman subsequently advised the Police Commissioner that all units within NSW Police need to provide accurate and appropriate advice to the FOI Unit in response to its inquiries.

Case study 47

A manager of a shipping firm had been involved in a long term dispute with another firm over tender applications to provide services to Lord Howe Island.

The manager requested all documents in relation to the Waterways Authority's involvement in an earlier FOI investigation that we had conducted as a result of his complaint about another agency. This had involved an oil spill at Lord Howe Island and the prosecution of the manager's shipping firm for that oil spill.

Various documents were exempted by the Waterways Authority because they were considered to be either internal working documents or subject to legal professional privilege. We considered that there should not be a blanket exemption for all internal working documents, so these were subsequently released. Some documents claimed to be subject to legal professional privilege were also released as in our view the exemption was either contrary to the public interest, the legal advice was incorrect or exemption of the legal advice served no good purpose and would only unnecessarily exacerbate current tensions in the shipping community. This resolved the complaint.

Case study 48

In 2002, the office of the Leader of the Opposition applied to Sydney Water under FOI for various documents relating to dividend payments and proposed price rises during the years 2002-2006. The former managing director of Sydney Water made the initial determination claiming that various documents were exempt. This prevented the opportunity for internal review under the FOI Act. Sydney Water also advised it needed to consult with NSW Treasury about many of the documents because they concerned Treasury's affairs.

We did not agree with aspects of Sydney Water's determination so we met with senior management to discuss our views. We then wrote suggesting that they review their determination and consider releasing a large number of documents. Sydney Water consulted with NSW Treasury and agreed to release some of the documents. Not long after the state election, Sydney Water advised us that Treasury had agreed to the release of further documents. However access to a draft statement of corporate intent was deferred pending its tabling in Parliament. The release of most of the documents resolved the complaint.

Case study 49

In late 2002, the office of the Leader of the Opposition applied under FOI for documents detailing productivity savings achieved by the Department of Health to fund pay increases. The initial determination claimed that the documents were 'cabinet documents' and were therefore exempt. In dealing with the application, the department's chief financial officer would not give the relevant documents to the FOI manager to make a proper determination. The manager therefore had to make the determination without seeing them.

In the internal review determination, the department claimed that the 'cabinet documents' were not subject to the FOI application and that other documents sought were held by Area Health Services and not the department. The only part of a document claimed as subject to the application was one sentence of one page. We met with representatives of the department and wrote to them about the conduct of both the initial determination and the internal review.

The Cabinet Office subsequently certified that most of the subject documents were 'cabinet documents'. The remaining part of the one page was released which resolved the complaint.

Scrutiny

We are responsible for keeping under scrutiny the complaint handling systems and practices of the police and agencies providing services to children.

The police are responsible for dealing with complaints against their officers. Our role is to make sure that they deal with these complaints properly. Agencies providing services to children are responsible for dealing with allegations of child abuse against their employees. However, they must notify us of these allegations and we are responsible for overseeing the way they handle them. Our work in these areas is discussed in this section under 'Police' and 'Child protection'.

We monitor the decisions agencies make in response to individual complaints as well as the policies and systems they have to deal with these matters. For example, we look at how well agencies use the feedback from complaints to improve their operations and we analyse complaint patterns and trends to help agencies better understand that feedback.

Our aim is to make sure that matters are handled in a fair, reasonable and transparent way and that agencies learn from the allegations or complaints they deal with.

We are also responsible for making sure that law enforcement agencies running covert operations involving undercover work and telecommunication interceptions comply with mechanisms designed to make them accountable for their actions. Our work in this area is discussed in this section under 'Covert operations'.

Finally, we are required to keep under scrutiny the operations of several laws, many of which give the police additional powers. For more details, please see 'Legislative reviews' in this section.

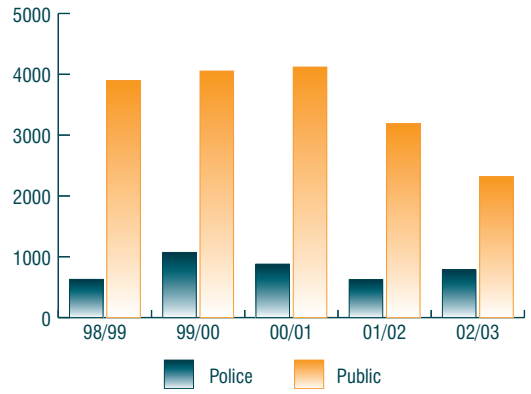
Police

Introduction

NSW Police and the Ombudsman have significant but distinct responsibilities for handling complaints about police.

Under the scheme established by the *Police Act 1990*, NSW Police have the primary responsibility for dealing with police complaints. This is consistent with the responsibility of any government agency to handle complaints about the conduct of its staff. In the area of complaints about police, a particular obligation falls upon police commanders to take responsibility for the effective investigation of complaints about officers under their command.

Figure 32: Police complaints received or notified – five year comparison



	98/99	99/00	00/01	01/02	02/03
Police	628	1,071	879	621	783
Public	3,894	4,053	4,119	3,183	2,316
Total	4,522	5,124	4,998	3,804	3,099

** Since January 2001 NSW Police has not been required to notify the Ombudsman of minor complaints from members of the public unless the matter has resulted in death, injury or significant financial loss. Since July 2001 one-off complaints of minor workplace harassment or discrimination have generally not been notified to the Ombudsman. The two changes have significantly reduced the number of minor complaints notified. This is reflected in this year's complaint figures - including reduced formal investigations of minor complaints.*

The Ombudsman's role is essentially to oversight how well NSW Police and its commanders are handling and investigating these complaints, managing officers who are the subject of complaints, and taking action to address any broader issues of police management that have been raised.

The Police Integrity Commission (PIC) is primarily a corruption fighting body, but also has an involvement with complaints about police. NSW Police and our office must notify the PIC of 'Category 1' complaints – those complaints that allege the gravest forms of police misconduct.

While the PIC has a broad power under its legislation to take over the investigation of complaints and to monitor NSW Police complaint investigations, they appropriately focus their resources on intensively investigating only a select number of matters involving police corruption and other serious misconduct. This means that, in practice, the Ombudsman is the agency principally responsible for oversighting how NSW Police handles complaints – including serious complaints about its officers.

The value of good complaint handling

How complaints are handled is a key management issue for public sector agencies, particularly NSW Police. The ability of any government agency to deal with complaints about its staff can be seen as a litmus test of good or poor management by the agency.

How well NSW Police deals with complaints is therefore an important indicator of the quality of NSW Police management generally. One of our specific obligations under the *Police Act* is to 'keep under scrutiny the systems established within NSW Police for dealing with complaints'.

Public confidence

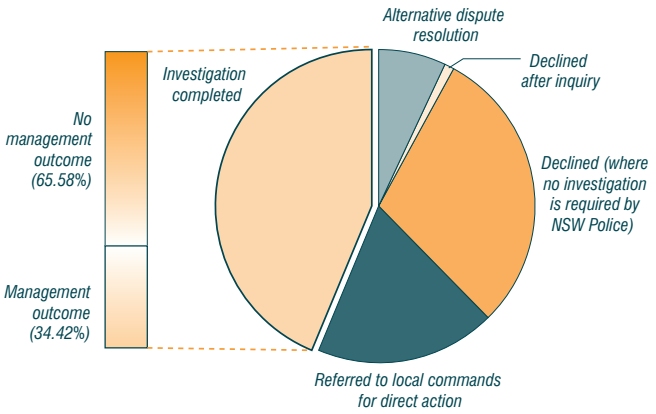
It is vital that complainants, police officers and the general public have confidence in the system for dealing with complaints about police. Inadequacies by NSW Police in handling and investigating complaints has the potential to undermine everyone's confidence in the integrity of the system.

*Figure 33: Police complaints received and determined**

Complaints received or notified	
Written complaints	3099
Oral inquiries	3114
Reviews	41
Total	6254

Action taken on written complaints*	
Alternative dispute resolution	225
Declined after inquiry	7
Declined (where no investigation is required by NSW Police)	959
Referred to local commands for direct action	601
Investigation completed	1412
Total	3204

Current investigations (at 30 June)	
Under investigation	1268
Alternative dispute resolution in progress	102
Total	1370



Complainants

For complainants, it is obviously important that NSW Police respond appropriately to their concerns. A poor approach to resolving the complaint, a flawed investigation, unnecessary delays, or an obviously inadequate outcome will understandably disappoint or anger a complainant. On the other hand, taking the complainant's concerns or allegations seriously, dealing with them appropriately and taking suitable remedial action where necessary should result in complainant satisfaction.

Police officers

It is also important that police officers about whom complaints are made are treated fairly. The very fact that an officer's conduct is being investigated will often be stressful. If the investigation is delayed, that stress is unfairly prolonged. Officers must also have the opportunity to put their side of the story during the investigation and have the merits of the complaint carefully assessed in light of the relevant evidence.

Any management action taken by a commander in relation to poor performance or improper conduct by the officer should be proportionate to the nature and seriousness of the conduct in question. Unfair or oppressive action can undermine the confidence of police in the integrity of the complaints system.

Figure 34: Findings table

	98/99	99/00	00/01	01/02	02/03
No management outcome (including no adverse finding)	537	1296	1487	1341	926
Management outcomes following investigation of complaints (including adverse findings)	435	649	1080	787	486
Total Investigation completed	972	1945	2567	2128	1412

Complaints as a resource for management

Good complaint handling also has benefits beyond dealing with the immediate issues of poor performance or misconduct by individual police officers. Used properly, complaints can be a significant resource for the better management of NSW Police.

Systemic problems

Complaints may reveal problems with existing policies, procedures and practices. It is significant that the Police Act recognises that a complaint may be 'indicative of a systemic problem involving NSW Police generally, or a particular area of NSW Police'. The police investigation of a complaint may therefore extend to an examination of the adequacy of relevant NSW Police policies and procedures. If an investigation reveals deficiencies in these policies or procedures, appropriate recommendations should be made and action taken to remedy any problems.

Officers of concern

The complaint histories of officers are a valuable resource for police. Our special report to Parliament in March 2002, 'Identifying and managing officers with complaint histories of significance', highlighted the need for police commanders to manage officers with complaint histories of significance fairly and more effectively. As we said in that report:

> Without consistent service-wide strategies to identify, supervise and manage officers with complaint histories of significance, their continued presence can pose serious risks to themselves, their colleagues, the police service and members of the public.

We also stressed in our report the importance of using complaint histories to enhance complaint investigations:

> *Checking an officer's complaint history supplements the information already available to investigators, helping with decisions about the degree of investigation required. Such checks can either heighten or allay concerns about the likelihood that, if proved, the conduct alleged might be related to broader conduct, competence, integrity or performance issues. These considerations are relevant to assessing the priority that should be given to particular lines of inquiry and are essential to appropriate investigative decision-making.*

Problems in commands

Complaints may sometimes indicate problems within particular commands. For example, an assessment of police internal complaints about poor management practices within a command and complaints by police about their colleagues could form the basis for improving the general management of the command and resolving workplace tensions.

A pattern of complaints by members of the public about oppressive or inadequate law enforcement practices in a particular area might provide a platform for examining the suitability of those practices or better consultation with the community involved.

For examples please see case studies 54 and 56.

Complaints should not be seen by NSW Police and its commanders and officers as an inconvenient distraction from the business of policing. Instead, complaint handling should be seen as an opportunity to identify and remedy actual or potential problems, whether these arise from the unreasonable or improper conduct of particular officers, inadequacies in police management or deficiencies in policy and procedure. Good complaint handling is both an indicator of good management and a tool for good management.

How we oversight complaint handling

Complaints received and notified

This year we received 6,213 complaints (oral and written) and notifications about police. This figure covers complaints and inquiries that we received from members of the public as well as complaints made by the public to NSW Police that were then notified to us. It also includes complaints by police officers about the conduct of other police (police internal complaints) that NSW Police is required to notify. Please see figure 33 for more details.

Complaints by police officers have increased by about 20% this year. This is strong evidence of the confidence of many police officers in the complaints system. Furthermore, of the 62 officers charged with criminal offences this year, 41 were charged as the result of the investigation of complaints made by other police officers. For more details, please see the statistics on officers criminally charged in figure 39.

Case study 50

An off-duty police officer was involved in a motorcycle accident and knocked unconscious. He was taken to hospital by ambulance.

During the police investigation of the accident, one of the nurses who treated the injured officer said she had been approached at the hospital by a friend of the officer – another police officer – who had asked whether a blood sample had been taken.

According to the nurse, the friend appeared to be intoxicated and said 'We are both cops, do you have to send off his blood alcohol?' It appeared to the nurse that the officer was trying to prevent a blood alcohol analysis of his friend's blood sample. Notwithstanding the friend's request, the sample was sent for analysis.

As a result, the officer involved in the accident was charged with driving with a high range prescribed concentration of alcohol. The other officer was charged with acting with intent to pervert the course of justice in relation to his alleged approach to the nurse.

Case study 51

There was a police investigation into a complaint that a female constable had become romantically involved with a man with a lengthy criminal history. It was found that the officer was in a relationship with the man, and even went away on a holiday with him when she knew that he was wanted for breaching bail conditions and was liable to arrest for doing so. In addition, it was discovered she had accessed the police computer for information about the man. As a result, the officer was criminally charged with neglect of her duties as a police officer.

The investigation also included inquiries into another complaint that the officer had improperly persuaded her sister-in-law to make a false statement against a person that she wanted to pursue for a minor traffic offence, as well as a complaint that the officer had subsequently attempted to assault her sister-in-law with a baseball bat.

The police investigator reached an adverse finding against the officer on both matters. Although there was insufficient evidence to prefer a criminal charge of perverting the course of justice, the officer was charged for the attempted assault.

The constable was found guilty of neglect of her police duties and fined. While the court decided that the attempted assault had occurred, no conviction was recorded.

The Commissioner subsequently removed the officer from NSW Police.

Case study 52

A police officer was socialising at a bar with colleagues when he became involved in a fight with other patrons. Witnesses said that the officer picked up a schooner glass and threw it at one man, causing serious facial lacerations, and then threw another glass at a second man cutting his cheek.

Police charged the officer with maliciously inflicting grievous bodily harm on the first man and maliciously wounding the second. After charging him, police restricted the officer to station duties. When the matter was heard at court, the magistrate found the officer guilty of both charges. As soon as the officer was convicted, police suspended him without pay.

The officer subsequently received a sentence of 18 months, suspended on the condition that he be of good behaviour. Consideration is being given to whether the officer should be removed from NSW Police.

Distinguishing between more serious and less serious complaints

The distinction between 'less serious' and 'more serious' complaints is determined by an administrative agreement made between the Ombudsman and the PIC in consultation with the Commissioner of Police. This agreement aims to streamline the complaint handling system and means that we can use our resources to maximise the impact of our oversight role.

We focus on closely oversighting the police investigation of more serious complaints, but still maintain an appropriate level of oversight of the police handling of less serious matters. We also have increased capacity to monitor police investigations and conduct our own direct investigations.

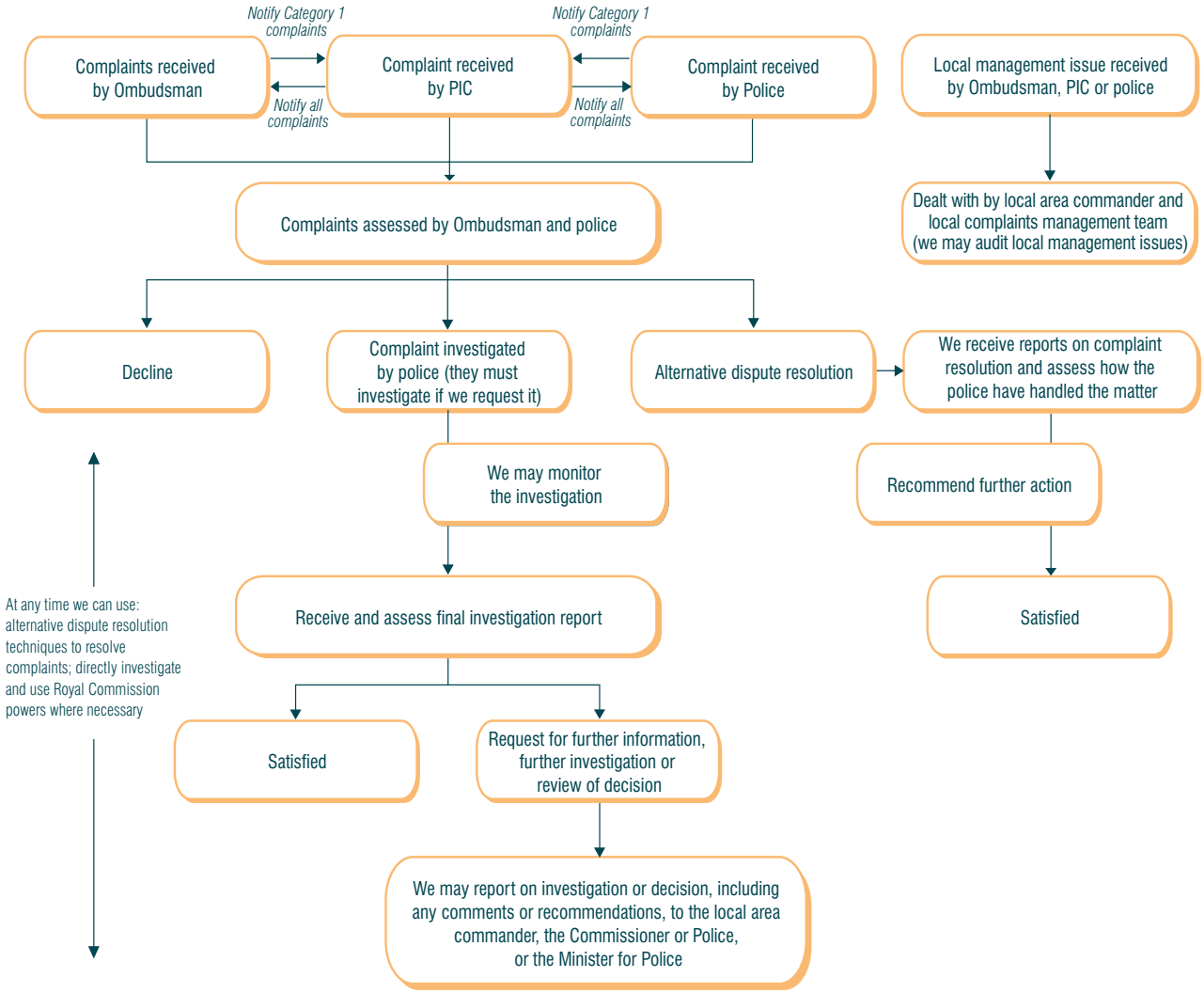
Performance Indicator
Number of audits conducted by Ombudsman

Target	00/01	01/02	02/03
1900	1443	2623	7701

Interpretation

Auditing of police records has increased since changes in January 2001 which mean commanders are not required to notify the Ombudsman of minor complaints from members of the public unless the alleged police failing has resulted in death, injury or significant financial loss.

Figure 35: Police complaints



Handling less serious complaints

We referred many of the less serious complaints that we received to the police for them to deal with, without the direct oversight of our office. Please see figure 33 for further details. These complaints generally concern customer service issues – that is, matters involving poor performance, minor mistakes and errors of judgment. Police commanders should be able to resolve or make brief inquiries into such complaints and take remedial management action where necessary, without the need for direct oversight by the Ombudsman. Remedial action may include such things as an apology to a complainant, the counselling of an officer, or the education of police in how to handle certain types of incidents or matters in a better way.

Complainants can still raise concerns directly with us about how the police handled their complaint. For example, there might have been an undue delay in responding to a complaint or a failure to give adequate reasons for the command's decision on the complaint. We pursue these concerns with police where appropriate.

Although we do not directly oversight the police handling of these less serious matters, we are required to audit their handling as part of our general oversight role, and we regularly do so. This year we audited all the complaint records of ten selected metropolitan, regional and rural local area commands to ensure that they were notifying us of complaints that they are required to notify. We also reviewed the actual police handling of the complaints and were pleased to see that most of them were dealt with appropriately. About 10 per cent of complaints were not notified to us but should have been – fortunately, most had been properly investigated or resolved.

Handling more serious complaints

Many of the more serious complaints that we receive or are notified of are investigated by police, with a requirement that we receive the final report on the investigation. We then carefully assess the quality of the investigation.

We directly oversight complaints alleging criminal conduct or other misconduct that might warrant stringent management action (including the possible removal of an officer from NSW Police), complaints about a lack of integrity or serious incompetence, and certain cases of alleged harassment or victimisation. In addition, we directly oversight complaints about any inappropriate police conduct in incidents involving deaths or injuries in custody, police shootings, and police vehicle pursuits resulting in death or serious injury. Case studies 50, 51 and 52 are examples of the sorts of matters we oversight.

Monitoring police investigations

We usually monitor police investigations of complaints by sitting in and observing interviews with the complainant, the police officer who is the subject of the complaint, and other crucial witnesses. This is often appropriate where the complainant is particularly vulnerable, or when it is critical that the effectiveness of the police investigation not be

Case study 53

In November 2001, we received a complaint from a police officer about other officers in a metropolitan command creating false records of knife searches and conducting unlawful knife searches. The officer alleged that the reason for the inflated statistics was encouragement by senior officers to drive up statistical data to justify police knife search powers. We saw this complaint as very serious. Firstly, it raised the issue of police carrying out illegal searches. Secondly, the statistics in question were relied upon by police, agencies such as the Bureau of Crime Statistics and Research and the community to inform views about the prevalence of criminal conduct and the development of appropriate law enforcement strategies.

After meeting with the police officer who made the complaint, we directed NSW Police to conduct an investigation. We also decided to monitor the investigation. We asked police to take immediate steps to preserve the integrity of police data that recorded knife searches.

As part of our monitoring role, we took various steps to ensure the integrity of the investigation.

- We continually contacted NSW Police over three months, until a police investigator was appointed.
- After discussions with the investigator, we raised concerns with senior police about the need for adequate resources for the investigation – this led to the creation of a four person strike force.
- We assisted the strike force by attempting to contact people recorded as having been searched.
- We observed interviews with police officers.

The strike force found that, although some police had made incorrect recordings of knife searches, they did not do so for unethical or corrupt reasons. Nor was there any evidence of unlawful searches by these officers. Rather, they recorded searches wrongly because of a lack of knowledge and inadequate supervision.

We closely reviewed the six volumes of evidence obtained by the strike force. We were of the view that the investigation itself was satisfactory and agreed that there was no evidence of corrupt conduct. However, we wanted to ensure that officers received guidance and education about the proper recording of the exercise of police powers, including their power to search for knives. The Assistant Ombudsman met with the Region Commander to discuss this suggestion and other issues highlighted by the complaint.

NSW Police agreed with our suggestion about the training of officers and the need to provide information to officers at the command about the nature and purpose of the investigation. They also agreed to review whether action could be taken to correct wrong information - in the event, this was not practicable. However, our suggestions about the need to audit the police recording of knife searches and to measure how the search power was used were not agreed to.

We therefore made a report to the Commissioner and Minister for Police about the matter, recommending that:

- there was a need for a continuing audit of records of knife searches
- statistics should not only focus on the number of searches but whether there is a decrease in knife related crime, whether searches are conducted in places and at times that knife attacks are common, and on the proportion of searches that result in knives being found
- relevant agencies should be advised of the concerns surrounding the reliability of knife search statistics.

We were critical of the failure of NSW Police to take effective action before 1 July 2003 to better ensure the integrity of policing statistics. However, we recognised that changes to police recording systems should result in the more accurate recording of knife and other searches.

We have also recommended NSW Police recognise the contribution of the police officer who made the complaint.

Performance Indicator
Direct investigations completed

Target	01/02	02/03
14	22	29

Interpretation

This year we more than doubled the number of direct investigations that we planned to do.

Performance Indicator
Investigations directly monitored

Target	01/02	02/03
20	10	18

Interpretation

With some complaints we feel the police need to be scrutinised more closely by directly monitoring their investigations. This year we monitored two less than the number we anticipated. However, this figure was an increase on the number monitored last year.

compromised by unsuitable investigative strategies. This year we monitored 18 police investigations. The importance of this monitoring role is shown in case study 53.

Conducting direct investigations

We are able to investigate not only complaints, but also the police investigation of a complaint and 'any related issues'. This means that we can use our direct investigation powers to make investigators and commanders accountable for particularly poor complaint investigations. We can also explore apparent deficiencies in NSW Police policies and procedures revealed by complaints and make recommendations for improvement.

This year we conducted 29 direct investigations, compared to 22 last year. Eighty per cent of our reports recommended changes to law, policy or procedure and the vast majority of these recommendations were accepted and implemented by NSW Police.

For more details, please see the performance indicators below. Case studies 57,59, 64 and 65 are examples of when we have used our direct investigation powers.

Alternative dispute resolution

Often a 'formal' investigation is not the best strategy for dealing with a complaint. We encourage and expect NSW Police to conciliate complaints, particularly those involving customer service issues. Conciliation is also appropriate if the complaint could be resolved by providing an apology or an explanation to the complainant of the reasons for the police activity or decision in question. Many complaints are resolved

Case study 54

A police officer spoke to a senior officer about ongoing problems he was having with a neighbouring family. The senior officer prepared a report about this conversation that suggested the officer was mentally unstable and had the document placed on the officer's personnel file.

The officer complained about the senior officer's report and it was found that the senior officer had misrepresented aspects of his conversation with the officer. On this basis, the officer's commander gave him an assurance that the report would be removed from his personnel file. However the report remained there for another eight months, despite the officer's ongoing efforts to have it removed.

The officer subsequently made a complaint to us about the police handling of the matter. After we referred this complaint to police for resolution, it was ultimately assigned to the commander who had failed to ensure the prompt removal of the adverse report in the first place. The officer again complained to us about the conflict of interests in his commander handling his complaint. In addition, in his role as a 'peer support' officer, he raised concerns held by others at the command about the management style of the senior officer.

We believed that conciliation would be the most appropriate way to try to resolve what had become a seemingly intractable dispute. Because the officer provided peer support to other officers, his dissatisfaction with the handling of the matter had the potential to affect morale at the command. We facilitated a conciliation that achieved the following outcomes:

- The commander acknowledged that the matter had been poorly handled and that the later complaints could have been avoided.
- At the request of the Assistant Ombudsman, the commander agreed to offer the officer a written apology.
- The commander also agreed to have regular meetings with peer support officers so that staffing issues could be addressed promptly, and to reinforce with his officers that they should come forward to management or to peer support officers with any concerns.

Case study 55

A superintendent with 30 years of service complained about the treatment he had received during a large-scale investigation into complaints about the management at his command. In particular, he objected to evidence given by a more senior officer during the investigation which strongly criticised his management style. The superintendent was particularly upset because he believed the senior officer had not communicated criticism of this nature directly to him. As a result of the investigation, police initially made an adverse finding against the superintendent, though this was subsequently overturned. The superintendent also raised concerns about a series of media reports in which he said another officer had unfairly portrayed him in a negative light.

As a result of these issues, the superintendent had become very demoralised and was seeking to leave NSW Police. In the circumstances, he wanted senior police to assist his early exit. When the superintendent made a complaint about these matters to our office, we facilitated a conciliation involving the superintendent and a Senior Assistant Commissioner. This conciliation achieved the following outcomes:

- The superintendent received a written apology that recognised the distress caused to him and his family and acknowledged that the investigation process could have been better handled.
- The senior officer who had been critical of the superintendent acknowledged that he had never communicated his criticisms directly to the superintendent, and that this was inappropriate.
- The Senior Assistant Commissioner arranged for the superintendent to work with the police legal section to develop a strategy to respond to any inaccurate representations made about him in the media. He also agreed to facilitate the fast-tracking of the superintendent's application to leave the police.

in this way and the satisfaction of complainants with the process is very high. For more details, please see figure 36 on 'Conciliations'.

There are, however, some matters that may be amenable to alternative dispute resolution but require a particularly sophisticated approach to resolve tensions and produce results satisfactory to all parties. There are also some matters that NSW Police is not necessarily in a good position to resolve. These include conflicts between police and the communities they serve and ongoing conflicts between police officers themselves. In such cases we are seen as being independent and impartial and can act as an 'honest broker' in assisting the parties to resolve the often difficult issues involved. This year we have conducted a number of conciliations concerning complex matters – please see case studies 54, 55 and 56.

*Figure 36: Conciliations**

Notifiable complaints conciliated	225
Minor complaints from members of the public dealt with by local commands directly	957
Complainant satisfaction, minor complaints (where recorded)	85%

** Since early 2003 the Ombudsman has required police to record whether minor complaints by members of the public are conciliated by local commands, and if so whether complainants are satisfied with police management of the complaint. The information recorded here has been provided by NSW Police.*

Projects on systemic issues

We conduct a variety of projects into systemic issues raised by complaints. Details of this work are discussed later in this section.

Legislative reviews

We are required to review the operation of various pieces of legislation that have conferred new and often controversial police powers. Our reports on these reviews take into account complaints about the police use of these new powers, as well as the difficulties and challenges encountered by police in exercising their powers effectively and responsibly. For more details, please see the section on 'Legislative review'.

Oversighting how the police handle serious complaints

We oversight the handling of complaints by police at a number of key stages in the process.

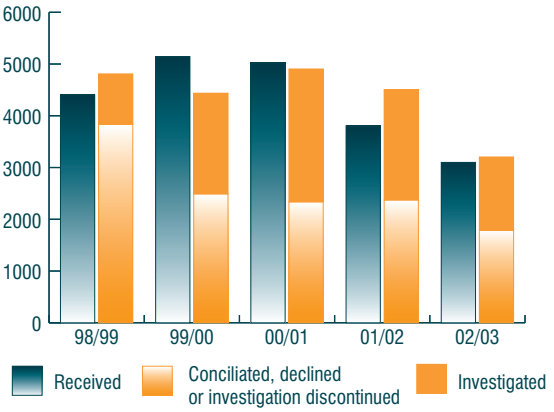
Responsibility for complaint handling

Police commanders are responsible for the effective investigation of complaints about officers under their command.

An important recent innovation by NSW Police is the establishment of complaint investigation teams at each command. The team generally consists of the commander, the crime manager, a professional standards manager and an executive officer. These last two positions were specifically designed to assist the command's handling of complaints.

The complaint management team, together with the investigator assigned to handle the particular complaint, is responsible for dealing with the complaint from start to finish. However ultimate responsibility for the handling of any complaint, and the quality of the investigation and its outcome, should rest with the relevant commander. In our oversight role, we pay particular attention to whether commanders have fulfilled their responsibilities – please see case study 57.

*Figure 37: Police complaints received and determined – five year comparison**



	98/99	99/00	00/01	01/02	02/03
Received	4,402	5,142	5,022	3,804	3,099
Conciliated, referred directly to local command for action, declined or investigation discontinued	3,837	2,491	2,337	2,373	1,792
Investigated	972	1,945	2,567	2,128	1,412

** Since March 1999 the figures have been affected by the legislative changes that reclassified some informal inquiries as investigations.*

Assessing complaints

The appropriate assessment of complaints is a vital element in complaint handling. It includes deciding whether the complaint must be notified to our office under the agreement between the Ombudsman and the PIC, and whether it is a category 1 complaint that must also be notified to the PIC.

The assessment should also determine whether any action should be taken on the complaint or whether the matter can be declined at the outset. One reason for declining a complaint is that the complainant has an alternative and satisfactory means of redress, such as the opportunity to have the issues in question determined in court proceedings. Another reason for declining a complaint might be that the substance of the complaint has already been appropriately dealt with. Another important aspect of the assessment process is the need to consider the complaint history of the officer or officers who are the subject of the complaint. Please see pages 65 and 75 for more details about the work we do in this area.

Our own assessments of the complaints we receive about police from members of public, and from police officers complaining directly to us about the misconduct of other police, take account of all these matters. In our oversight role, we check that the complaints NSW Police notifies to us have

Case study 56

We facilitated a meeting between representatives of a suburban community centre, staff from a nearby community legal centre and the local area commander. The meeting had been requested by the legal centre after it had received a large number of complaints from families and residents of a public housing estate about alleged over-policing and harassment by local police. We organised the meeting because we had also received complaints about these issues. The main aim was to improve the relationship between the police and the residents of the housing estate. We achieved this by negotiating the following outcomes:

- The officer responsible for investigating the current complaints would contact the legal centre and provide an update about the progress of his investigations.
- A particular duty officer would act as the contact for any further complaints from the legal centre and the community centre.
- The commander would deal directly with the legal centre to promote the speedier resolution of future complaints.
- The community centre would arrange a meeting with the young people affected, particularly those involved in the complaints. The local area commander would attend to speak to them about the background to the police operation that had led to the complaints and explain what he expected of his officers. An Ombudsman staff member would also be there to discuss how our office handles complaints.
- The local area commander would emphasise to his officers that no particular family was to be targeted by police unless they were identified as high risk offenders.

Case study 57

A man complained that he had suffered a broken leg in an altercation with police while in custody at a local area command. He also claimed police had delayed referring him to hospital for medical treatment.

The man had been charged with assaulting police and maliciously wounding a police officer. Police declined to investigate the complaint on the basis that the man would have an opportunity to have his complaints determined at the court hearing. However we believed this opportunity was very unlikely, and required an investigation of the complaint. The relevant commander refused to comply with our direction. We made two further attempts to get the police to investigate the matter, but the commander refused to do so. We then decided to conduct a direct investigation into the handling of the complaint.

We asked for an explanation of the legislative basis for the commander's refusal to investigate the complaint. The commander conceded that there was no such legislative basis and that his approach to the complaint had been 'problematic'. In our report on the matter, we pointed out that the commander's approach had both delayed the investigation of the complaint and led to a formal investigation by our office of issues that should have been resolved earlier. However, we also noted that we had had a number of discussions with the commander which had been beneficial in improving his command's complaint handling.

Case study 58

In May 2001 NSW Police received a complaint that, at the request of a private car hire operator, some police officers had agreed to take part in an unauthorised 'sting' operation aimed at identifying unlicensed car hire operations. The task of investigating the complaint was given to a detective sergeant, whose competence we had previously questioned.

In February 2002, we asked for an explanation for the delay in dealing with the matter. The police told us that they expected to complete the investigation by early May 2002. They also said that management action, in the form of complaint investigation training, would be taken in relation to the detective for his delays in dealing with the matter.

In December 2002 when we had still not received the investigation report, we decided to conduct our own direct investigation into the reasons for the delay. We found that:

- NSW Police did not effectively supervise or manage the investigation of the complaint.
- The delay was unreasonable and had an adverse impact on the quality of the investigation.
- Police had failed to follow through on the undertaking to us that the detective would receive training in complaint investigation.

We have asked NSW Police to tell us exactly what management action they will now take in relation to the officer, and to provide us with confirmation of the officer's attendance at an investigation training course. We have also asked for clarification of who is responsible for supervising complaint investigations like this, where the investigator is not working under the supervision of a local area commander.

Case study 59

A person complained anonymously to police about a local area commander. The one-page complaint raised issues about alleged deficiencies in the quality of the commander's management but lacked any significant detail.

The police launched a large-scale formal investigation into the matter. Two officers conducted the investigation, 29 officers were interviewed and a further 31 provided written reports. The investigation took over six months to complete. It then took the investigators a further three months to complete the report which consisted of four lever arch files containing over 100 attachments. Because police had not notified us of the complaint until the investigation was already complete, we were not able to intervene earlier and attempt to prevent a waste of resources. However, once aware of the matter, we decided to conduct our own investigation into the handling of the complaint.

We asked NSW Police to comment on whether the investigative approach was appropriate and on the total cost of the investigation. Senior police acknowledged that the investigation was excessive and estimated that it had cost about $150,000. In our report, we recommended that police use this matter as an example of an excessive investigation when training complaint investigators in the use of proper investigative strategies.

Case study 60

In March 2001 a woman complained to police at a remote command that police from the command had harassed and improperly arrested her two sons, aged 16 and 20, and improperly used capsicum spray on them during their arrest. She also complained that police had not contacted her to let her know her younger son was in custody, in breach of their legislative obligation to do so. Six months later, in August 2001, the woman sent a copy of her complaint to us when police failed to take any action on the matter. Although we promptly alerted the command to the complaint, the command did not complete its investigation until September 2002.

When we received what we considered to be an unsatisfactory investigation report, we decided to conduct our own direct investigation into the matter. We found that when the woman had first made her complaint, police had not recorded it on the complaints information system. It is very disturbing that we may never have found out about the complaint at all if the woman had not sent it to us. We also found that police had not created any custody records or other official records about the arrest and detention of the woman's 16 year old son. This, and the passage of so much time, created very real difficulties in attempting to determine the actual merits of the complaint.

The police admitted that their response to the complaint was unsatisfactory and advised us of a number of measures being taken to improve complaint handling, including the regular monitoring of the status of complaint investigations.

been properly assessed and, if not, alert the command to any deficiencies in the assessment. In particular we use complaint histories, and the profiles we have prepared on officers of concern, to reinforce with police where the complaint history of particular officers should be taken into account in the investigation.

Allocating an investigator

Police commanders are responsible for allocating appropriate officers to resolve or investigate complaints. It is important that these officers have the appropriate skills to undertake the conciliation of, or inquiries into, the complaint in question. It is also vital that they do not have a conflict of interests in handling the complaint.

As we noted in last year's annual report, NSW Police have introduced intensive training courses for officers who are responsible for investigating complaints as well as courses for commands in the general management of complaints. These courses are designed to ensure that investigators are properly skilled in both resolving less serious complaints and investigating the more serious complaints.

Complaint management teams should also be alert to any conflict of interests that an officer may have in handling a particular complaint.

Our oversight role includes intervening if we believe an investigator does not have the skills to investigate, or continue to investigate, a complaint. Please see case study 58.

Choosing investigation strategies

It is essential that the nature of the investigation is appropriate for the issues raised by the complaint. A relatively simple customer service complaint should only warrant brief inquiries and an attempt to resolve the complaint through discussion with the complainant. In contrast, an allegation of criminal conduct or other serious misconduct requires a more formal investigation as it may lead to criminal charges or reviewable management action such as the removal or demotion of an officer. The Supreme Court or the Industrial Relations Commission can review stringent management action of this kind.

Joanne Scott, Julianna Demetrius, Laurel Russ and Brendan Delahunty of our police team

Case study 61

Police suspected that a man was involved in serious drug offences and had a store of firearms. When they raided his home they only found some marijuana, a small number of marijuana plants and a small amount of ammunition.

A few days after the raid, police received information suggesting the man had been tipped off by a police officer who lived nearby. The next day, police conducted a second raid and again found only a small amount of marijuana.

There was a police investigation into whether a police officer who lived across the road had tipped off the offender. This officer worked in an area of NSW Police that dealt with sensitive information about criminal activity.

The investigator established that the officer had made two calls to the mobile phone of the offender. One of the calls was made on the day of the second raid, several hours before it took place, while the other was made two days after the second raid. The investigator also discovered that, some months before the raids, the officer had accessed the police computer for information about the suspect and other occupants of the house.

When questioned, the officer admitted being aware of police interest in the house but denied having any contact with the occupants other than "exchanging formalities in the street". As to the computer accesses, the officer claimed to have been suspicious about the activities of the occupants and had accessed the computer for this reason.

The investigator questioned the officer about the reason for the phone call to the offender made on the day of the second raid. The officer claimed to have rung the occupant about the officer's house alarm - she did not elaborate on exactly why this was necessary, but was not questioned further. The investigator did not question the officer at all about the call made two days after the second raid.

The police investigation report made no adverse findings against the officer but recommended the officer be counselled for failing to record the reasons for accessing the police computer.

After reviewing the report, we were concerned about its lack of rigour. We requested that police conduct further inquiries and appoint a new investigator.

The new investigator examined the telephone records again and found that the officer had made 15 mobile phone calls to a former occupant of the house during the month in which the raids took place. Telephone records also showed that this former occupant was in almost daily contact with the current occupants of the house. When questioned, the police officer said she knew the first name of the former occupant and that her relationship with him was based on concern for his health. The investigator made no adverse findings against the officer.

We asked the investigator to explore whether the officer had accessed the details of the former occupant on the police computer. The resulting police inquiries showed that the officer had accessed the computer on the former occupant 13 times.

The officer had not documented these accesses and they did not appear to be related to her policing duties.

The police investigation found the officer had not been 'completely forthright' about her knowledge of and relationship with the former occupant. Our view was that the officer had actually been untruthful and asked police what action was proposed to manage the officer. As a result of our intervention, NSW Police have recorded adverse findings against the officer for untruthfulness and unlawful computer access, and the officer has been placed on restricted duties.

Some complaints involve a variety of issues, ranging from minor to very serious. Investigators should ensure that the extent of the inquiries into each issue suits the gravity of the particular issue.

In oversighting both the assessment of complaints and final investigation reports, we pay particular attention to whether suitable investigation strategies were planned and have been adopted. Investigators need to comply with their legislative obligation under the Police Act to 'carry out the investigation in a manner that, having regard to the circumstances of the case, is both effective and timely'.

Case study 59 is an example of the inappropriate and costly use of formal investigative strategies.

In carrying out complaint investigations, investigators must also 'have regard to any matters specified … by the Ombudsman as needing to be examined or taken into consideration'. Part of our assessment of complaints involves deciding whether investigators should be alerted to particular issues, inquiries or strategies that we believe should be considered in the course of the investigation.

Making adequate inquiries

A failure to pursue appropriate lines of inquiry obviously affects the quality of an investigation. If relevant evidence is not obtained, it is difficult or impossible to make proper findings. Failing to obtain all the evidence before interviewing the officer who is the subject of the complaint often means that the officer cannot be properly questioned about the matter. In some cases this also means that the integrity of the investigation is compromised, perhaps irretrievably.

We have the power to require information and explanations from NSW Police to determine if a complaint has been properly dealt with. We also have the power to request further investigation of a complaint if we believe there are deficiencies in the initial investigation. If we do this, NSW Police must then either investigate the matter further or explain why it considers any further investigation is unnecessary or inappropriate. Case study 61 is an example of where we requested police to make further inquiries.

Ensuring the investigation is not delayed

The police are required to conduct complaint investigations in an effective and timely manner. Unduly delayed investigations can cause dissatisfaction for the complainant and unnecessary stress for the officer. However, delays in investigations can have other serious ramifications. Vital documents may have been disposed of or lost. Crucial witnesses may be harder to locate. The accuracy of the recollection of witnesses about past events may be affected by the passage of time. It may also be difficult to take otherwise appropriate management action in relation to the unsatisfactory or improper conduct of the officers if the conduct occurred a considerable time ago. Unfortunately, this may especially be the case where reviewable management action could have been implemented. The delay can mean that, on review, the action will be

Case study 62

A police officer provided information to police about an alleged assault by another officer on a member of the public. The matter was investigated and the officer in question was criminally charged with assault occasioning actual bodily harm. In his defence, the officer gave evidence that he had been suffering from post-traumatic stress disorder as the result of his police work. The magistrate dismissed the assault charge under section 32 of the Mental Health Act on the basis that the officer was suffering from a mental illness or condition. In doing so, the magistrate observed: "There is certainly something wrong with a Police Service in whom the community is entitled to have confidence if the mental and psychological welfare of persons who serve in it are not guarded with a great deal of concern for their welfare and benefit, so that the community can be properly and safely served".

NSW Police has advised us the officer has since applied for a medical discharge.

In response to this case, we have suggested that the police should review the management of the officer before the assault took place including determining whether his managers were aware of his condition, took steps to manage the risks involved or offered support to the officer. We have also asked for information about what has been done to provide the officer with support since the magistrate's decision. Our interest in this case is consistent with our ongoing oversight of improvements by NSW Police to its systems for ensuring police welfare.

Case study 63

Closed circuit television (CCTV) cameras are installed in the custody areas of many busy NSW police stations. If a person complains that a police officer assaulted them while they were in custody, the evidence recorded on the CCTV video becomes highly relevant.

When we review the way police investigate allegations of this kind, we check whether the investigator has examined the videotape of the custody area. We can also ask to see the video evidence as part of our review. Our recent research into the effectiveness of CCTV coverage in complaints alleging police assaults in custody has shown that many alleged assaults are not captured on video or there are issues about the quality and early disposal of videotapes. We have recently begun a direct investigation into these issues.

Case study 64

The 'computerised operational policing system' (COPS) is the main NSW Police computer database. Access by police to information on COPS for reasons other than their policing duties, for example personal matters, is against the law. Unlawful access may involve serious breaches of privacy for the person whose records are accessed.

NSW Police has policies and procedures that aim to prevent unlawful abuse of the system. The policy requires local commanders to conduct regular audits of COPS accesses by their officers, and to check the reasons for any irregular access.

In March 2001, we finalised a direct investigation into the extent to which commanders were complying with this requirement. Our investigation found that a large proportion of commands were not conducting thorough and frequent audits. However, NSW Police advised us that it had recently developed a 'command management framework' designed to ensure better auditing of COPS accesses by police. Standard operating procedures were also introduced in July 2001 to guide commanders on how to conduct the audits. In 2002, NSW Police checked the performance of commands in high risk areas. They found that, while improvements had been made in the area of auditing COPS accesses, a number of commands were not adequately following the standard operating procedure guidelines. We therefore launched a further direct investigation to assess the level of compliance by a variety of commands with the guidelines for auditing police computer accesses. We are currently assessing the information obtained during our investigation.

regarded as 'harsh, unreasonable or unjust'. Case study 60 is an example of a delayed investigation and the problems that can arise.

One way that we check the turnaround times of police complaint investigations is to review potentially delayed investigations across NSW Police. Our reviews identify those matters where the police investigation started more than six months ago and no explanation has been provided for the delay. This year we did two reviews, covering about 180 prolonged complaint investigations. We required the commands involved to give us reasons for the delay and advice on the further progress of the matter. Our reviews prompted police to expedite outstanding inquiries and investigation reports.

The number of delayed complaint investigations has been reduced by about half from the time of our review of delayed investigations in 2002. However although the number of seriously delayed investigations has been reduced, the overall turnaround time for complaint investigations has increased. The reasons for this are not entirely clear. One reason may be recent changes to the administrative agreement which have limited the types of matters that must be notified to us.

The more serious notifiable matters require thorough investigation and it will therefore often take longer to complete the investigation. Another reason may be the introduction of complaint management teams. Their involvement in assessing complaints, developing investigative strategies, and determining appropriate management action at the end of the investigation may be extending the length of the investigation periods. Whatever the reasons, this matter reinforces the need for NSW Police to consistently benchmark the performance of commands in relation to complaint investigation turnaround times and to hold commanders to account for unacceptable delays.

Assessing complainant satisfaction

The command responsible for an investigation has a legislative obligation to consult with the complainant about the outcome of the investigation and advise them of any action taken, or proposed to be taken, as a result of the investigation.

Our assessment of investigation reports includes examining whether this has been done and whether complainants are in fact satisfied with the process and outcome of the investigation.

NSW Police has advised us that about 70 per cent of complainants are satisfied with the investigation of their complaints. However, there are variations in complainant satisfaction levels across commands. This may well arise from the way in which complainant satisfaction is measured by different commands. Our view is that NSW Police needs to capture information about complainant satisfaction, with both the process and the outcome of the investigation of their complaint, in a consistent manner. They would then be in a position to monitor complaint investigation performance across all commands.

Case study 65

In April 2003, the Ombudsman tabled a special report in Parliament on our review of more than 3,500 speeding tickets issued by police using radar equipment in highway patrol cars. As part of our review, we spoke to highway patrol officers and senior police as well as radar specialists. We concluded that NSW Police, and in particular highway patrol officers, generally do a fair and professional job of policing speed.

The vast majority of speeding tickets we audited were correctly issued. Only 18 tickets – or 0.5 per cent - were definitely wrong.

Although all the motorists issued with incorrect tickets were travelling over the legal speed, they were ticketed for a higher penalty range than was appropriate. We therefore asked NSW Police to consider refunding the excess money paid and reinstating any excess demerit points deducted. This recommendation was accepted. The police also advised that three people who were issued with wrong tickets had had their licences suspended.

We asked the Commissioner to review these matters and consider whether to pay compensation to anyone who had suffered losses because they were issued with an incorrect speeding ticket.

Our review also made recommendations about police training and procedures, equipment testing and the format of speeding tickets. The police response has been constructive and positive. Additional training has been and will be provided to highway patrol officers to ensure ongoing assessment of their competence in using radar equipment.

Case study 66

Under professional distance guidelines in operation at the Police College, staff members were required to declare to a supervisor the development of any personal or intimate relationship with a student because of the potential for a conflict of interests.

However, following a number of complaints, it became apparent that staff members were not adhering to this policy. It also became evident that the practice of declaring relationships did not adequately address the various issues raised by the complaints. These included issues such as power imbalance, the professionalism of staff and future police officers, and the potential for fallouts resulting from broken relationships.

As a result, the college set up a working party to establish clear professional distance guidelines. The codes of conduct for instructors and students were amended to prohibit sexual relationships between staff and students altogether, with stringent sanctions for any breaches – for example, breaches by students may result in their being found unsuitable for employment with NSW Police.

Case study 67

An Aboriginal community complained that police had conducted alcohol breath tests on people driving to and from a funeral – including members of the deceased's family.

Police investigated the complaint and an officer from our Aboriginal complaints unit monitored the investigation. It was found that the police had handled the incident very poorly.

As a result, the commander of the police station involved provided a personal apology to the family and the community, and arranged for police to undertake cultural awareness training. The apology was publicised in the local press and on radio. One community member said 'That's the only time we've heard police say they made a mistake'.

The sensitive way in which the police investigation was handled went a long way to restoring the trust of the community in the local police.

Deciding on appropriate management action

During and after police complaint investigations, investigators and commanders have to recommend or take suitable management action in response to any issues revealed by the investigation. This may include issues of performance, integrity or deficiencies in police practice or procedures.

If we are not satisfied with the management action taken, we have the power to require NSW Police to review the matter and advise us of the outcome of that review – please see case study 62. This case study also illustrates our continuing interest in how well NSW Police deals with issues of officer welfare.

We also track state wide trends in the types of management action taken during and at the end of complaint investigations. Our analysis indicates that there may be an over-reliance on 'counselling' as a supposed remedy for poor performance, a response that is seen by many officers as punitive in nature. There may well be a need for the greater use of more sophisticated techniques such as mentoring, training and increased supervision.

Figure 38: Common management outcomes over all regions

Outcome	98/99 (%)	99/00 (%)	00/01 (%)	01/02 (%)	02/03 (%)
Management counselling	46.5	43.0	43.3	40.2	35.9
Training – command	11.3	12.0	12.8	12.1	9.6
Training – officer(s)	5.2	5.9	6.6	6.9	7.4
Change in policy or procedure	8.3	10.8	8.7	9.3	9.6
Supervision increased	6.0	5.5	5.2	6.3	8.7

The adequacy of NSW Police's handling of more serious complaints

Our scrutiny of police investigations into serious complaints suggests that the majority of complaints are handled well. In addition, police have generally responded appropriately to our concerns about deficient investigations and inadequate or unsuitable management action and taken steps to remedy outstanding problems. Nevertheless there is still room for improvement, particularly in relation to failures to 'nip problems in the bud', delays and faulty investigative practices.

A large part of our project work is designed to encourage NSW Police to make its complaint handling systems more effective and so overcome the problems we have identified. For a long time we have pushed for NSW Police to develop benchmarks for complaint handling. They now have performance indicators for complaint handling and will use these to examine the quality and timeliness of complaint investigations and the satisfaction levels of both complainants and police.

The computerised complaint management system 'c@ts.i' should assist in the accurate measurement of performance. We will be monitoring the steps taken by NSW Police to assess complaint handling performance across commands, improve those commands that are under-performing, and recognise and promote the good work of particular commands.

Case study 68

Local area command Aboriginal consultative committee meetings provide a forum to discuss policing issues and improve relationships with Aboriginal communities. However the meetings of the committee in one area lapsed because members of the Aboriginal community believed they were being harassed by police for raising concerns about the quality of local policing, senior police did not attend, and the meetings produced no practical results.

We became aware of the problem when we visited the command as part of our assessment of the command's initiatives in dealing with the local community. We called a meeting with Aboriginal community representatives to find a solution to the problem. They suggested that the Aboriginal committee representatives should be drawn from the whole community and meetings should be co-chaired by police and an Aboriginal representative. They also suggested that meetings should have a clear agenda and a commitment to achieving practical outcomes from all members. The commander welcomed this solution and organised further committee meetings of the type recommended.

We were pleased to be involved in facilitating a resolution of the problem and hope that the renewed meetings will help in improving the relationships between police and the local Aboriginal community.

Our project work

During 2002-2003 we conducted a variety of projects to address some of the broader issues raised by police complaints. For example we reviewed the use of closed circuit televisions in police stations. We also prepare complaint profiles on officers of concern, assess the effectiveness of different types of management action, analyse complaints by police about the conduct of other officers, and work to improve relationships between the police and various community groups.

Systemic issues – investigations and reviews

Some of our project work involved directly investigating aspects of policing practice such as the use of closed circuit televisions in police stations and how well local area commands audit police access to confidential information. Please see case studies 63 and 64 for more details. We also reviewed the issuing of tickets to motorists for speeding offences detected by police radar equipment. The results of this review were the subject of a special report to Parliament – please see case study 65.

Officers of concern

Complaints can tell us about actual or potential problems with particular officers. For example, a police instructor with a history of sexual misconduct was moved from the Police Academy to reduce his unsupervised contact with student officers. Despite high-level advice barring him from training positions, he was promoted to acting education officer at his new local command. He returned to the academy a few weeks later where he allegedly sexually assaulted a student officer and was criminally charged.

One of our continuing projects is preparing comprehensive complaint profiles on officers of concern. The profiles are used in assessing new complaints about these officers and to suggest suitable investigative strategies. They can also be used to examine the adequacy of management action taken by NSW Police after the complaint has been investigated. We use the profiles when discussing with commanders the strategies that are being, and could be, used to manage these officers.

In December 2002, the Parliamentary Committee on the Office of the Ombudsman and the PIC produced a research report on trends in police corruption. The report recommended that the Ombudsman and the PIC assist NSW Police to establish indicators for an early warning system to identify and assist 'vulnerable' officers – that is, officers who are or may be vulnerable to corruption. A joint research committee, consisting of senior members of staff from all three agencies, has now been established and has had regular meetings to consider the issue of vulnerable officers.

The joint research committee is also being used as a consultative forum on developments within NSW Police in relation to the risk management of officers. In addition, we see the committee as a possible avenue for the coordination of information exchange between NSW Police, the PIC and our office about officers who may need sophisticated management because of their significant complaint histories.

Complaint handling by commands

One of our key projects is monitoring the performance of different commands across NSW. We look at factors such as the time taken to deal with complaints, complainant satisfaction, how successfully alternative dispute resolution techniques are used, the adequacy of investigations, and the range and suitability of management outcomes.

This work allows us to provide feedback to NSW Police and particular commands on the trends that have emerged so that issues of concern can be identified and remedied. We have also initiated specific projects to review the effectiveness of different types of management action and whether promised management action has been implemented.

Complaints by police about other police

We have recently started a detailed analysis of complaints by police about the conduct of other officers. We hope that the information from this analysis will help NSW Police to manage these complaints better, as well as address the situation of both police whistleblowers and officers who are the subject of a complaint. Case study 66 gives an example of how complaints by police about other police can reveal deficiencies in existing policies and practices and provide a platform for their improvement.

Figure 39: Officers criminally charged

	98/99	99/00	00/01	01/02	02/03
No of complaints leading to charges	89	70	76	71	61
No of officers charged	103	72	80	73	62
Total charges laid	122	134	129	121	123
Officers charged following complaints by other officers	63 (61%)	41 (57%)	52 (65%)	40 (55%)	43 (67%)

Police and Aboriginal communities

Our Aboriginal Complaints Unit has worked closely with police over a number of years on practical ways to improve their interaction with Aboriginal communities. Since early 2003, we have been closely examining the relationship between particular commands and their local Aboriginal communities.

The Assistant Ombudsman (Police), the complaints manager, a senior researcher and members of the Aboriginal Complaints Unit have been meeting with police commanders, their officers and staff and with Aboriginal community representatives and key service providers to assess police initiatives in addressing sometimes entrenched problems. These initiatives include measures to reduce the problem of domestic violence, to divert young Aboriginal people from the criminal justice system, and to reduce high rates of imprisonment. We have also been able to facilitate improved relationships between police and a number of Aboriginal communities – please see case studies 67 and 68.

Julianna Demetrius, manager, police team, Joanne Scott, Aboriginal complaints unit and Assistant Ombudsman (Police) Steve Kinmond meet Commander Steve Bradshaw of Wagga Wagga.

Working with community groups

We regularly meet with community groups to discuss complaint handling and develop initiatives to resolve issues of concern. These groups have included community legal services, youth groups, advocates for people with disabilities, drug and alcohol counsellors, minority ethnic communities and the homeless. The focus of our work is on improving the ability of police and the community to resolve issues together.

The value of our work in this area is illustrated by case

study 56, an example of a successful conciliation of a difficult matter by our staff.

Training and development work with police

We have met with hundreds of police at commands across the state to discuss any concerns they may have about the complaint handling system, to explain our role in the oversight of complaints about police, and to dispel any misconceptions they may have about this role. The feedback about the value of these sessions has been very positive.

We are active participants in the regular five-day training courses for officers who handle complaint investigations, stressing the importance of conducting quality investigations.

We have also made presentations to many groups of probationary officers – these sessions have included discussing how to handle some of the ethical challenges they may confront in their future policing careers.

Ombudsman meetings with the Commissioner of Police

The Ombudsman meets with the Commissioner of Police, Mr Moroney, every two months to canvass issues raised by our oversight of the police handling of complaints and our investigation and project work. This Joint Standing Committee, which the Assistant Ombudsman (Police), the Senior Assistant Commissioner and other senior police officers also attend, has been instrumental in improving the police management of complaints.

Over the past year, it was agreed that the committee would monitor major projects relevant to the effective investigation of complaints. For example, NSW Police accepted the recommendations in our special report to Parliament in 2002 'Identifying and managing officers with complaint histories of significance'. As a result, we are assisting NSW Police to develop a clear and fair policy about how complaints about officers will be taken into account when making decisions about promotions. Although significant progress has been made with this policy, we have stressed the need for it to be finalised as soon as possible. We are also providing input into arrangements for the transfer of officers. We believe the focus should be on using transfers as a good management tool rather than as a punishment, reducing the risk of corruption, and giving local area commanders a say in the officers who are transferred into their command.

Another significant NSW Police initiative, prompted by our suggestions, is the development of a new complaints management manual. The Joint Standing Committee will be monitoring the trial of the manual in a number of commands before it is rolled out across the state.

The implementation of c@ts.i

It has long been the aim of NSW Police, the Ombudsman and the PIC to share information about police complaints. The implementation of the NSW Police computerised 'customer assistance tracking system' (known as c@ts.i) means that investigators, commanders, our police complaints team and the PIC now all have immediate access to information about each complaint at the same time. It also means that statistics about complaints and their management can now be calculated on mutually agreed common criteria.

The PIC has developed a partner system to c@ts.i called the Police Oversight Data Store or PODS. The information on PODS is drawn from a number of NSW Police computer systems and provides extra intelligence on individual officers and local area and specialised commands, as well as information on significant issues. Our access to PODS has enhanced our oversight role and project work.

The c@ts.i project has presented significant challenges. We have been involved in the development of the system from the outset and contributed to its reporting and other capabilities. We have also monitored the impact of c@ts.i on our work practices to try to capture the benefits of the new system. At the same time, we have had to confront unforeseen complications such as slow computer processing times and frequent breakdowns of the system. We have highlighted to NSW Police the importance of investing adequate resources for the further development and reliable operation of c@ts.i so that we can maximise our capacity to effectively fulfil our oversight responsibilities.

Performance Indicator
Reports recommending changes to law, policy or procedure

Target	01/02	02/03
70%	63%	80%

Interpretation

At the end of a formal investigation we issue a report containing recommendations for improvement. This year 80% of our reports recommended changes to law, policy or procedure. This exceeded our target..

Performance Indicator
Recommendations implemented

Target	01/02	02/03
80%	96.6%	93.3%

Interpretation

After we make recommendations for improvement it is important to see how many of them were implemented by the police. We cannot force them to make our recommended changes but if they do not we can report our concerns to Parliament. This year over 93% of our recommendations were implemented. Although this was well over our target, the figure was slightly lower than the previous year.

Child protection

Introduction

Over 7,000 agencies across the government and non government sector fall within the child protection jurisdiction established by Part 3A of the *Ombudsman Act 1974*. There are hundreds of thousands of paid employees and a larger number of volunteers who interact frequently with children and young people every day. Thankfully, only a very small number of these people are ever the subject of child abuse allegations.

Our legislation requires heads of agencies to notify the Ombudsman within 30 days of becoming aware of any child abuse allegation or conviction against an 'employee'. The term 'employee' is defined broadly to include paid employees as well as anyone engaged to provide a service to children such as volunteers, subcontractors, foster carers and religious education instructors. The agency must also:

- investigate the child abuse allegation
- properly document the investigation process
- advise the Ombudsman of any management or disciplinary action taken as a result of the investigation
- explain its decision making process.

The agencies we oversee are mostly those that provide services such as schools, child care centres, health care facilities, agencies providing out of home care (for children unable to live with their own families) and juvenile justice centres. These agencies are referred to as 'designated agencies' and must notify any child abuse allegations against their employees even if the allegation refers to alleged behaviour outside the workplace. This could include, for example, an allegation against a child care worker in their capacity as a volunteer sports coach of children. All public authorities that are not 'designated' are required to notify allegations of child abuse only if the behaviour occurs in the workplace.

Our role under the Act is to monitor the investigation of child abuse allegations against employees and to determine whether the investigation and any subsequent action are satisfactory. This allows us to address some of the systemic issues that were identified in the Wood Royal Commission report in 1997. These issues include a lack of coordination, failure to recognise and report child abuse, and mismanagement of child abuse allegations including the failure to investigate them. We also:

- work closely with agencies during their investigations to ensure proper investigative practices
- conduct direct investigations if there is evidence of systemic failures
- scrutinise the systems agencies have for preventing child abuse and for dealing with child abuse allegations against employees
- handle complaints about the way an agency has dealt with a child abuse allegation
- conduct training and liaison activities so that agencies understand their responsibilities and increase their competence in handling child abuse allegations
- produce education materials that explain what needs to be reported and how matters should be handled.

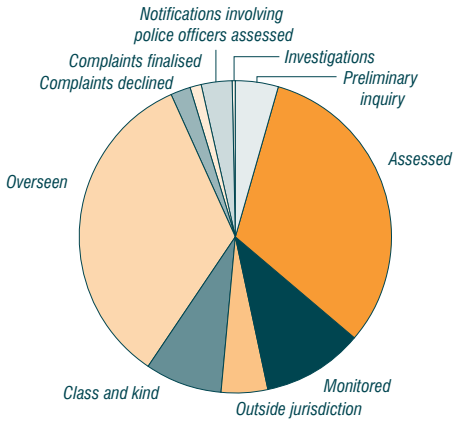
We have been impressed this year by the continuing good practice, commitment and allocation of resources by the Department of Education and Training (DET) to the protection of children and fair processes for teachers. There has also been a significant improvement in the reporting and investigation of child abuse allegations in the independent school sector. This improvement has been facilitated by the work of the Association of Independent Schools (AIS).

Despite our best efforts to explain the way we work and why, we continue to witness examples of misinformation and resistance to legislative obligations. This is most notable in the education sector. Education unions, some employers and a small number of disaffected employees have provided misleading and sometimes incorrect information to the public, their members and employees. Please see case study 69. Such conduct has unnecessarily generated fear among parents and teachers, the majority of whom are professional, competent and caring.

Statistics

This year we received 2,473 (2,560 including police) notifications from agencies. Figure 40 provides a breakdown of the complaints and notifications received this year.

*Figure 40: Child protection notifications and complaints received and determined**



Note : Of the cases received this year 35% were received as completed final reports, 35% were incomplete when received and were oversighted by us, and 12% were monitored. We needed to make preliminary inquiries in 6% of cases.

Complaints received	
Written notifications	2,473
Written complaints	87
Oral inquiries	795
Reviews	2
Total	3,357

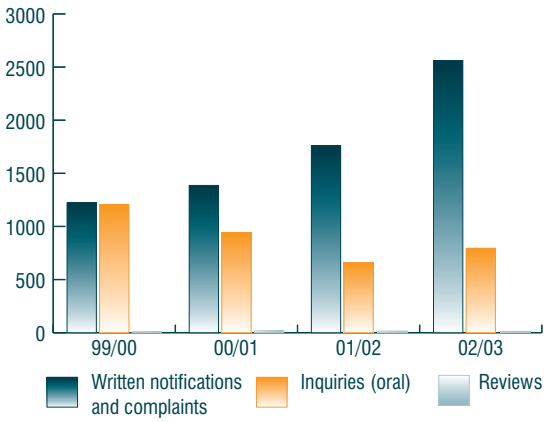
Complaints determined (written)	
Preliminary inquiry	121
Assessed	865
Monitored	285
Outside jurisdiction*	131
Class or kind notification assessed	217
Overseen	921
Complaints declined	56
Complaints finalised	32
Notifications Involving police officers asessed**	87
Investigations	9
Total	2,724

Current Investigations (at 30 June)	
Notifications being monitored	311
Notifications being investigated	3

** notifications may be outside jurisdiction because they do not involve a child, an employee or 'child abuse' as defined in the Ombudsman Act.*
*** notifications involving police officers are dealt with by the police and overseen by our police team in the same way as other allegations of police misconduct.*

There has been a significant (63%) increase in notifications received this year compared with last year, and a 24% increase in the number of complaints.

Figure 41: Complaints and notifications received – four year comparison (including police)



Case type	99/00	00/01	01/02	02/03
Written notifications and complaints	*1,221	*1,435	1,758	2,560
Inquiries (oral)	1,203	939	661	795
Reviews	2	5	4	2
Total	2,426	2,379	2,423	3,357

Performance indicator – Average time taken to assess notifications

Target	00/01	01/02	02/03
5 working days	10	5	3

Interpretation

We aim to assess notifications within an average of five days of receiving them. This year we exceeded our target, assessing notifications within three days.

Performance indicator – Average time taken to assess final investigation reports

Target	00/01	01/02	02/03
30 working days	33	30	49

Interpretation

We aim to assess all final investigation reports to determine whether or not allegations have been handled satisfactorily within 30 days. The increase in the time taken to assess final investigation reports this year compared with last year can be attributed to a slight difference in the way we have calculated the figures.

Another contributing factor was the time taken for agencies to respond to requests for further information about their investigative processes which caused some delays in finalising assessments and feedback to agencies. However the increase in notifications received from agencies this year was the most significant factor as it placed more of a demand on resources.

What is child abuse?

What it is not…

We recognise that employees who work with children are in a nurturing role and there will be circumstances in a school, child care centre or out of home care placement where it is appropriate and necessary to have some physical contact with children. We have tried to make it clear to agencies that the following behaviour on its own would not be considered abusive and need not be reported to the Ombudsman. This 'non-reportable' behaviour could include:

- helping a child who has been physically hurt or is distressed
- providing appropriate physical assistance in a special education/residential setting or in a gymnastics class
- giving a spontaneous pat on the back to acknowledge achievement
- guiding a child by the shoulders, hands or arms
- having a difference of opinion with a child.

There is other behaviour that demonstrates inappropriate professional behaviour or misconduct but on its own would not be regarded as child abuse and would not be reportable to the Ombudsman. We expect that agencies would follow their usual disciplinary procedures for dealing with such misconduct as:

- yelling or swearing at a child or group of children
- making rude gestures at a child
- inappropriate references to a child as, for example, 'stupid' or 'smelly'
- discussing personal family issues with a child
- having informal classroom discussions on topics with sexual connotations.

What should be reported

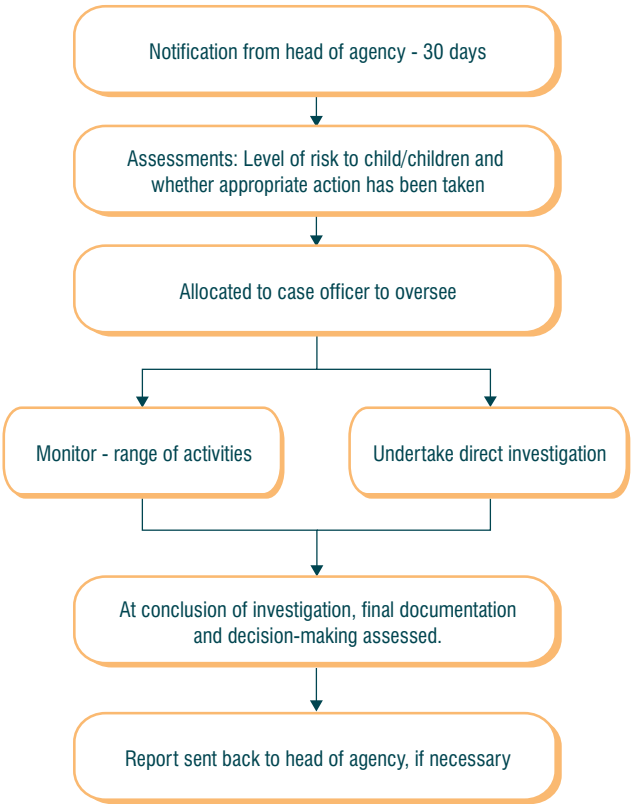
Child abuse is defined in the *Ombudsman Act* as:

- assault (including sexual assault) of a child, or
- ill-treatment or neglect of a child, or
- exposing or subjecting a child to behaviour that psychologically harms the child.

The definitions apply whether or not the child has consented to the behaviour. The definitions are broad to take into account the particular vulnerability of some children, to track repeat offenders and to prevent patterns of low risk behaviour from escalating to serious offences. A 'child abuse allegation' means an allegation of child abuse against a person or an allegation of misconduct that may involve child abuse.

Some agencies remain concerned about what should be notified and send matters to us that may constitute misconduct, but do not fall within the definition of child abuse and are therefore not within our jurisdiction. Most agencies are clear about what constitutes an allegation of sexual assault, but there still appears to be some confusion about other forms of child abuse.

Figure 42: Child protection notifications



Physical assault

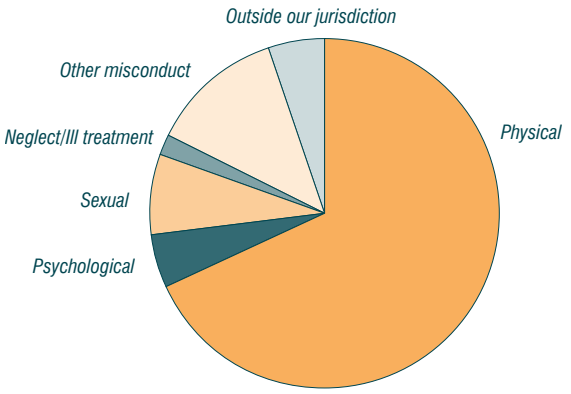
We accept allegations of physical assault as being in jurisdiction if the alleged behaviour and/or actions of the employee were hostile or reckless, and

- the alleged behaviour and/or actions resulted in physical connection with the child, or
- a child perceived the employee's behaviour or actions as threatening and/or believed they would suffer harm.

Sixty eight per cent of allegations made this year involved physical assault. Of these allegations, 38% related to hitting or kicking a child and 7% involved the use of an object. We assessed the majority of these cases as being satisfactorily investigated.

Case study 70 shows how we assess notifications to determine if the alleged behaviour constitutes a physical assault. In this case we decided that the teacher's behaviour did not constitute a physical assault.

*Figure 43: Breakdown of notifications by primary allegation**



** This figure shows a breakdown of notifications from all agencies excluding NSW Police*

Issue	Total
Physical	1,684
Psychological	122
Sexual	184
Neglect/ill treatment	47
Other misconduct	307
Outside our jurisdiction	129
Total	2,473

Ill-treatment

Ill-treatment in the employment context is the least well defined type of child abuse and represents a small number of notifications.

Ill-treatment of a child occurs where a person who has a legitimate authority to chastise or discipline a child, such as a foster carer or a teacher, disciplines or corrects a child in excess of what is reasonable or appropriate for the situation. Discipline can also be considered inappropriate or excessive if it is unsuitable for the child for a specific reason such as the child's age, physical ability or developmental level.

For example, we accepted a notification as ill-treatment where it was alleged the carer had made a young child sit on a toilet overnight because he had wet his bed. Case study 71 illustrates another allegation of ill-treatment.

Neglect

Neglect is the failure by a caregiver to provide a child with the basic physical necessities of life such as adequate food, shelter, medical care or supervision. Neglect usually develops as a pattern of behaviour that results in harm to a child over a period of time. It can also occur as a single significant incident where a caregiver fails to fulfil a duty or obligation resulting in actual or potential harm to a child eg leaving a child unattended in a car on a hot day. Neglect is more than negligence. Negligence is inattention or carelessness rather than failure to fulfil a duty of care.

We accept allegations of neglect as being in jurisdiction if:

- the child's physical, emotional or safety needs were not met by the employee
- the employee failed to fulfil a duty of care
- the alleged conduct caused or had the potential to cause harm to the child.

Only 2% of notifications received this year involved neglect of a child. The majority of these were about the behaviour of foster carers, employees of the Department of Juvenile Justice (DJJ) and local government funded childcare centres. Case study 72 is an example of an allegation of neglect.

Behaviour causing psychological harm

We use a definition of behaviour causing psychological harm that is quite narrow and only covers serious, persistent and targeted maltreatment of children. Single instances of inappropriate behaviour, such as yelling at a child or calling them names, would not be notified to us. Case studies 73 and 74 show what is and what is not considered to be behaviour causing psychological harm.

This type of abuse is potentially more destructive than other forms of abuse but is seldom the focus of research or intervention. For an allegation to be accepted as being in our jurisdiction, it must include three components.

1. Sustained or repeated behaviour directed at a particular child including humiliation, belittling, verbal abuse or making excessive demands, or a single incident that resulted in severe repercussions for a child.
2. A claim that a child has suffered harm including wetting themselves, vomiting, refusal to attend school or sleep disturbances.
3. A claim that the alleged harm was a direct result of the alleged behaviour.

Five per cent of notifications to us were allegations of psychological abuse.

Misconduct which may involve child abuse

An agency needs to assess any misconduct involving a child to identify whether it involves possible child abuse. If the misconduct does not involve child abuse, the agency should follow its normal disciplinary procedures. This category of allegation should only be used if the initial information suggests the allegation may be part of a pattern of behaviour which may involve sexual abuse, may indicate misconduct which poses a significant risk to children, or may when investigated show that serious child abuse has occurred. Twelve per cent of notifications we received this year were allegations of misconduct that might involve child abuse.

While allegations involving inappropriate comments or swearing at a child constitute inappropriate behaviour or misconduct, they do not need to be notified. However, inappropriate comments of a sexual nature directed towards a particular student do require notification under this category as they may form part of a pattern of 'grooming' behaviour.

Grooming is behaviour used by offenders to build a child's trust and test their boundaries before involving the child in sexual activity. Notifications that involve the use of emails, Internet chat rooms and text messages/sms as tools to groom and to obtain access to children for abusive purposes have increased. We are concerned this technology that enables private and confidential communication provides an additional means to groom children (please see case study 75). We reported last year on an investigation of inappropriate communication via text messaging and emails to young women that led to criminal charges. The offender pleaded guilty and has been given a community service order. Disciplinary action against him is also possible.

Main areas of our work

Strategic directions

Community liaison and education have been an important part of the child protection team's work over the past four years. However, as agencies and community groups become more familiar with our role and practices improve, the need for general information has lessened. This year our focus shifted to providing more specific advice about different aspects of investigative practice. We have also continued to run free child protection policy development workshops and training sessions about topics such as risk management. Because of the increased understanding of child protection and investigation issues and improvements in investigations and reporting, this year we have used our powers to scrutinise and monitor notifications more extensively than before.

When we monitor an agency's investigation, we closely watch the progress of the investigation and give advice about a range of issues. We have found this to be an effective way of educating agencies about investigative processes and ensuring a specific matter is satisfactorily investigated. The outcome has been a reduction in the number of investigations we need to conduct and fairer processes for children and employees.

Auditing of agencies also gives us the opportunity to provide agencies with feedback on how their procedures are being implemented, to identify good practice, and to provide advice about how systems could be improved.

Class or kind determinations

Our legislation allows us to enter into class or kind determinations with agencies when we are satisfied that their investigative practices have reached an acceptable standard and we are confident these practices will continue.

In July 2001, we developed class or kind determinations with the Department of Education and Training (DET) and the Catholic Commission for Employment Relations (CCER). The determinations allowed these agencies to report certain child abuse allegations to us by monthly schedule as long as there were no prior allegations against the employee and no harm to the child. They included provision for us to audit agencies' processes and to withdraw the determination at any time, particularly if we were no longer confident of an agency's response.

We have audited DET and the CCER three times since the determinations were made. Our audits found that the majority of matters reported to us by schedule had been investigated satisfactorily. Most of the recommendations we made following the audits have been implemented.

In 2002, we reviewed our class or kind determinations. As part of this review we classified the various types of child abuse allegations then notifiable to the Ombudsman as low, medium or high risk behaviour. We then considered the effect of factors such as the age of the alleged victim on the risks associated with the behaviour. We used this information to determine the categories of behaviour that could be excluded from notification in the new class or kind determinations negotiated with DET and the CCER.

The new determinations took effect in April 2003 for DET and in May 2003 for the CCER. The determinations mean that those agencies do not have to notify:

- most first time allegations of physical assault, except where undue force was used by the employee or the alleged behaviour resulted in harm or injury to the child
- first time allegations of neglect involving the failure to provide adequate supervision or medical treatment if the risk of harm was reasonably perceived at the time to be low.

The determination also differentiates between allegations involving children from pre-school to grade 4 and older children, in recognition of the greater vulnerability of younger children. The determination with the CCER has also been extended so that Catholic independent schools are able to notify the Ombudsman of some allegations of physical assault or neglect by schedule. We are discussing a similar arrangement for other independent schools with the Association of Independent Schools and will consider extending the determination to other organisations that satisfy our requirements.

Case study 69

The May issue of the Teachers Federation newspaper contained a copy of a letter to the Minister for Education from a teacher. He complained about the impact of the child protection legislation on him as a result of an investigation into an allegation of child abuse against him by a student at his school. The teacher stated that despite the fact that the allegation had been found to be false, he now had his name on three databases - DET, the Commission for Children and Young People (CCYP) and the Ombudsman.

We were interested in the issues he raised and checked our database to see if his complaint was justified. We found no relevant record. Concerned that DET had not notified the allegation to us, we wrote to the department asking for any information

We were told that a student had complained about a fracas at the school. When the principal clarified the facts of the incident with the student, in the presence of his parent, there was no allegation of child abuse.

The Child Protection Investigation Directorate (CPID) recorded the incident and decided not to notify the matter to the Ombudsman or to the CCYP as the incident was clearly not an allegation of child abuse.

The Teachers Federation did not check the facts of the case with DET, CCYP or us before publishing this letter. A Sydney daily newspaper also used the same example without checking the source.

Case study 70

A female school teacher was alleged to have slapped a student's feet when asking the student to remove them from a desk. The teacher admitted she had tapped the student below the knee to reinforce to the student that she should remove her feet which were directly in front of a computer monitor on the desk. The investigator determined that the allegation of child abuse was not sustained.

We advised the agency that the alleged behaviour did not constitute a physical assault. The contact with the student was not hostile or reckless and was not perceived by the student as threatening. Our recommendation was that the finding should be 'not child abuse' rather than 'child abuse – not sustained'.

Case study 71

We received an allegation that a teacher at a school for children with special needs had physically assaulted and ill-treated a student with intellectual disabilities. The allegation was that when the teacher discovered a six year old child had soiled himself she dragged him off the toilet, crying and kicking, and forced him to remove his underpants. She then made him get back onto the toilet and demanded that he relieve himself there. When the child was not able to comply, she pulled him from the toilet and forced him to wash his soiled underpants in the sink.

The teacher denied any inappropriate conduct towards the child. She confirmed that she had 'asked' the child to rinse his underwear but stated that in doing so she had been following a program that was designed for the parents to use with the child at home. The school decided that there was insufficient evidence to sustain the allegation of ill-treatment. The teacher was advised that under no circumstances were children to wash their soiled underwear at school.

We were satisfied that the investigation finding was reasonable given the available evidence. However, the parents of the alleged victim were not notified of the allegations involving their child. Given the nature of the allegations against the teacher, the student's vulnerability and his alleged distress, it was our expectation that the school would inform the parents at the earliest opportunity. We also commented on the agency's delay in notifying the Ombudsman of these allegations some 12 months after they had first been raised at the school.

Case study 72

We received a notification alleging that foster parents were responsible for the failure to thrive of a one year old girl with special needs. There was no medical reason for the child's weight loss. It was reported that the foster parents interfered with necessary medical treatment for the child and failed to comply with instructions for feeding her. The agency conducted an interim risk assessment liaising with health professionals. The child was placed in hospital and the foster parents were allowed supervised access. The investigation sustained the allegation and the child was removed from the care of the foster parents. The child successfully started the feeding schedules that were originally planned for her and has gained weight since being removed from this placement.

Case study 73

We were notified of an allegation that a female ex-student had suffered psychological harm as the result of a sexual relationship she had had with a male teacher while she was in Years 11 and 12. The relationship continued after the student had finished school and ended when she was 22. The student is now 30 and has received extensive counselling for her inability to sustain other relationships. The student was interviewed and, as a result of her disclosures, the matter was referred to NSW Police.

It was subsequently agreed that. while the relationship may not amount to criminal conduct, there was sufficient evidence of inappropriate behaviour by the teacher for the school to conduct an investigation. The teacher was directed to perform alternative duties pending the findings of the investigation. The allegation of psychological harm was sustained and the teacher agreed to resign. His name was placed on the school's not to be employed list and the school complied with its statutory obligations to notify the CCYP.

Case study 74

We received a notification from a boarding school of an allegation of psychological abuse of a student by a staff member. The student reported that the boarding supervisor was victimising her and placing her under emotional pressure.

The principal investigated the allegations and found instances of the boarding supervisor publicly berating and threatening other students. The principal concluded that while a relationship of mistrust and tension had developed over time between the boarding supervisor and the student, causing the student to feel stressed and unhappy, there was no evidence that the boarding supervisor was deliberately targeting this student. Although the student felt that she was living in an environment of perceived threat and victimisation, there was no clear evidence of psychological harm because the student was not being targeted. While it was found that the staff member had breached the school's code of conduct and ethos by publicly humiliating students, the allegation of psychological abuse was not sustained. We supported this finding.

Case study 75

We received a notification that a high school teacher had been sending a female student inappropriate and personal emails. The investigation included an examination of the student's home computer and computers at the school. During the investigation it was reported that the principal had previously spoken to the teacher about his email contact with students. There had also been prior matters reported which concerned the teacher's interactions with female students. This included touching a student inappropriately, attending a student's home uninvited and sending notes, letters and cards to specific students.

DET completed a risk assessment that identified a long standing pattern of behaviour by the teacher consistent with grooming. As the teacher had been spoken to previously about his behaviour with students and appeared unwilling to change, it was recommended that the teacher be placed on alternative duties while the current allegation was investigated.

Greg Williams, legal officer in the child protection team and Barbera McCauley, executive assistant to the Ombudsman with our librarian, Sharat Arora.

How we handle notifications

When we receive a notification or a complaint, the first thing we do is assess if it is in our jurisdiction. There are occasions when an agency sends us a matter that does not fit the definition of child abuse in our legislation. This year we declined 129 matters that did not meet the definition. Please see case study 76.

We encourage agencies to contact us for advice if they are unsure if a matter should be reported to us or about what inquiries to make to clarify a complaint or report. To help agencies make these decisions, we have developed and distributed a fact sheet to clarify the types of behaviour that require notification

Oversight

Once we have accepted a notification of a child abuse allegation against an employee, we assess whether the initial response by the agency was satisfactory. If the alleged behaviour is a low risk matter and the agency's initial response is satisfactory, we take no further action until they send us their final investigation report – except to give advice if requested. Once we have reviewed the investigation report, we advise the agency whether or not their investigation and any findings made were satisfactory and whether any consequent action they took was appropriate. Please see case study 77.

Monitoring investigations

We monitor all investigations of child abuse notifications where there is a significant risk to children or other parties. These include allegations of child sexual assault, misconduct that may involve child abuse, or allegations involving senior staff. Many of these investigations are lengthy and complicated and some risk being compromised without our close scrutiny. We also monitor matters where an agency demonstrates an inability to properly investigate an allegation or significantly delays the completion of a matter.

When we monitor a matter, we take an active role in the agency's investigation. This includes asking for and assessing progress reports, conducting planning and review meetings

Case study 76

A juvenile justice centre notified us of an allegation that a casual youth worker had physically assaulted and threatened a detainee. The allegation was investigated and sustained and the worker was issued with a written caution and a 'notice to show cause' why disciplinary action should not be taken.

The detainee also alleged that another youth worker had attempted to dissuade him from complaining about the assault and threats. The department also investigated this allegation - as a breach of discipline. Although this second allegation was notified to us, the conduct did not fall within our definition of child abuse and was therefore not within our jurisdiction. We were, however, interested in the department's response because detainees are often reluctant to complain about misconduct and abuse by youth workers for fear of reprisal. This hinders DJJ's ability to fulfil its duty of care to detainees and its responsibilities for preventing and responding to allegations of child abuse against employees.

The worker in this instance admitted making inappropriate comments and expressed regret at having done so. He was cautioned and required to undergo refresher training in relation to the department's code of conduct. We were impressed by DJJ's response to this incident.

Case study 77

A teacher was accused of pushing a student's head into a piece of furniture. This particular allegation was not sustained by DET because the student conceded that the incident may have been accidental. We became concerned, however, when DET's report revealed a range of other allegations involving the same teacher over a period of time.

Although these incidents were minor when considered in isolation, taken together they demonstrated a pattern of behaviour that was of concern. Each of these matters had been managed locally. School authorities had spoken to the teacher on each occasion, but evidence of these conversations was only anecdotal because insufficient records had been kept. DET considered disciplinary action but, because of the lack of proper documentation about previous incidents, decided against it. They did invoke a clause of the Education Teaching Service Regulation 2001 that ensured close supervision of the teacher by a school principal and regular reports on the teacher's conduct. In the circumstances we accepted this as a satisfactory outcome.

Case study 78

In August 2001 DoCS notified us of alleged inappropriate behaviour by a foster carer towards a 13 year old girl. The allegation, first made in December 2000, was that the foster father touched the girl on her thighs in a way she did not like. He allegedly told the girl that he had touched all the foster girls in his care. Our review indicated there had been previous allegations of a similar nature that had not been satisfactorily investigated. Also, despite multiple allegations against this carer, DoCS had not conducted a risk assessment. We therefore recommended that DoCS reinvestigate the matter.

We monitored the department's reinvestigation of all the allegations against the carer. Three girls had made specific allegations against him of sexually inappropriate behaviour. Given the significant time that had elapsed and the unwillingness of one of the girls to cooperate with the investigation, DoCS was only able to sustain the allegations involving one of the victims.

The carer made a number of admissions but did not seem to think that his inappropriate physical contact or suggestive comments were unacceptable. After the matter had been reinvestigated, the foster carer was immediately deregistered.

and sitting in on interviews. Please see case studies 78-81 for examples of monitoring. Some of the issues we look at with agencies during this process include:

- possible avenues of inquiry
- the type and level of evidence required
- risk management
- assistance from other investigative bodies
- the weighing of evidence
- findings
- management or disciplinary options.

Making a finding

Case study 82 is an example of a wrong finding being made. This, or failing to make a finding, is a fault we sometimes see in investigations. The purpose of an investigation is to ascertain the facts of a matter. Making a finding is the final and essential step of an investigation because it is the conclusion drawn from those facts. The finding should form the basis of an agency's decision about any action that needs to be taken.

In addition, any decision contrary to an employee's interests should only be made after the employee has had the opportunity to respond to the finding and proposed action. This vital element of procedural fairness is not possible if the employee is unable to identify with certainty the actual finding of the investigation and the basis upon which it has been reached.

Direct investigations

This year we began three formal investigations (case studies 83, 84 and 86). We also finalised eight we had started last year.

We conducted fewer formal investigations than last year because of the increased use of our monitoring powers. We decided to formally investigate only those matters that indicated serious systemic issues and those where the desired outcomes could not be achieved by using our other powers.

Complaint handling

Sometimes parents, employees or other interested parties complain to us about the way an agency has investigated a child abuse allegation. Parents raise concerns about an agency's lack of action to investigate their complaint, the findings and leniency of action taken, or about not being kept informed. Employees complain to us about delays, lack of procedural fairness and the findings made against them.

Last year we received 87 written complaints. When we assess complaints, we make sure that the agency complained about has been given the opportunity to resolve the complaint. In 2002-2003 we declined 31 complaints, advising the complainant that they should first approach the agency themselves or that we would send their complaint to the relevant agency. We also told these complainants to contact us if they were not satisfied with the agency's response so that we could consider what further action we might take.

Case study 79

An independent school contacted us for assistance and advice about a letter and information it had received from the principal of a school in another state.

A former student of the interstate school had alleged that his male teacher had indecently assaulted him when he was in Year 6. The student claimed that the teacher had been good friends with his family and had undertaken outside school activities with him, but had also inappropriately touched him a number of times.

The interstate principal had made inquiries and discovered that this teacher was currently teaching in an independent school in New South Wales. The information was provided to the principal of the teacher's current school who asked for our assistance. Rather than investigate the allegations directly, we decided to monitor the school's actions and provide advice and support as necessary.

We met with the independent school and discussed its risk assessment and what inquiries it could make, taking into account the former student lived in another state and the offence had occurred some time ago. The school informed us that when they had employed the teacher, they had done a referee check with the interstate school. They were told that the teacher had showed a tendency to form close relationships with his students.

The school told us that the teacher was currently displaying similar grooming behaviour towards a Year 6 student - a close relationship with the student's family, taking the student alone to sporting and other social activities, allowing the student to sit on his knee and having the student to stay overnight at his home.

The school decided to engage an independent investigator who made inquiries of the former student, his family and the school in Queensland. The investigation of all matters found that child abuse was sustained in relation to the Queensland allegations and the teacher had breached his professional boundaries with the current student in NSW. The teacher resigned from the school and his name was reported to the CCYP.

This matter highlights the importance of schools doing full referee checks and clarifying any issues about previous behaviour with students. It also highlights the importance of independent schools having good child protection policies and codes of conduct.

Case study 80

In April 2000 we were notified that a senior employee of the NSW Ambulance Service, a designated agency, had been charged with offences relating to possessing and publishing child pornography. The service conducted a thorough risk assessment and the employee was stood down on pay until the criminal charges were finalised.

In December 2001 the employee pleaded guilty to criminal charges of possessing child pornography and was convicted of that charge in January 2002. He was consequently suspended without pay pending the outcome of a disciplinary inquiry.

The employee then asserted that he had pleaded guilty on legal advice and that he had no knowledge of the pornographic images on his computer. A committee of inquiry was established, as required by the relevant regulations, to investigate his claim.

We monitored this investigation and found it to be rigorous and the documentation meticulous. The employee was given numerous opportunities to respond to the allegations and was offered counselling during the process. The employee was found guilty of disciplinary offences and was dismissed from his employment in May 2002.

Complaints are a useful way for us to track an agency's compliance with its reporting obligations. In some cases we may not have received a notification from a particular agency and will seek a notification from them. It also provides employees with the opportunity to present other information if they believe their matter was not properly investigated. Please see case study 85.

Audits

In 2002-2003, we continued to conduct audits to scrutinise the systems agencies have in place for preventing child abuse by employees and for handling and responding to child abuse allegations or convictions involving employees. Our audits include analysis of policies and procedures, site inspections and interviews with staff and parents. We also provide feedback to the agency on what we find.

This year, the response from agencies to the audit process has been very positive. Staff and management willingly participated, with many stating that they welcomed external scrutiny and saw it as an opportunity to identify areas for improvement. We audited 15 agencies including independent and SSP schools ('schools for specific purposes'), two juvenile justice centres, an area health service and a community health centre. We also began an audit of independent schools with boarding facilities.

We were concerned that notifications received from the Department of Health have been low over the past four years. Our audit of an area health service and a community health centre revealed that although staff had a thorough understanding of children at risk of harm there was some confusion about what constituted an allegation of child abuse in the workplace.

Audits of 'schools for specific purposes'

Following audits conducted in 2001-2002 of a number of schools providing services for students with disabilities in both the government and independent school sectors, we provided individual schools with specific recommendations addressing any issues we had identified. This included the need for accredited training for staff in the appropriate use and methods of restraint and the revision of various school policies and procedures.

A number of schools have responded positively to our recommendations. In addition the Department of Education and Training, the largest education provider for children with disabilities, has briefed all its SSPs on their reporting obligations to the Ombudsman and on the role of the Child Protection Investigation Directorate (CPID).

We audited some departmental SSPs after these briefings and noted that staff in these schools now have a better knowledge of their reporting requirements in relation to child abuse allegations. We are currently preparing a comprehensive report to the department on the systemic issues identified during these audits.

Case study 81

DoCS notified us of an allegation made by a 14 year old girl that her foster father had sexually assaulted her. The girl's presentation at the time of disclosure was consistent with the allegations and an initial medical assessment indicated there was evidence to suggest she had been sexually assaulted. The girl and other children who were in the placement at the time were removed.

A number of issues arose relating to DoCS' investigation of this case. There was a significant delay in formally interviewing the girl and her alternative placement was inappropriate. The foster father had contact with the girl on several occasions during this placement and put pressure on her to retract her allegations, which she did.

DoCS initially did not confirm the case because of the girl's retraction. Although the girl had also disclosed that there were other victims of sexual assault (who were now adults), the department did not consider interviewing them. Neither did it evaluate or assess the risk that this carer may have posed to other children. The case also demonstrated a lack of coordination within the department including JIRT, the community service centre and the out of home care branch.

After our intervention, DoCS reviewed its original decision and confirmed the allegations on the basis of the evidence available. The foster carer was deregistered as he was considered an unacceptable risk to children.

The case resulted in an internal review by DoCS which identified several areas where case practice was insufficient or flawed and lacked coordination. The review made recommendations that, if implemented, should help DoCS to ensure that such poor practice is not repeated in the future.

Case study 82

We were notified by DET of allegations that a teacher had exposed a class of year 8 students to inappropriate written material on his personal website.

During a drawing class, the teacher suggested the students access the site to view pictures of his artwork but told them not to open an associated site that contained the inappropriate material. However, a number of students opened the site and read the material, apparently without the teacher's knowledge. One student accessed the site on her home computer, printed out the material and showed it to her parents. It consisted of stories written by the teacher that included sexual experiences.

A few days later, having learned that the students had accessed the site, the teacher removed the links to it.

After a thorough investigation, the department sustained the allegations as child abuse but with no further action required. Based upon the available evidence, we assessed the actions of the teacher as not being child abuse.

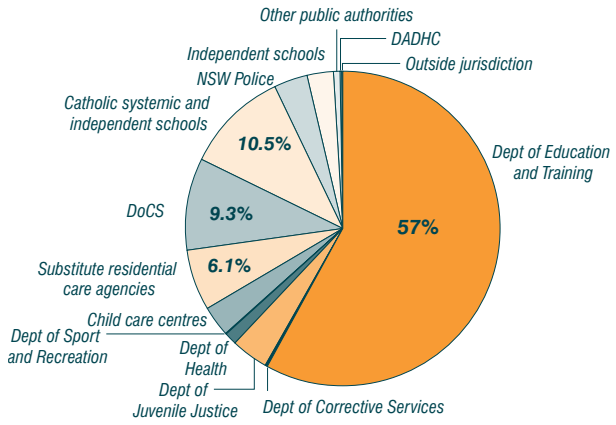
There was no evidence that the children exposed to the material suffered or sustained psychological harm. There was also no evidence suggesting the teacher's behaviour was that of grooming as the teacher had advised the students not to access the site and his behaviour was not directed at specific students.

We requested that a change of finding be made and, on review, DET reassessed the outcome as not child abuse.

How agencies are performing

The increase in notifications this year is attributable to the increase in notifications from DET, DoCS and agencies providing substitute residential care.

Figure 44: Notifications by agencies



Notifications by agencies	02/03
Dept of Education and Training	1,460
Dept of Corrective Services	6
Dept of Juvenile Justice	96
Dept of Health	32
Dept of Sport and Recreation	2
Child care centres	79
Substitute residential care agencies	158
DoCS	238
Catholic systemic and independent schools	268
NSW Police	87
Independent schools	68
Other public authorities	17
DADHC	4
Outside jurisdiction	3
Total	2,560

Department of Education and Training

DET remains the largest notifier of child abuse allegations and reported a significantly higher number of matters this year than it has in the past. This is partly due to the extensive training program that the CPID conducted with school principals and the reporting by schools who had not previously notified. Thirty five per cent of the notifications came from schools that had not previously made a notification.

We continued to meet regularly with the CPID this year and discussed issues such as findings, extending the class or kind determination, reporting matters to the Commission for Children and Young People (CCYP), definitions of child abuse and case related matters. We reported last year that DET had concerns about the making of findings under our legislation. We were able to resolve this matter satisfactorily.

Catholic schools

Catholic schools, including both systemic and independent schools, notified 268 matters. This is 10% of the matters reported to the Ombudsman.

The Catholic Commission for Employment Relations (CCER) is the 'head of agency' for all Catholic systemic schools and most independent Catholic schools. We have continued to meet regularly with the CCER to discuss concerns about its systems for reporting and investigating child abuse allegations and to provide advice about specific investigations.

This year the focus of our meetings with CCER has been to extend the previous class or kind determination. The new determination means that certain low risk matters are not now notified to the Ombudsman.

We also discussed our concerns about the investigative practices of some of the Catholic education offices, the restructure of the CCER, and the low numbers of matters reported to the CCYP. We provided advice on the standard of proof required to support sustained allegations of sexual assault against employees. Other concerns discussed were:

- individual case matters, particularly allegations against clergy and other lay people who provide a service to Catholic schools
- delays in providing information and final investigation reports to the Ombudsman
- the adequacy of the CCER's risk assessments in relation to employees who are the subject of sexual assault allegations or allegations of grooming behaviour.

Our meetings with CCER management are a useful forum to raise and resolve any concerns held by either organisation.

Independent schools

There has been a slight decrease in the number of matters reported by independent schools in 2002-2003. However, the overall quality of their investigations into allegations has improved significantly. We found that 75% of completed investigations were satisfactory or demonstrated good practice.

Most principals capably investigated the allegations themselves. Some principals chose to engage external investigators because the allegations made were serious, complex or involved allegations against a principal or other executive staff member. We have advised schools that do this to approve the scope of the investigation and to monitor its progress so that only necessary resources are expended. In most cases the allegations do not require a complex investigation.

After our meeting with principals of boarding schools last year, we undertook to audit a number of independent boarding schools and we continue to do this.

Our education and training initiatives in 2002-2003 included an extensive joint training program with the AIS, providing workshops to principals of independent schools throughout New South Wales. The AIS continues to be a valuable link between independent schools and our office. We have also met with them to discuss individual case matters and to look at ways to extend the class or kind provision in our legislation to independent schools.

Substitute residential care

This year we received 158 notifications from the substitute residential care sector - this is 74% more than last year. Overall, this sector made up 6% of all notifications received.

We continue to receive notifications from agencies that are notifying for the first time. We put this down partly to our mail out to over 180 agencies reminding them of their reporting obligations. We have concentrated our efforts and resources into telephone support when agencies first notify. This gives them the opportunity to improve and develop their processes and we plan to continue this focus in 2003-2004.

We have seen a significant improvement in the quality of the investigations conducted by agencies that have previously notified matters to us. These agencies have received feedback about their investigations, have reviewed their practice, and improved their investigation processes and child protection policies. Some agencies appear to be more confident about requesting assistance from us once a notification is made. This often results in a better investigation.

The quality of investigations in this sector, as well as the level of understanding of our role, is still variable. We have completed a major audit and follow up training with one large agency and are in the planning stages of another.

Department of Juvenile Justice

The Department of Juvenile Justice notified us of 96 allegations this year. This represents almost 4% of all agency notifications.

Audits of two juvenile justice centres revealed a strong commitment to child protection. Centre staff displayed a willingness to assist our scrutiny of the department's systems for handling and responding to child abuse allegations against employees. The director general has also commented on the value of our role in scrutinising the department's systems and making recommendations for improvements.

A juvenile justice facility notified us of a detainee's allegation that he had been inappropriately strip searched. The strip search appeared to have been conducted within departmental guidelines and did not constitute child abuse. However, because a strip search can be an invasive and traumatic experience for any young person, we will continue to monitor any allegations about inappropriate strip searching to ensure strict compliance with guidelines.

Case study 83

During one of our audits in 2001-2002, we became aware of a matter that had not been finalised in over 12 months. The allegations against the employee had been investigated by the police and he was charged with child sexual abuse offences. The charges were later withdrawn at court and the employee remained in his position working with children.

When we reviewed this file we were concerned about the nature of the allegations, the employee's role working with children, the limited information the agency had about the allegations and its delay in providing any information to us. It also appeared that the agency had not conducted a risk assessment when the criminal charges were withdrawn.

We asked the agency for further information and made inquiries of the police. We then decided we would investigate the agency's handling of this matter.

On notice of our investigation, the agency undertook a risk assessment and engaged an independent investigator to investigate. The child sexual abuse allegations were not sustained, but an allegation of neglect was. We discontinued our investigation when it became clear the agency was handling the matter appropriately.

Due to the nature of the neglect allegation and the risk posed by the employee, the agency terminated the employee's employment. He has since made an unfair dismissal claim to the Industrial Relations Commission.

Case study 84

DoCS investigated child abuse allegations against an employee of a local council. The allegations related to behaviour that could be regarded as 'grooming' such as inappropriate cuddling, rubbing and fondling.

DoCS interviewed workers from another service and advised the council that it had 'confirmed abuse' of two of the clients of that service by the council employee. DoCS did not provide the council with any details about the nature of the alleged child abuse.

Having received no response to informal inquiries of DoCS aimed at clarifying a number of issues, we decided to investigate its handling of this matter.

Our investigation found that DoCS had failed to:

- investigate child abuse allegations against an employee of another agency
- provide information on the truth or otherwise of child abuse allegations against employees
- properly exchange information with relevant agencies
- properly record 'at risk reports' on its client information system (CIS).

We also found that there had been poor communication between DoCS and the other agencies who had joint responsibilities in such matters.

As a result of the investigation we made a number of recommendations with which DoCS has fully complied.

Case study 85

The Teachers Federation complained that an allegation of physical abuse should not have been made as the teacher was acting to protect a child from injury. There was no need for us to take any action in regard to this complaint.

Our normal oversight procedures ensured that the finding of the investigation, which was that there was no physical abuse and that the teacher had acted to protect the child from danger, was validated.

Delays with departmental investigations of alleged child abuse remain a concern. However, the department is increasingly recognising the need to finalise investigations in a timely fashion to minimise the stress on the alleged victim and the employee who is the subject of the allegation.

We are monitoring the department's current initiatives to reduce delays.

Local government

There has been a 5% increase in the number of notifications received from the local government sector this year, 43 in all. As with last year, this represents 2% of all notifications by agencies.

Many of these notifications related to council employees working in council licensed family day care schemes and child care centres. Child abuse allegations against council family day carers are notifiable to the Ombudsman as, under our legislation, they are considered to be employees.

Some councils' responses to child abuse allegations have improved significantly and show that their experiences and commitment have combined to produce better systems and improved practice. We are also pleased that some councils readily use our telephone inquiry service.

NSW Police

Notifications involving police officers are dealt with by our police team, in the same way as other allegations of police misconduct. Our child protection team also oversees them. Last year we reported 230 police notifications - this included matters referred to the child protection team that were assessed as not being allegations of child abuse. This year we have recorded only those matters alleging child abuse, a total of 87 compared to the 115 reported last year. This still represents a 24% decrease in the number of notifications of alleged child abuse.

Department of Community Services

Last year we investigated DoCS' consistent failure to send their notifications to us within the requisite 30 day period. We found that approximately half the notifications made since May 1999 had taken longer than 30 days. DoCS had also failed to adequately define the processes involved in investigating allegations against its employees and failed to adequately inform employees of its responsibilities to notify us. We made a number of recommendations as a result of the investigation.

DoCS has advised us that they have made some progress towards meeting their own benchmarks for timeliness of notifications to the Ombudsman. They have also continued to develop internal procedures for investigating allegations against employees and will be providing an information sheet about the notification and investigation process to all foster carers currently registered with DoCS.

Case study 86

We decided to conduct a direct investigation into allegations of child abuse made against two foster carers employed by DoCS. One of the foster carers was a former district officer of the department. We became concerned about the failure of the department to finalise this matter and its ability to address serious systemic issues raised throughout our monitoring of the case.

The original allegations concerned two male foster children aged 8 and 6 years of age. They were diagnosed by medical practitioners as suffering from psychosocial growth failure while in the care of the foster carers. The allegations raised serious concerns about DoCS' level of supervision and case management of the placements.

The alleged deficiencies in the care provided by the foster parents were confirmed by the dramatic improvements in weight, height and social maturity made by the children when they were placed in alternative care.

In view of the poor care practices of the foster carers, we were concerned about the department's apparent failure to revoke their authorisation to continue to foster in NSW or to notify child protection agencies in another state to which the foster parents had moved. In addition, we had concerns about the lack of any risk assessments undertaken by the department in response to allegations made against these employees in relation to their natural children. Another issue of concern was discrepancies relating to the previous employment of the female foster carer when she was a district officer supervising state wards. These included misrepresentation of her academic qualifications for her employment and apparent alteration of departmental case management files of other children in foster care.

Our final recommendations were aimed at correcting the department's shortcomings in its intervention and documentation of this matter, and at establishing mechanisms and procedures that could improve future handling of 'abuse in care' allegations. The department has complied with some of our recommendations and is required to report on its overall compliance in the near future.

Case study 87

A child care centre received a serious child abuse allegation against an employee. As the allegations were subject to a joint DoCS and police investigation, interagency communication became an issue.

Without the details of the allegation it was difficult for the centre to fully assess the risk. They decided that the employee was to be fully supervised while in contact with children. The police asked the centre to review this decision and they removed the employee from his duties for the remainder of the investigation.

The centre had difficulties with their investigation as there had been limited information provided about the allegation and the criminal investigation was delayed.

DoCS eventually provided the centre with relevant information. Under s.248 of the Children and Young Persons (Care and Protection) Act 1998, DoCS advised the centre of both the details of the allegation and the outcome of its investigation. This allowed the centre to fully address their responsibilities to the employee and the children.

This year we introduced a different method of recording allegations against foster care couples. Instead of recording the allegation as one notification, we recorded them as two separate notifications if allegations were made about both carers.

There has been a 82% increase in the number of notifications made by DoCS this year. Taking into account the changed counting arrangements, this is a real 64% increase in notifications compared with last year. This increase may be attributable to improved reporting.

We have raised a number of systemic issues with DoCS at our regular meetings. One is DoCS' reluctance to share information under s.248 of the Children and Young Persons (Care and Protection) Act 1998. This issue has been difficult to resolve and is the subject of a working party that involves DoCS, CCYP and the Ombudsman. The importance of this issue is shown in case study 87.

We also became aware that DoCS was failing to notify CCYP about some serious child abuse allegations. We twice challenged its decision and in both cases DoCS reviewed its decision and notified CCYP.

We have also raised concerns about DoCS staff interviewing foster carers together about child abuse allegations. This is a practice that may compromise the integrity of evidence and the outcome of an investigation.

Childcare centres

This category includes all licensed private and community based childcare centres as well as those run by local councils. There has been a 15% decrease in the number of notifications received from the childcare sector this year - 79 compared with 93 last year. Given the large number of licensed childcare centres we are concerned about the comparatively low level of reporting.

Despite our community liaison and training efforts, it has been difficult to reinforce reporting obligations with this sector. There are a number of reasons for this. These reasons include:

- no centralised body in the private sector to take on a quality assurance role
- a high turnover of staff
- a high level of change in centre ownership and appointment of centre directors
- a sense that the sector is overwhelmed by administrative/ managerial responsibilities and lacking in skills and knowledge
- a conflict of interest issue with small centres that involve parents in management committees or where some of the staff are employed in a family business.

We try to address these issues by dealing with case and centre specific issues as they arise. We will also continue to audit centres and provide training on investigation practice and risk management.

Department of Health

The Department of Health has notified 32 matters this year. Although this is 14 more than last year, it seems a low number of notifications given the large number of staff working with children in health facilities. There is a proportionally higher notification of sexual abuse allegations than in other agencies and fewer reports of physical assault.

Our discussions with the department have resulted in changes to the process for notifying us of child abuse allegations against employees. All notifications, including those from area health services (AHSs), are now first submitted to their Employment Screening and Review Branch (ESRB) for management and review. This process has been developed to improve communication between the AHSs, ESRB and the Ombudsman.

We meet with the ESRB on a bimonthly basis to discuss systemic issues and specific cases. Continuing concerns throughout the department include a lack of understanding about what needs to be notified, significant delays in reporting matters, and unsatisfactory documentation of the investigative process. ESRB has also advised of difficulties in obtaining risk assessment information from agencies such as DoCS or NSW Police.

During 2002-2003, we began an audit of the Hunter AHS and plan to audit others in the coming year.

Some area health services have asked for risk management workshops similar to one we ran in the Greater Murray Region and we are evaluating how best to respond to this need.

Other public authorities

Unlike designated agencies, other NSW public authorities only have to report to us if the alleged child abuse arises in the course of the person's employment with the public authority.

This year we received 13 notifications from public authorities that are not designated government agencies.

Legislative review

We have an important role in helping agencies understand and comply with their legislative responsibilities under the suite of child protection legislation passed in 1998. We do this by making submissions, participating in working groups and providing legal advice.

We made two extensive submissions to DoCS during the community consultation process on the draft Children's Services Regulation 2003. We anticipate that the draft Children's Services Regulation 2003 will be gazetted in the 2003-2004 financial year. This will enable the automatic staged repeal of the Family Day Care and Home Based Child Care Services Regulation 1996 and the Centre Based and Mobile Child Care Services Regulation (No. 2) 1996. The commencement of Chapter 12 of the *Children and Young Persons (Care and Protection) Act 1998* will have to coincide with, or precede, the gazettal of the new regulation.

DoCS has advised us that item 23 of Schedule 2 to the *Children and Young Person Legislation (Repeal and Amendment) Act 1998* will come into operation at the same time as Chapter 12. This will bring all forms of children's services within the Ombudsman's child protection jurisdiction. Currently, our jurisdiction only includes centre based children's services and family day care services run by a public authority.

During the year, we also participated in a joint working party with DoCS and the CCYP that has refined the operation of s.248 of the *Children and Young Persons (Care and Protection) Act 1998*. The section enables DoCS to provide or receive information from a wide range of agencies about the safety, welfare and well being of an identified child or children. DoCS has been reluctant to share information even when it would clearly help another agency to protect children from further abuse.

The Commission for Children and Young People (CCYP)

We have worked closely with the CCYP during 2002-2003 to improve the implementation of the child protection legislation.

The CCYP was concerned about the low numbers of matters reported to them compared to the number reported to the Ombudsman. As part of our scrutinising responsibility, we wrote to the CCYP, DET and CCER for a schedule of completed relevant disciplinary proceedings that had been notified to the CCYP. At the same time, we audited our records to obtain a list of serious matters that we determined should be notified and compared these with the CCYP list. It was clear some matters had not been notified and we have written to the agencies recommending these matters be notified. As standard procedure we now ask for evidence of notification to the CCYP in all the matters we monitor.

We were concerned that some agencies that had notified the CCYP were subsequently requesting withdrawal of this notification, sometimes as a result of pressure from the unions. The CCYP informed us it did not have the power to investigate the legitimacy of such a request. We have now developed a protocol with the CCYP so that they ask for our advice when a request for withdrawal is sought.

During 2002-2003, we participated in the working party that was convened to review the Working With Children Check guidelines and look at the impact of Part 3A of the Ombudsman Act on employees. Our main concern was that the guidelines had consistent definitions and promoted a seamless and workable approach. The revised guidelines have been finalised and significant changes to reporting requirements to the CCYP have been made.

The working party also discussed Part 3A of our legislation. We advised them of the extensions to the class or kind determination that took effect in April and of our plans to make other determinations as agencies establish their capacity to properly manage child abuse allegations.

Employees resigning before child abuse investigations are finalised

Some agencies have not always dealt with child protection concerns in an appropriate way. We have found cases where employees are either allowed or persuaded to resign before the investigation of a child abuse allegation starts or ends. We have also seen cases where employees have been dismissed for misconduct (not relating to child abuse) and the child abuse allegations have been ignored and not investigated.

Although this may solve the immediate dilemma for the employer, it can pose risks for children that those employees may work with in the future. It may also create legal problems for the agency if the employee subsequently claims 'constructive dismissal' ie that he or she had no choice but to resign.

We understand that if an employee resigns before the completion of an investigation there is little that an employer can do to prevent the departure. Our concern is primarily when an employer promotes resignation to avoid investigating alleged child abuse. This is not a satisfactory outcome for anyone.

We suggest agencies seek legal advice about what options are open to them in these situations. If an employee insists on resigning before the investigation is finalised, the agency should check what powers it has to refuse to accept the resignation or to withhold entitlements until the investigation is completed.

If an employee leaves the workplace before the investigation is completed, the agency is still required to collect as much information as possible to determine whether, on the balance of probabilities, the alleged incident occurred or not. Wherever possible, the employee should still be given the opportunity to respond to the allegations. The agency should send the results of the investigation to us and, if appropriate, report the matter to the CCYP.

Trends and patterns

Our analysis of the information we collect from notifications gives us a better understanding of child abuse in the workplace. We use this information to help agencies develop strong child protection policies and effective responses to child abuse allegations. It also helps us to target the most effective way to use our resources.

We also encourage agencies to collect relevant data for use in their own child protection initiatives.

Agency reporting patterns

There were similar patterns of reporting across agencies, except for the Department of Health.

All agencies, except the Department of Health, reported proportionally more allegations of physical assault than any other kind of abuse. The second highest type of abuse reported was misconduct that may involve child abuse.

Independent schools were proportionally the highest reporters in this category (23%). Agencies providing substitute residential care reported 17% of allegations received and DJJ reported 14%. These agencies have in common a residential component to their services.

Sexual assault (184 notifications or 8%) constituted the third highest type of child abuse allegation reported. The Department of Health had the highest proportion of allegations of sexual assault with 43% or 15 notifications , followed by the Department of Sport and Recreation (35%, 2 notifications) and other public authorities (20%, 4 notifications). DET, DoCS and Catholic schools reported the highest actual numbers of sexual abuse allegations with 85, 24 and 22 respectively.

Behaviour causing psychological harm was the second lowest abuse type reported (5%). DET (69), DoCS (21), Catholic schools (20), independent schools (9), agencies providing substitute residential care (5) and a childcare centre (1) were the only agencies to notify allegations of behaviour causing psychological harm.

Neglect was the lowest abuse type reported (2%). All agencies except the Departments of Sport and Recreation, Health and Corrective Services, and independent schools reported allegations of neglect. DET, DoCS, DJJ and local government were the highest reporters both proportionally and in actual numbers.

Types of abuse reported

Allegations of misconduct that may involve child abuse made up 12% of notifications reported to us this year. Of these 28% related to inappropriate comments, 22% related to inappropriate touching, 16% related to inappropriate relationships and 34% related to other misconduct,

Eight per cent of notifications received this year related to sexual assault, 5% to behaviour causing psychological harm, 2% to neglect and 5% of notifications were not of child abuse allegations.

Agency findings

The following findings were recorded about the notifications finalised during 2002-2003:

- 32% of matters were sustained
- 19% of matters were found not to be child abuse
- 37% of matters were not sustained due to insufficient evidence
- 5% of matters were false
- 1% of matters were vexatious
- 3% of matters no finding made.

Our assessment of agency findings was that:

- in 80% of cases we found the agency finding to be reasonable
- in 15% of cases we were unable to assess the agency finding
- in 5% of cases we found the agency finding to be unreasonable.

Three per cent of matters were not in our jurisdiction so we did not record our assessment of the agency finding.

In 36% of cases we found the overall agency investigation to be unsatisfactory.

Allegations of physical assault (37%) and neglect (26%) had the highest percentages of sustained findings followed by sexual assault allegations (19%), misconduct that may involve child abuse (18%) and lastly behaviour causing psychological harm (11%).

Multiple allegations against employees

In the 2381 matters closed this year, 11% of the employees involved had had previous child abuse allegations made against them. Of these allegations, 84% were made 0-2 years ago, 8% were made 3-5 years ago, and 2% were made 6+ years ago. In 6% of matters the date on which the previous allegation was made was unknown.

Of those cases where previous allegations were made 0-2 years ago, 2% were from child care centres, 11% were from DoCS, 47% were from DET, 14% were from DJJ, 13% were from the Catholic sector, 3% were from independent schools and 8% were from substitute residential care agencies.

This information helps us work with agencies to improve their systems for preventing child abuse. In the case of repeat offending patterns, we ask agencies to analyse and address:

- the contextual issues in which the behaviour arises
- the competence of the employee
- behaviour management issues of children
- the effectiveness of the management or disciplinary options available to them.

Community liaison and training

The aim of our liaison work with agencies is to provide accurate and useful information to help them understand what they have to do and how best to do it. We do this through workshops, briefings, conference presentations and by producing educational materials.

This year we concentrated on providing workshops on risk management, investigative practices and developing child protection policies. We continue to provide briefing sessions about the legislation to new agencies or to agencies where there has been a significant change of key staff.

We also take the opportunity to talk to agencies about current issues and any changes to the way we are working. We have held sessions with the large agencies that have centralised investigation units and with employer representatives about how to assess whether or not a complaint is in jurisdiction.

During 2002-2003, we presented seven child protection policy development workshops to 219 agencies and briefings to 126 participants from 19 agencies. Some of the agencies represented were local councils, the Departments of Health and Ageing, Disability and Home Care, the Australian Montessori Education Foundation, the Department of Community Services, Dalmar and a number of child care centres.

Our risk management and investigative practices workshops target managers who are responsible for conducting investigations or risk managing situations after an allegation of child abuse has been made against an employee. A total of 89 managers from four agencies attended these workshops.

In the workshops, we use case scenarios that reflect the activities of the agencies to explore the risk assessment of employees and allegations and possible risk management strategies. Feedback from participants has been very positive and we will continue to conduct these workshops next year.

We are developing new fact sheets on the sufficiency of evidence and assessing allegations. A revised version of our current guidelines and the new fact sheets will be available later this year.

Child Protection Forum

The Child Protection Forum began in 1999 and meets bimonthly to discuss current issues, investigative practice and legislative or policy changes in child protection. It brings together a range of staff who are responsible for child abuse investigations in the workplace.

We have conducted four child protection forums this year and the number of agencies represented has increased. Some of the issues that have been canvassed include trends and patterns in child abuse notifications, procedural fairness, security and storage of the records of child protection investigations, and 'without prejudice' apologies.

Due to an increase in notifications related to child pornography and inquiries from agencies about investigating such matters, we invited two representatives from the NSW Police Child Protection Squad to attend the forum held in April 2003.

Performance Indicator
Reports recommending changes to law, policy or procedures

Target	01/02	02/03
90%	100%	100%

Interpretation

At the end of each formal investigation, we provide a report to the agency concerned containing recommendations for improvement. We aim to recommend changes to law, policy and procedures in 90% of our reports. This year, we exceeded our target.

Performance Indicator
Recommendations implemented

Target	01/02	02/03
80%	93%	86%

Interpretation

We monitor the degree to which the recommendations that we make in our reports are implemented by the agencies concerned. We aim to have 80% of our recommendations implemented. This year, we exceeded our target.

Legislative reviews

Over the past five years Parliament has given us a significant role in reviewing the early implementation and application of new legislative powers conferred on police and other government agencies.

During 2002-2003, we have undertaken or are in the planning stages for reviews of 14 Acts. Please see below for details of each review.

Our research strategies involve analysis of data held by relevant agencies, direct observations of the powers being used, analysis of complaints, surveys of and focus groups with stakeholders, literature reviews, and reviews of other relevant jurisdictions.

While considerable work occurs during the operation of the legislation, we are also extensively involved with the relevant agencies in developing processes to capture information prior to the legislation coming into effect. For example, the *Law Enforcement (Powers and Responsibilities) Act 2002* is a major overhaul of police powers, and we have been asked to conduct three reviews under this legislation, along with a related review of search warrants. NSW Police will be undertaking a major education and awareness initiative to give effect to this legislation, and we have been endeavouring to ensure that the establishment of information systems for our reviews is integrated into the planning process.

We appreciate the resource constraints on agencies, particularly NSW Police, that may affect the collation of information during the review period. Our involvement in the planning process for the implementation of the legislation is a critical feature in developing effective and cost-efficient systems to enable us to carry out reviews. The co-operation of agencies in these processes is essential for us to make comprehensive and accurate assessments of the legislative powers in action.

Our research strategies offer unique insights into the day to day operation of these powers, enabling us to offer a considered view to the Parliament and the community on the fairness and effectiveness of the legislation in practice.

DNA sampling and other forensic procedures

The Crimes (Forensic Procedures) Act 2000 regulates the circumstances in which police can carry out forensic procedures on suspects, 'volunteers' (as defined by the Act) and people convicted of 'serious indictable offences'. Our role is to scrutinise how police use the powers provided by the Act.

Some of the forensic procedures covered by the Act are:

- taking DNA samples, fingerprints, swabs and dental impressions
- taking photographs of tattoos or scars, and
- external examinations of a person's body.

The Act sets out how the forensic material may be taken and when it must be destroyed. It also outlines the rules for the participation of NSW in the National DNA Database maintained by a number of Commonwealth agencies.

Forensic DNA sampling of serious indictable offenders

DNA and certain other forensic samples can be obtained from inmates and detainees serving a sentence of imprisonment on the basis that they have been convicted of a serious indictable offence. If the offender does not consent to the DNA sampling, police can apply for an order from a senior police officer or, in some circumstances, from a court to authorise the sampling.

The DNA profiles obtained from these samples can be placed on the DNA database and compared to DNA profiles obtained from samples found at crime scenes.

Since the commencement of the Act in January 2001, NSW Police have attempted to obtain DNA samples from all eligible serious indictable offenders in order to build a substantial archive of DNA profiles for the DNA database. NSW Police believes that this 'mass sampling' of offenders will provide a valuable

tool to assist in the investigation of crimes and increase the speed at which crimes are solved.

People who have been convicted of serious indictable offences make up approximately 75% of the people imprisoned in NSW. During our first review period (1 January 2001 to 5 July 2002), NSW Police obtained DNA samples from:

- 9,952 inmates in adult correctional centres
- 49 detainees in juvenile detention centres
- 402 detainees in periodic detention centres.

Our review

Some of our activities in reviewing the DNA sampling of serious indictable offenders were as follows.

Discussion paper

Our paper received 49 responses from a range of stakeholders, including inmates, police, correctional centres, government agencies and community organisations.

Interviews with serious indictable offenders

We interviewed 192 inmates at 12 different maximum, medium and minimum security correctional centres across the state after police had taken a DNA sample.

Focus groups with police and corrections staff

We held focus groups with the police and correctional officers involved in the DNA sampling process, and with correctional centre welfare staff.

Interviews with managers of juvenile justice centres

We spoke to senior managers in all NSW juvenile justice centres.

Interviews with police in other jurisdictions

We spoke to police in all Australian states and territories and also police in the United Kingdom and Canada about the way DNA samples are taken from prisoners in their jurisdictions.

Audit of video recordings of forensic DNA sampling

We audited 254 video recordings of interactions between the NSW Police inmate testing teams and offenders, including videos of DNA samples being taken by force.

Audit of records held by the DNA laboratory

We conducted a random audit of 164 DNA samples taken from offenders, including a comparison of NSW Police records and those held by the DNA laboratory.

The final report of our review of the DNA sampling of serious indictable offenders will be provided to the Attorney General, the Minister for Police and the Commissioner for Police.

Forensic procedures carried out on suspects and volunteers

When amendments were made to the Act by the *Crimes (Forensic Procedures) Amendment Act 2002*, we were given a second review period from 1 June 2003 to 31 December 2004. This phase of our review will focus upon forensic procedures carried out on suspects and 'volunteers'. We will also continue to monitor the use and destruction of DNA profile information and the exchange of information between police in NSW and other jurisdictions.

The child protection register

The *Child Protection (Offenders Registration) Act 2000* came into effect on 15 October 2001 and requires that the Ombudsman monitor the operation of the Act for two years.

The Act provides for the establishment of a 'child protection register' to be maintained by NSW Police. It requires people who have been convicted of certain specified offences against children to register with the police upon their release into the community and provide police with certain information about themselves, including the names that they use, their address, and details of their employment and of motor vehicles they use. They must also advise police about any changes to those details. It is an offence to fail to comply with the reporting requirements or to supply false information.

The police can use the information on the register to monitor registrable persons and to assist in the investigation of offences against children. Access to the information on the register is limited to specified operational areas of NSW Police and is not accessible by members of the public.

A number of issues have been identified during our review by community groups and others. We published a discussion paper in September 2003 inviting submissions from interested individuals as well as from public and private sector organisations.

Questioning drivers and their passengers

The *Police Powers (Vehicles) Amendment Act 2001* was passed and assented to in October 2001 and commenced operation on 1 January 2002.

The Act clarified when police could seek identification details from drivers of vehicles suspected of involvement in an indictable offence, in line with recommendations we made in our earlier review of the *Police Powers (Vehicles) Act 1998*. The Act also conferred additional powers on police to enable them to ask passengers in a vehicle suspected of having been involved in an indictable offence to identify themselves, the driver and other passengers, and to ask passengers for proof of their identity.

We were required to review the operation of the additional powers for the first 12 months after assent to the Act. A research project was conducted to assist the review. This included the examination of all police and court records

associated with the use of the additional powers, and speaking with police officers who had used the powers. We also examined recording practices and education and training.

A report on our review has been prepared, and is currently the subject of discussion with NSW Police prior to finalisation and presentation to the Minister for Police.

Drugs in premises and public places

The *Police Powers (Drug Premises) Act 2001* commenced on 1 July 2001 and conferred new powers on police to deal with 'drug premises'. These are defined as any premises being used for the manufacture or supply of prohibited drugs. While the impetus for the introduction of this law was drug law enforcement issues that had emerged in the Sydney suburb of Cabramatta, the application of the law is state wide.

The primary intention of the Act was to give police additional powers to deal with drug supply. The Act creates a new type of 'drug premises' search and establishes several key offences:

- being found entering or leaving drug premises
- organising, assisting or conducting drug premises, and
- allowing premises to be used as drug premises.

The Act also gives police an additional tool to deal with the street level drug trade by extending police powers to issue 'reasonable directions', such as 'moving on' a person they suspect is in a public place for the purpose of buying or selling drugs.

Our review of the Act includes a research project that will examine a range of police and court records and will obtain evidence from people who have direct and specific knowledge of the impact of the law. Some of the research activities include:

- scrutinising uses of the Act in selected local area commands, including Cabramatta
- conducting a qualitative analysis of police records including search warrant documents and intelligence reports
- interviewing police who have applied and worked with the legislation
- contacting various local health agencies, drug user groups and academics to seek their views on the Act's practical effects
- collating demographic data, including age, sex and ethnicity (including Aboriginality) of people charged under the Act
- auditing drug 'move on' incidents in selected local area commands across the State.

In July 2003, we released a discussion paper and called for submissions from those who have an interest in the implementation of the Act.

Internal searches for drugs

The *Police Powers (Internally Concealed Drugs) Act* officially commenced on 1 July 2002, and established a regime for the carrying out of 'internal searches' on persons who are suspected of swallowing or otherwise internally concealing a prohibited drug possessed for the purposes of supply. An 'internal search' in this context includes the use of X-ray or other forms of medical imaging, but does not include actual intrusion into a person's body cavities.

The Act provides that, where the search indicates the potential presence of drugs, the suspect may be detained at a hospital or medical surgery for an initial period of 48 hours (which may be extended) to obtain evidence from the person's faeces.

NSW Police originally decided to trial the operation of the Act in five local area commands. Police in these commands were to make use of two hospitals nominated by NSW Health. It is understood that the plan to trial the powers in selected areas will no longer proceed. NSW Police and NSW Health are currently attempting to resolve a number of issues to allow state wide roll out of the legislation in future.

We are making inquiries with both NSW Health and NSW Police to monitor progress on this issue.

Sniffer dogs

Drug detector dogs

We are now more than halfway though our review of the *Police Powers (Drug Detection Dogs) Act 2001*. The Act commenced in February 2002 and we are required to review its operation for two years.

The Act regulates the use of dogs by police officers for the purpose of detecting the presence of prohibited drugs. Police can use drug detection dogs without obtaining a search warrant in relation to specified persons, including persons at, leaving, or entering sporting events, parades and concerts, as well as bars and clubs and other venues where alcohol is both sold and consumed. The dogs can also be used to detect drugs on persons on, entering, or leaving public transport on specified routes. In addition, police can use drug detection dogs with a search warrant if they have a reasonable suspicion that people in a public place may be committing a drug offence.

Since February 2002, we have observed more than 15 operations in ten different locations in which drug detection dogs have been used. We have witnessed use of the dogs at night and during the day, on trains and at railway stations, at a dance party, in bars, pubs and nightclubs, and on the street. We have attended small locally run operations and larger 'Vikings' operations. We aim to attend a wide variety of locations and premises across NSW. The cooperation we have received from the NSW Police Dog Unit and local police has been excellent in facilitating our observational work.

Every time a drug detection dog and handler attend a police operation, police collect data about drug indications, searches, drug finds and other matters. We have been analysing this information to look at the types and amounts of drugs being detected by the dogs. We are also looking at the 'hit' rate, that is, the number of searches that result in drugs being located compared to the overall number of searches.

While statistical information is important for our review, it is equally valuable to obtain information directly from police, community groups and businesses so that we can report on their attitudes to, and experience of, the drug detection dogs. To this end, we have interviewed managers and licensees of bars and nightclubs, conducted focus groups and interviews of police, and spoken to individuals who have been 'sniffed and searched'. Further interviews and focus groups of this nature will be conducted during the remaining period of the review.

To try to encompass the views of the broader community, we will also be surveying members of the public during police drug detection dog operations. Our discussion paper about the use of drug detection dogs will be published before the end of 2003 and we will be encouraging any interested group or individual to send us their comments.

Firearms and explosives detector dogs

The *Firearms Amendment (Public Safety) Act 2002* came into operation on 15 July 2002. This Act gives police the power to use a dog to carry out searches for firearms or explosives in any public place without a search warrant. We are monitoring the use of this power for two years.

While training dogs to detect explosives is fairly common around the world, training dogs to detect firearms is practically unheard of. It is even rarer to train dogs to detect firearms on a person. This makes the firearms detection dog program run by NSW Police a ground-breaking initiative.

As with the review of drug sniffer dogs, we have been conducting observational research. We have noticed that many people assume that the firearms/explosives detection dogs are drug detection dogs. On one occasion a person dropped some of the illegal substance 'ecstasy' on the ground as police approached, under the misapprehension that he was about to be screened by a drug detection dog. As the police had observed the man in the possession of 'ecstasy', he was charged. During our review we hope to explore a number of issues such as:

- how effective the dogs are in controlling illegal firearms
- public and officer safety in the event that a firearm or explosive is detected on a person
- the accuracy of the dogs in detecting firearms and explosives
- the utility of the dogs in anti-terrorism operations.

While the firearm detection dogs are proving beneficial to police in locating guns and ammunition at crime scenes, they have not yet found a gun on a person during searches in public places. This is despite approximately 65% of their time being spent on public searches during high visibility policing operations. However, on one occasion in the past six months, an explosive detection dog did find some ammunition in a licensed premises.

Our review will continue for the next year, during which we will be consulting community groups to hear any compliments or concerns they have about the use of the dogs.

On-the-spot fines for some criminal offences

The *Crimes Legislation Amendment (Penalty Notice Offences) Act 2002* came into effect on 1 September 2002, establishing a trial scheme in which police may issue 'on-the-spot' penalty notices (known as 'criminal infringement notices' or 'CINs') for certain criminal offences. The year long trial is operating in twelve local area commands, and implementation is being monitored by the Ombudsman.

The scheme permits police to issue fines for offences such as common assault, obtaining money by false representation, offensive language or conduct and shoplifting (of goods less than $300). Recipients of a CIN can make arrangements to pay the fines within specified time periods or can elect to have the matter dealt with at court.

Persons under 18 years cannot be issued with a CIN. The Act also allows police to take fingerprints 'in the field' – for example outside a police station - when they have issued a CIN.

The intention behind the legislation is to increase police visibility within the community by reducing the amount of time spent 'behind a desk' by officers and to take a more visible role in the administration of law enforcement duties.

Several issues of interest to the review have been identified, including:

- whether the introduction of the CINs saves police time or resources and, if so, whether any time and resources saved have resulted in a greater police presence on the streets
- any efficiencies resulting from CINs from a court perspective
- the proportion of CINs that are paid
- the effect that a history of CINs might have on a police officer's exercise of discretion to prefer charges against a repeat offender
- police compliance with the statutory obligation to destroy fingerprints taken from a CIN recipient where the penalty has subsequently been paid
- any 'net widening' effect resulting from the Act, that is, whether CINs are issued for offences which historically attracted a lesser penalty, such as a caution or a warning
- the impact of the trial on different communities, including minority ethnic, non-English speaking and Aboriginal communities.

In September 2003, we published a discussion paper inviting submissions from interested individuals and both public and private sector organisations.

Non-association and place restriction orders

The *Justice Legislation Amendment (Non-association and Place Restriction) Act 2001* commenced on 22 July 2002 and provides for the Ombudsman to monitor the effect of the Act's amendments for a two year period.

The Act amends several pieces of legislation relating to sentencing, bail and sentence administration. When imposing a sentence on a person convicted of an offence punishable by six months imprisonment or more, a court may also make a 'non-association order', prohibiting the offender from associating with a specified person or a 'place restriction order', prohibiting the offender from visiting a specified place or district. These orders take effect after the person's release from incarceration. They may also be made as a condition of bail, parole, leave or home detention.

The scope for such orders is qualified. The persons specified in a non-association order must not include any member of the offender's 'close family' (as defined in the Act). In addition, the places specified in a place restriction order must not include the offender's home or their family's home, their workplace, any educational institution at which the offender is enrolled, or any place of worship the offender regularly attends. Non-association and place restriction orders are not to exceed 12 months in duration. The court is only to make such orders if it is satisfied that it is reasonably necessary to do so to ensure the offender does not commit any further offences.

The Ombudsman's review will examine the impact of the Act on offenders, particularly the impact on juveniles and those from indigenous and rural communities. To date very few orders have been made. However, we will continue to analyse information collected from the Departments of Juvenile Justice and Corrective Services as well as from the courts, and enquire about the effects of the legislation from representatives of the various agencies involved in the justice system. Issues of interest will include:

- the circumstances under which orders are made
- information provided by the police to recipients of orders to assist them in complying with an order and its restrictions, and
- the manner of the enforcement of orders by the police.

A discussion paper inviting submissions from interested individuals and both public and private sector organisations will be published during 2003 and will assist in the conduct of our review.

Some of the staff in our legislative review team

Transfer of young people from juvenile justice to adult correctional centres

In January 2002, the *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001* commenced operation, with a requirement that its 'operation and effects' be scrutinised for a period of three years by the NSW Ombudsman.

The Act was introduced to ensure that all those convicted of serious children's indictable offences are transferred from juvenile detention centres to adult correctional centres by the age of 18 years, unless the court considers that there are 'special circumstances' justifying their remaining in juvenile detention. No juvenile offenders sentenced since the commencement of the Act are eligible to remain in a detention centre beyond the age of 21 years.

As part of our review, the Department of Juvenile Justice files for offenders sentenced under the new Act are being examined for documents related to their sentencing and to the circumstances surrounding their transfer to the adult correctional system. Offenders subject to an order under the Act are also being interviewed shortly after their transfer to a correctional centre, and asked for some personal information and about their experiences of both juvenile detention and the adult correctional system. Information will be also be sought from other groups, including Department of Juvenile Justice and Corrective Services staff, on the circumstances relating to particular offenders and the impact of the legislation as the review progresses.

To date, approximately 42 offenders, who committed their offences before the age of 18 years and were under the age of 21 when charged, have been sentenced under the new legislation to serve part or all of their sentences in juvenile detention. Six serious children's indictable offenders have been transferred to the adult correctional system earlier than the date nominated by their sentencing judge as a result of incidents, such as assaults and malicious damage offences occurring in juvenile detention.

Additional powers for correctional officers, dealing with escapees and the right of victims of serious crimes to address the Parole Board

The *Crimes (Administration of Sentences) Amendment Act* 2002 and the *Summary Offences Amendment (Places of Detention) Act 2002* commenced in February 2003 and are both being reviewed by the Ombudsman for a period of two years. This legislation:

- changes the procedures that correctional officers and police officers must follow when an escaped inmate is arrested
- increases the powers of correctional officers to stop, search and detain people or vehicles that are 'in or in the immediate vicinity of' a place of detention
- authorises correctional officers to use dogs and reasonable force when stopping, searching and detaining people and their vehicles
- creates new penalties for not complying with a direction given by a correctional officer in relation to the stop, search and detention powers, and for failing to produce anything detected in a search when requested to do so by a correctional officer
- permits the seizure and destruction of property brought unlawfully into a correctional centre, and
- gives victims of serious offences the right to make an oral submission to the Parole Board when the offender is being assessed, without requiring the prior approval of the Parole Board.

This review is at a preliminary stage, and will involve a range of research methods to examine a number of issues including:

- the adequacy of training and guidelines for correctional officers
- any effect of the new stop, search and detention powers on the amount or type of prohibited goods entering correctional centres
- the use of the new stop, search and detention powers by correctional officers, and any effect on visitors to correctional centres
- action taken when a prohibited item is detected, including the seizure and destruction or temporary confiscation of goods, the imposition of criminal charges or other penalties
- the incidence of victims of serious offences making oral submissions to the Parole Board, their level of satisfaction and the impact on outcomes.

Future legislative reviews

Over the next six to twelve months, we expect to start four new legislative review projects. Three of these new reviews come under the *Law Enforcement (Powers and Responsibilities) Act 2002*. An additional review role is established by the *Crimes Legislation Amendment Act 2002*. As at the end of the 2002-2003 financial year, the relevant provisions of both of these Acts are yet to commence.

The *Law Enforcement (Powers and Responsibilities) Act* consolidates many existing police powers into one legislative instrument. The Act also introduces some new, or substantially revised, police powers. Three of these new powers are to be reviewed by the Ombudsman:

- searching people arrested or in police custody
- managing a crime scene
- obtaining financial documents from 'deposit taking institutions' such as banks and building societies if the documents are connected with an offence.

The *Crimes Legislation Amendment Act* amends the *Search Warrants Act 1985* by conferring a power on police to detain on the premises a person who has been arrested during the execution of a search warrant. The legislation originally had a proclaimed commencement date in May 2003. However, the proclamation was amended by Parliament and an official commencement date for the legislation has yet to be confirmed.

The Ombudsman will review the legislative provisions of each Act for a period of two years after they begin operation.

Covert operations

In NSW there are currently three pieces of legislation that authorise law enforcement agencies to commit acts within NSW, for the purposes of investigations, that would otherwise be illegal. These agencies include NSW Police, the Crime Commission, the Independent Commission Against Corruption, the Police Integrity Commission, the National Crime Authority, the Australian Federal Police and the Australian Customs Service. These three Acts are:

- Telecommunications (Interception) (NSW) Act 1987
- Listening Devices Act 1984
- Law Enforcement (Controlled Operations) Act 1997.

The Acts give authorised law enforcement agencies the power to intercept telephone conversations, plant listening devices (commonly known as 'bugs') to listen to and video conversations and track positions of objects, and to carry out undercover operations which may involve committing breaches of the law (for example, being in possession of illicit drugs).

The agencies may only use these powers if they follow the approval procedures and accountability provisions set out in the relevant Act.

Different approval and accountability regimes

The three Acts were developed in isolation and, as a result, the accountability processes set out in them are quite different from one another.

To plant a bug or intercept a telephone conversation, an officer must apply to a judicial officer or, in the case of telephone intercepts, a member of the Commonwealth Administrative Appeals Tribunal (AAT) for a warrant. To conduct an undercover operation, officers need only apply to the chief executive officer of their agency.

The Ombudsman monitors compliance with the accountability schemes set up for the use of telephone intercepts and undercover operations. Our role in relation to controlled operations is significantly more extensive than our role in relation to telephone intercepts.

There is currently no external monitoring of compliance with the *Listening Devices Act* (which governs the use of bugs) by the Ombudsman or any other body. Such a scheme was recommended by the NSW Law Reform Commission in its interim report on surveillance in 2001 and was the subject of a private member's Bill introduced into Parliament in 2002. No further developments have occurred in the interim period.

Controlled operations

There is a strict regime of accountability for controlled operations which aims to minimise abuse of the operational realities of criminal and corruption undercover work. As agencies do not have to consult anyone external to the agency before carrying out undercover operations, we have a significant role monitoring the approval process. Agencies are required to notify us within 21 days if an authority has been granted or varied, or a report has been received by the agency's chief executive officer on the conduct of a controlled operation.

We are also required to inspect the records of each agency at least once every 12 months. We have the power to inspect those records at any time and make a special report to Parliament if necessary.

Telecommunication interceptions

As a judicial officer or member of the AAT already scrutinises the process of granting a warrant for a telephone interception, our role does not include ensuring compliance with approval procedures. Instead, we audit the records of agencies carrying out telephone interceptions. The records document the issue of warrants and the use of information gathered. Some of the records have to be given to the Attorney General, kept under secure conditions, or destroyed once specified conditions no longer apply.

Our role is to ensure that these provisions are complied with. We are required to inspect each agency's records at least twice a year. We also have discretionary power to inspect their records for compliance at any time.

We report the results of our inspections to the Attorney General. We can report on breaches of certain requirements, including any contravention of the *Telecommunications (Interception) Act 1979* (Cwlth) (the Commonwealth Act).

This year a review of aspects of the Commonwealth Act was carried out by Mr Tom Sherman on behalf of the Commonwealth Attorney General's Department. The Ombudsman made certain recommendations to Mr Sherman as part of that review.

Over time it has become evident that changes introduced to the Commonwealth Act have not been incorporated into the State Act. As a result there are several differences between the reporting and recording requirements of commonwealth agencies and those of state agencies. We believe the requirements of the legislation should be consistent and our recommendations were designed to ensure that the Commonwealth Act and the State Act were complimentary.

Our reporting requirements

We have to make two separate reports on our work in the area of controlled operations and telecommunication interception.

We are required to deliver the report on our telecommunication interception work to the Attorney General within three months of the end of the financial year. We are forbidden from including details of this work in our annual report.

We have to present the report on our controlled operations work to Parliament as soon as practicable after the end of the financial year. This year's report is available from our office.

Staff from our police team meet to discuss the progress of a project

Community services

The Ombudsman's role – promoting a robust, accountable and responsive community services system

In December 2002, the Community Services Commission (the former commission) amalgamated with the NSW Ombudsman. This has given the Ombudsman an expanded role in relation to community services in NSW. A new statutory Community Services Division (the division) was established to carry out these functions. A Deputy Ombudsman was appointed as Community and Disability Services Commissioner and heads the division.

Although there was some opposition to the amalgamation proposal, the legislation underpinning the amalgamation offers a strong foundation for promoting and protecting the rights and best interests of consumers of community services in NSW. In addition, the Ombudsman's jurisdiction was expanded to include licensed boarding houses, and the review of deaths of certain children, young people and people with disabilities in care.

The legislation under which the former commission had operated – the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) – was retained with some amendment (*Community Services Legislation Amendment Act 2002*) and this, combined with the strength and certainty of the Ombudsman's existing powers, has created a strong consumer protection regime.

The Ombudsman's legislative functions under CS-CRAMA operate on three levels:

- Individual – addressing issues of concern for individuals.
- Service based – promoting quality community services so that positive consumer outcomes are achieved.
- Systemic - promoting systemic improvement so that service systems are responsive to, and capable of meeting, consumer needs.

Coverage of community services

The Ombudsman's jurisdiction covers all community services provided by:

- the Department of Community Services (DoCS)
- the Department of Ageing, Disability and Home Care (DADHC)
- non government service providers who are funded, licensed or authorised by the Minister for Community Services and Minister for Ageing and Disability Services – these include licensed boarding houses and fee for service agencies.

'Services' include the exercising of statutory or other functions by service providers as well as:

- Child protection and support services - including the adequacy and reasonableness of DoCS' response to risk of harm reports, DoCS' provision of casework and other support and referral services for families, and the DoCS Helpline.
- Out-of-home care (OOHC) services for children and young people - including all brokered or residential services, intensive family support, case management support, leaving care and after care services and respite care.
- Home and community care (HACC) services - including food services such as meals on wheels, community options programs, home help, personal care, respite care, community transport, and services provided by the Home Care Service of NSW.
- Services for people with a disability - including residential and respite care, licensed boarding houses, community access, community support services, PSO/ATLAS programs, day programs and attendant care.
- Supported accommodation and assistance program services (SAAP) - including refuges for families, young people, women and men, proclaimed places, support, brokerage, outreach and referral services.

In assessing standards of service and conduct by community service providers, the Ombudsman considers compliance with the objects, principles and provisions of community welfare legislation and whether the service provided is in the best interests of the consumer.

Our primary functions

We have eight key functions ranging from dealing with complaints and making recommendations to improve complaint handling procedures to inspecting visitable services and promoting access to advocacy support.

Dealing with complaints

We deal with complaints about government and non-government community service providers, encouraging local resolution wherever possible. We also assist people to make complaints. For more details, please see the section on handling complaints.

Reviewing complaint handling systems

The objects of CS-CRAMA include fostering an environment in which complaints and independent monitoring are seen positively, as a way of enhancing service delivery. We review the efficiency and effectiveness of complaint handling systems and make recommendations to encourage the resolution of complaints at a local level and to improve complaint procedures.

Providing information and training

Through our education and training activities we aim to promote and encourage high quality community services and foster awareness of consumer rights and needs. We provide information, education and training about making, handling and resolving complaints about the delivery of community services.

Reviewing the situation of persons in care

We review the care and circumstances of children, young people and people with a disability who are in the full-time care of government and funded non-government services or who live in licensed boarding houses. We can review the situation of individuals or groups. A review looks into all relevant aspects of a child or person's life and care circumstances. We report on our review to the relevant Minister and include recommendations about how the circumstances of the child or person might be improved.

Reviewing the deaths of certain children and people with a disability

We review the deaths of certain children and young people, people with a disability in care and residents of licensed boarding houses. We look at the causes and patterns of those deaths and identify ways in which they could be prevented or reduced.

Monitoring, reviewing and setting standards for the delivery of community services

We have a mandate to promote and assist the development of standards for the delivery of community services. This work is intended to improve those services and benefit the lives of vulnerable consumers. Our legislation enables us to:

- educate relevant parties about those standards
- monitor and review the delivery of community services and related programs, make recommendations for improvements, and promote the rights and best interests of service receivers
- review the cause and patterns of complaints and identify ways to remove or minimise those causes.

Inspecting visitable services where children, young people, people with a disability and residents of licensed boarding houses live

'Visitable services' are accommodation services for children, young people, people with a disability and residents of licensed boarding houses. Official Community Visitors visit over 1,200 of these services as the 'eyes and ears' of the Minister for Community Services and the Ombudsman.

Our role is to ensure that visiting resources go to those in care who are most vulnerable and Official Community Visitors are well supported.

Promoting access to advocacy support

We promote access to advocacy support for people receiving, or eligible to receive, community services to make sure that they are able to participate in making decisions about the services they receive.

Working with services

We are committed to working cooperatively with the service providers within our jurisdiction to improve services for consumers.

We try to resolve most matters as quickly and as informally as possible and only investigate complaints when no other avenue of resolution seems appropriate. We are particularly mindful of the considerable change and development that DoCS is undergoing and try to contribute positively to this process. The director general's advice on how the reforms are progressing informs the assessment we make of issues brought to our attention.

Our staff have high levels of skill and experience in the community services sector, both government and non-government, and are well placed to review and evaluate the provision of services. Our processes allow agencies to comment on our views throughout an investigation and to have input into any recommendations we make. We are therefore confident that when we make suggestions or recommendations, these help agencies to take practical steps towards improving their policies, procedures and practices. This view is supported by the high level of compliance by agencies with our recommendations.

Memorandum of understanding

In June 2003, the Ombudsman and Director General of DoCS signed a memorandum of understanding (MOU) undertaking to work together to identify problems and deal with complaints about DoCS and to ensure that they are appropriately and quickly resolved or rectified. Wherever possible, the emphasis is on informal resolution at the local level. We also hold regular liaison meetings with relevant DoCS staff.

We are now negotiating an MOU with the Director General of DADHC.

Handling complaints about community services

Under the *Ombudsman Act* and CS-CRAMA we handle complaints about the conduct of DoCS, DADHC and non-government community service providers that are funded, licensed or authorised by the Minister for Community Services or the Minister for Ageing and Disability Services.

People receiving, or eligible to receive, services or their representatives can complain to us about the provision, failure to provide, withdrawal, variation or administration of a community service.

What we do and how we do it

Our key functions in handling complaints about community services are to:

- provide advice, information and referral services
- assess all formal complaints, facilitate the local resolution of matters, refer complaints for conciliation and investigate the most serious complaints
- inquire into major, systemic issues affecting community services and service providers
- review the complaint handling systems of service providers.

We are committed to resolving issues for consumers of community services so that their circumstances are improved and they get services that meet their needs. We do this without compromising our impartiality and without advocating for either consumers or service providers.

We define matters brought to us as either inquiries or complaints. Inquiries are oral or written matters where we provide information, advice or referral to another agency and do not actively intervene ourselves. Complaints are oral or written complaints where we directly intervene.

Our complaints workload

The merger of the former commission and the Ombudsman's office has complicated the reporting of community services complaints for 2002 - 2003. During the period 1 July-1 December 2002, both the former commission and the Ombudsman handled inquiries and complaints about DoCS and DADHC under different legislative and procedural requirements. The former commission received 108 complaints/inquiries about DoCS in this period with many of these being referred to the Ombudsman. There is, unfortunately, the possibility of some double counting of complaints and inquiries in this period.

The Community Services Division (the division) of the Ombudsman now handles all these complaints.

Complaints statistics pre and post merger have been combined to provide a report of our complaint handling in 2002-2003. Because of the possibility of some duplication, it is not possible to make accurate comparisons with complaint statistics from previous years. This will be remedied in our next annual report.

An overview of complaints

Figure 45: Community services matters handled

	New matters	Matters from previous year	Total
Inquiries	1559	23	1582
Complaints	599	104	703
Total	2158	127	**2285**

These figures are made up of:

- 331 inquiries and 106 complaints made to the Ombudsman between 1 July and 1 December 2002
- 421 inquiries and 186 complaints made to the former commission between 1 July and 1 December 2002
- 809 inquiries and 305 complaints made to the Ombudsman after 1 December 2002.

Figure 46: Who was complained about?

	2002-2003	
Service provider	**Number**	**%**
DoCS		
Child protection services	175	25
OOHC services	111	15
Other (incl. requests for assistance, licensing)	41	6
Adoption	7	1
Total	332	47
DADHC		
Disability services	97	14
Home care services	54	8
Policy, strategy and funding services	38	5
Total	189	27
Non-government funded or licensed services		
Disability services	94	14
SAAP services	29	4
OOHC services	23	3
HACC services	18	3
Family support services	4	0.5
General community services	6	0.5
Children's services	3	0.5
Other	3	0.5
Total	179	26
Total	703	100

Figure 47: Complaint issues

Community service sector program area	**% issues raised**
Child protection services	33%
Disability accommodation services	28%
Out-of-home care services	15%
Disability support services	11%
Supported accommodation and assistance programs (SAAP)	4%
Aged services	3%
Adoption services	1%
Children's services	1%
Family support services	1%
General community services	1%
Disaster welfare services	0%
Out of jurisdiction	2%
Total	100%

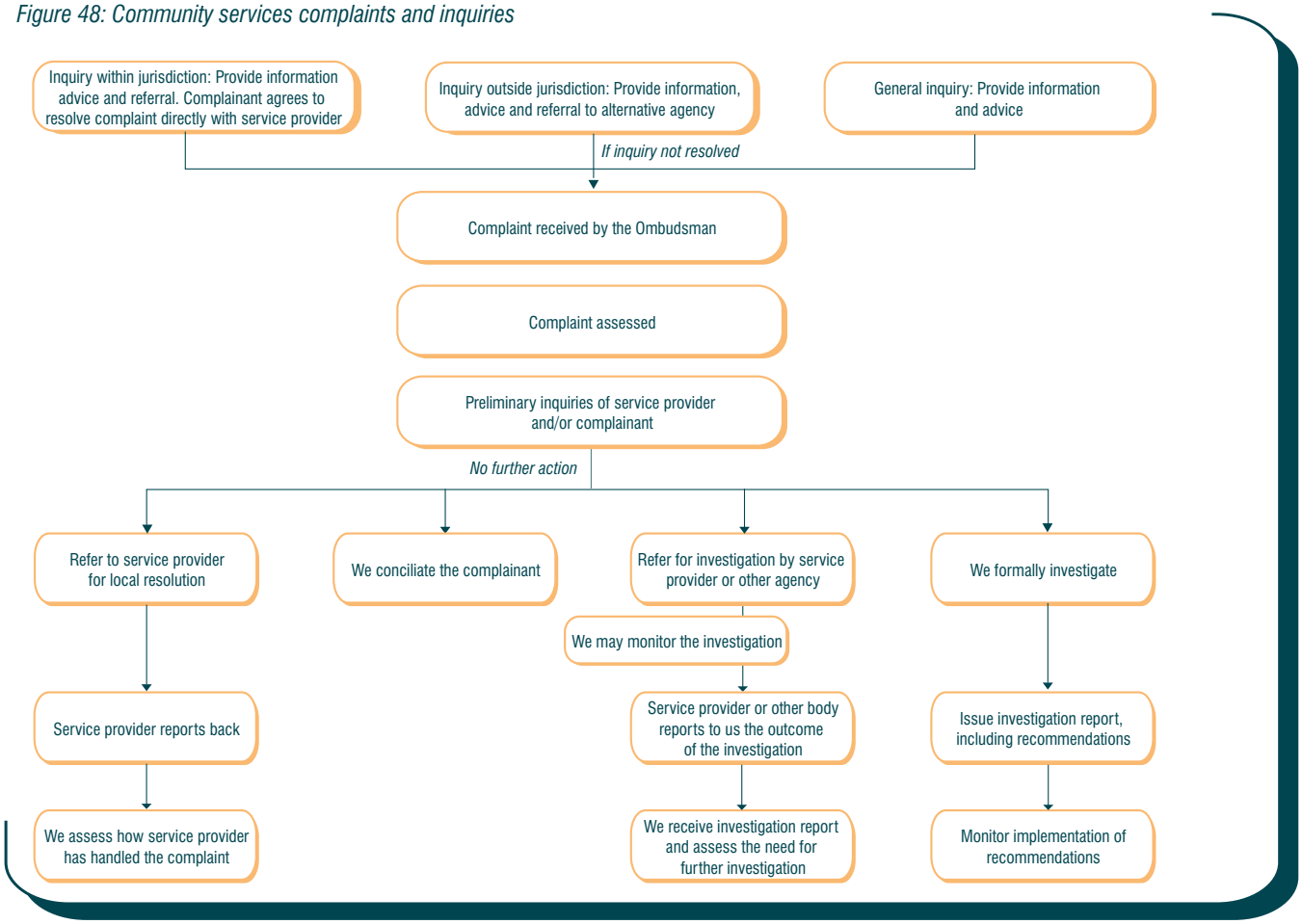
Analysing trends

Analysing trends in complaints and issues helps us with our investigation, inquiry, policy and service improvement work.

Casework and case coordination or management matters made up about 45% of all complaints this year. The issues included:

- failing to meet the individual needs of service receivers (17%)

Figure 48: Community services complaints and inquiries



- failing to address the human rights of service receivers including their education, maintenance of family relationships, health, hygiene, nutrition and safety (12%)
- failing to involve service receivers, or their families and advocates, in planning and making decisions affecting them (4.5%)
- providing inadequate information to service receivers about case decisions and the reasons for them (4%)
- inadequate responses to allegations of abuse in care by disability accommodation services (4%)
- inadequate arrangements to help children, young people and people with disabilities in care maintain family relationships (3%).

Other issues that were frequently complained about were:

- inadequate responses by services to complaints made about service provision (12%)
- issues about access to or exiting from services (10%) – the majority of issues related to disability accommodation and support services, HACC services for the elderly and people with a disability, SAAP services, and DADHC's decision not to fund disability accommodation and support services.

Figure 49: Outcomes of inquiries finalised

	Total	%
Inquiry - within jurisdiction		
Information and advice provided	647	37
Premature – advised to make internal complaint to DOCS	207	12
Complainant agrees to resolve complaint with service provider	111	6
Complainant decides not to pursue complaint after advice	40	2.5
Advised to seek legal advice (civil/criminal matter)	36	2
Refer complainant to other agency	33	2
Premature– advised to make internal complaint to DADHC	20	1
Premature – advised to make internal complaint to NGO	18	1
Refer complainant to advocacy support	8	0.5
Total	1120	64
Inquiry - out of jurisdiction		
Information and advice provided	232	13
Advised to seek legal advice (civil/criminal matter)	56	3
Refer to government agency	25	1.5
Refer to non-government agency	9	0.5
Refer to other agency	8	0.5
Refer other Ombudsman team	6	0.5
Total	336	19
General inquiry		
Information and advice provided	189	11
Other action	53	3
Refer to government agency	39	2
Advised to seek legal advice (civil/criminal matter)	7	0.5
Refer to other agency	4	0.25
Refer to non-government agency	2	0.25
Total	294	17
Total	1750	100

Providing advice, information and referral

During 2002-2003, we handled 1,581 inquiries where we provided information and advice or referred people to other agencies if we could not help them directly. We finalised 1,533 of these inquiries during the year, resulting in 1,750 outcomes – there is sometimes more than one outcome per inquiry.

Handling complaints

Assessing complaints

We assess all complaints based on the information provided by complainants and service providers. We inform all complainants in writing about how we propose to deal with the issues they have raised. During 2002-2003 we finalised 572 formal complaints.

Some of the matters in the table below have been brought forward from the previous year. This applies, for example, to a number of the matters monitored because we do not consider an investigation finalised until compliance with recommendations is complete.

We are currently dealing with 128 complaints that we received in 2002-2003.

Figure 50: Outcomes of formal complaints

		2002-2003
Complaint outcome	**Number**	**%**
Substantive explanation or advice provided	235	41
Premature, referred to agency/concurrent representation	50	9
Right of appeal or redress	38	7
Resolved to Ombudsman satisfaction by service provider after complaint	37	7
Referred to service provider for local resolution and report back to Ombudsman	38	7
Withdrawn by complainant after substantive advice provided/complaint resolved/alternative avenue pursued	43	7
Outside jurisdiction	15	3
Conciliated	14	2
Resolved by service provider before complaint was made	9	1
Investigation declined on resource/priority grounds	7	1
Formal Ombudsman investigation – adverse findings, recommendations made and implemented	7	1
Advice/explanation provided where no or insufficient evidence of unreasonable conduct	6	1
Trivial/remote in time/insufficient interest/ commercial matter	5	1
Referred to service provider for investigation and report back	2	0
Other	2	0
Substantive advice/ information provided without formal finding of unreasonable conduct*	62	11
Formal Ombudsman investigation discontinued	1	0
Formal Ombudsman investigation – no adverse findings; recommendations made and implemented	1	0
Total	572	572

** this category refers to a former commission category where investigation reports were not published, but feedback was provided after investigation.*

Making preliminary inquiries

We make preliminary inquiries if we need to clarify issues or find out the best option for resolving the complaint. Sometimes we seek a formal response from a service provider and ask them to provide relevant files. We particularly do this if the issues are complex, raise serious questions about the care, treatment or safety of a service receiver, or involve significant issues of public interest.

If the service is willing to resolve the complaint, or the information provided by the complainant and service provider satisfies us that there are no serious or significant issues warranting action by us, we decline the complaint. Even if we take no further action on the individual complaint, we may make comments and suggestions aimed at improving systemic issues such as policies and procedures. In some circumstances, we monitor the service provider's response to these informal recommendations. We made comments to service providers about individual and systemic issues in 62 (11%) of the complaints we determined in 2002-2003.

Facilitating local resolution

We try to have complaints resolved at the local level as this is often the quickest and most effective way of handling them. It is especially important in the community services sector where service receivers and providers are often involved in a long-term relationship of support or care.

When we refer a complaint to a service provider for local resolution, we monitor their action and ask them to report back to us with the outcome. We also try to consult with complainants about their satisfaction with the outcome, although we are not always able to contact them.

Figure 51: Outcomes for finalised formal complaints referred for local resolution

	2002-2003	
Complaint outcome	**Number**	**%**
Resolved	16	42
Partially resolved	15	40
Not resolved	5	13
Result not known	2	5
Total	38	100

Referring complaints for conciliation

In addition to helping to resolve complaints at the local level, we formally conciliate complaints. Both the complainant and the service provider must voluntarily agree to participate in a conciliation.

In 2002-2003 we conciliated 14 complaints about service provision issues that involved an ongoing relationship between the complainants and service providers. Ten of the complaints were about disability accommodation and support services, two were about HACC services and two were about SAAP services.

Case study 88

A number of people complained to us about a non-government disability accommodation and support provider and the way services, including day programs, were being provided to nine disabled residents in three group homes. None of the complainants wished to be identified in the complaint. We had a further complaint from a parent of a service receiver who raised similar issues.

The issues included allegations of abuse of residents, restrictive practices and inadequate systems for administering medication. We informed the service of the specific complaint issues raised and asked for their response. They acknowledged deficiencies in their care of the residents in relation to many of the allegations and told us what they were doing to address the problems.

However, the service's response raised additional questions about some aspects of their operations so we decided to take a 'service improvement' approach. We prepared a report about key areas requiring further action including policies, procedures and practices relating to the handling of allegations of sexual abuse, and the systems for managing restrictive practices, medical consent, complaint handling, incident reporting, staff induction, training, monitoring and supervision, and information dissemination.

The service agreed to review their client policies and procedures manual and set up a working group of management, staff and carers to do the review. We are monitoring the outcome of the review and how the service implements our recommendations. Throughout the process we have liaised closely with the official community visitor who visits the service and provides us with information about the ongoing daily care provided to residents.

Case study 89

A mother complained to us that staff in the group home where her son lives were administering his medication without her consent.

In response to our inquiries, DADHC acknowledged that there were issues about how staff had been obtaining consent and told us what they were doing to address the problem. As DADHC had taken action to resolve the complaint, we decided to take no further action. However we did give feedback about the issues we had identified concerning medication administration practices in the group home and how staff were trained to administer medication and obtain consent.

DADHC has since told us that they have adopted our suggestions and implemented new procedures and staff training.

Case study 90

A palliative care social worker complained to us about the Home Care Service's response to referrals made on behalf of palliative care patients being discharged from hospital. A home care assessment officer had told the social worker that palliative care patients were not eligible for home care. She also complained about the length of time before Home Care provided services to people who were eligible for them.

We made preliminary inquiries and Home Care advised us that the information given by their assessment officer was incorrect. Palliative care patients are eligible as long as they meet the general requirements.

Home Care made arrangements for the manager of their assessment and referral centre to meet with the social worker and other hospital staff to provide information about the assessment process and policy and procedure for prioritising Home Care services, and to discuss any other concerns that might be raised.

The social worker was satisfied that Home Care's action resolved her complaint.

An agreement was reached in 11 conciliations, the parties could not reach agreement in one, and two were abandoned when the parties decided not to proceed.

Referring complaints for investigation

We can refer complaints to service providers, funding agencies or other relevant agencies for investigation. We do this if a service provider:

- has an established internal complaints handling and investigation system
- agrees to us monitoring the investigation
- agrees to report the outcome of the investigation to us.

In 2002-2003, we referred three complaints to service providers for them to investigate.

- A complaint about early intervention and support services for a family was referred to DoCS. Their investigation and subsequent action resolved the complaint.
- We referred a complaint to a NGO service about their arrangements for supporting a child with disabilities. Their investigation identified issues of concern about support arrangements and changes have now been implemented.
- We referred another complaint to a NGO disability accommodation service about their services for a person with a disability – outcome pending.

Investigating the most serious complaints

During 2002-2003 we investigated 20 complaints raising serious questions about the current care, treatment or safety of service receivers, or significant issues of public interest. Nine of these investigations were finalised during the year.

After an investigation, we make recommendations to improve services for individual service receivers or the service delivery system as a whole. We monitor the action taken and report to the complainant, service providers and the relevant Minister - and sometimes to funding agencies - the action taken by service providers to implement our recommendations.

Monitoring recommendations

We monitored the implementation of recommendations from a number of investigations where adverse findings were made about the conduct of services. These included:

- services provided to adults with disabilities by NGO disability accommodation services (four investigations)
- disability support services provided to adults with disabilities by DADHC (three investigations)
- DoCS' child protection and support services to children and families (two investigations conducted by the general team)
- an NGO fee for service, out-of-home care agency's behaviour management plan for a young person in care (one investigation).

Case study 91

A mother complained about the decision of a non-government HACC service to exit her daughter from the service. The daughter is in her 40s and has intellectual and psychiatric disabilities.

We asked the HACC service for information about their decision and the process they followed. We considered that there was nothing unreasonable about the actual decision. It had been made on the basis of prioritising services to those with greatest need and did not disadvantage the woman's overall service provision as she was receiving services from a number of different government and non-government agencies. However, we did have concerns about the process followed, including the lack of a policy and procedure and an inadequate complaint handling procedure. We raised these concerns with the service and they agreed to review their current policies and procedures. We are monitoring this process.

Case study 92

A foster carer with a non-government, out-of-home care agency contacted us. She cares for an 11 year old boy who, at times, is very difficult to manage. She complained that she was receiving insufficient guidance and support from the agency and from DoCS who were responsible for the boy's overall case management. We contacted both agencies who agreed to meet the foster carer and try to resolve the complaint. The carer had already tried to resolve the complaint, so we actively facilitated this attempt at resolution by making suggestions about how it should be approached.

The agencies reported that they had reached an agreement with the carer about how they would support her and the boy in the future, including how they would communicate should problems arise. The carer was satisfied with this outcome.

Case study 93

A man complained about the support being provided to his young disabled son in a non-government disability group home. The complaint raised issues about the compatibility of residents, the development of the son's independent living skills, his lack of contact with his peers, and the failure to properly implement his individual plan. The father had previously complained to the service and, though there were letters exchanged and meetings held, the complaint had not been resolved.

We decided to conciliate the complaint after discussions with all relevant parties. The son decided he was happy for his father and his advocate to attend the conciliation without him, but gave us information about how he felt about the home. An agreement was reached which included an assessment of the son's needs, a commitment to look for a more appropriate group home, and more support for him to develop friendships and independent living skills. The conciliation also helped the parties to understand each other's concerns, and the reasons for previous decisions, and make initial steps to rebuild trust.

Case study 94

Last year we reported on our investigation of DoCS' policies, procedures and practices for determining when to intervene in Family Court proceedings if they have information about children and families or if there are concerns about risk of harm for children involved in the proceedings.

Throughout 2002-2003 we have monitored DoCS' implementation of the recommendations we made. DoCS has signed a MOU with the Family Court and a meeting has been held to develop a protocol. The Family Court is also proposing to roll out the Magellan Project Australia wide and DoCS is expecting an approach from the Family Court about its participation.

However, DoCS have not yet finalised the new written procedures to guide their intervention in Family Court proceedings, nor have they developed a relevant case management system. We will continue to monitor their actions in 2003-04.

We ended our monitoring in five of these investigations because we were satisfied that the services involved had complied with our recommendations.

Current investigations

Six complaints are still being investigated – three about DoCS' child protection and support services to children and families (two of which also involve DoCS' assessment, support and supervision of foster carers), one about DADHC's support and accommodation services for children and young people with disabilities, one about DADHC's licensing and monitoring of boarding houses for people with disabilities, and one about services to an adult with disabilities by an NGO disability support service.

The general team began two of these investigations. A third is being conducted jointly by staff of the division and the child protection team.

Investigations terminated

Five matters investigated by the former commission were completed without reaching adverse findings about service providers' conduct. These are not considered investigations under the Ombudsman legislation. In each case comments were made about aspects of service provision. Three of these concerned NGO out-of-home care services, one an NGO disability accommodation provider, and one a supported accommodation and assistance service for women.

Inquiring into major systemic issues

We conduct our own inquiries when information from complaints, reviews of people in care, official community visitors or other sources raise serious concerns about individual and systemic issues in a service.

Reviewing complaint handling systems

The Ombudsman has a specific function and powers to review service providers' complaint handling systems. The aim of these reviews is to help service providers improve their existing systems so that they can resolve complaints more effectively at the local level.

We undertake reviews both within specific sector program areas and in individual services. We use a modified version of the Australian Standards for Complaints Handling as a benchmark for good complaint handling practice. We give feedback to services on what they are doing well and make recommendations about how procedures and practices could be improved. We also link service providers with our education and training activities.

During the year we reviewed complaint handling in five DADHC and 14 non-government disability respite care services and two non-government disability services - one community options program and one accommodation service. We are currently monitoring the implementation of our recommendations.

Case study 95

We received separate complaints from three former employees of a service that provides fee for service out-of-home care. The service provides intensive support and placements for young people who typically exhibit challenging behaviour and have had many unsuccessful placements during their time in care.

The complaints raised significant concerns about the safety of the young people, whether the service was meeting their individual needs including providing counselling and psychological support, and whether there were satisfactory record keeping practices in place.

Our examination of the service's files and interviews with service staff and DoCS caseworkers concluded there was no clear evidence to support the complaints. We therefore discontinued the investigation but drew the service's attention to a range of issues. These included their file management practices, the lack of detail in progress reports about issues affecting some young people, the extent of evaluation of young people's progress in care, and the lack of clear guidance to staff about behaviour management. The service has responded positively to these comments.

Case study 96

A man complained about his long-standing conflict with Home Care whom he relies on for domestic assistance and personal care. His complaint was initially about Home Care's manual handling practices which they claimed were necessary to conform to OH&S requirements. The complaint broadened to include Home Care's training of staff in manual handling procedures, management of client injury, client confidentiality and the handling of complaints by, and about, the complainant.

Our investigation identified deficiencies in Home Care's policies and procedures and some irregularities in their management of the complainant's service needs. We recommended that Home Care:

- review their customer service agreement
- evaluate and amend their 'Referral and assessment procedures for the provision of HACC services' to make sure they have an effective policy and practice framework for dealing with customer requests for reviews of services
- develop a policy and practice framework for handling complaints about client injury incurred during the provision of services
- review their complaint handling policy and procedures to make sure they comply with relevant requirements – we had previously made related recommendations about Home Care's complaints handling system after our review of complaints handling in 15 Home Care branches
- develop an internal review system and procedures to manage unresolved complaints and train staff in the management of complex complaints
- review and amend their guidelines on managing complaints about clients
- review whether they provide adequate guidance to staff about customer confidentiality.

Home Care, through DADHC, accepted all the recommendations and have reported to us on their implementation. They have developed new draft policies and procedures that have been considered by their peak bodies reference group and reviews of practice are underway.

We are also monitoring DADHC's implementation of recommendations about complaint handling in the Home Care Service following our reviews of 15 Home Care branches in 2001-2002.

Our monitoring has confirmed that DADHC has satisfactorily planned and implemented action in response to all our recommendations.

Case study 97

A boy's legal representative complained to us about his placement, care and support by a non-government fee for service out-of-home care provider. The boy is 14 years old and has been in care since he was a toddler. He had been charged with a number of offences involving property damage and assaults. His solicitor was concerned that the boy's criminal charges had resulted from the service provider's failure to provide the necessary support, particularly behaviour management.

The boy has a complex range of emotional and psychological conditions requiring intensive support. He had previously been in foster care but had been placed for nine months in a service providing intensive 24-hour supervision on a one-to-one basis. DoCS provided ongoing case management.

When the complaint was made, the boy had been in custody for two weeks. The service provider had refused to take him back because of his escalating behavioural problems which they considered placed staff and other residents at risk. We decided to investigate as the complaint raised serious questions about the services provided to the boy and his future placement and care.

Our investigation did not substantiate all aspects of the complaint, but we did find that some of the service's actions were flawed. In particular, we found that the service had no specific plan to address the boy's behavioural problems. We also identified that some practices, in relation to the service's record-keeping and reporting to other agencies including DoCS, did not meet acceptable standards and potentially affected their ability to properly address the boy's behavioural problems.

In our final report, we recommended that the service review their policies and procedures for:

- preparing and formulating stand alone case and behaviour management plans for individual clients
- maintaining records of their own case notes and contacts with outside agencies about individual clients, rather than relying on external sources
- keeping case notes of all material contacts with third parties about individual clients.

During the course of the investigation, the boy was placed in another non-government out-of-home care agency. As his long-term care was at issue, we also undertook a review of his circumstances. The review identified that the new placement, and better planning by DoCS and the new service for his behavioural problems, had a positive impact on the boy's behaviour and resulted in fewer serious incidents. As a result of the review we made recommendations about his long-term need for an intensive and therapeutic care placement.

Case study 98

In 2000-2001 the former commission initiated an inquiry into a funded, non-government disability service after receiving complaints, and reports from Official Community Visitors, that raised concerns about the adequacy of the services provided.

The final inquiry report in November 2002 noted that the service had made significant progress in addressing the deficiencies we had identified in relation to some aspects of individual planning, behaviour management, medication and health services.

Central to the improvements were changes to the structure and management of the service, the progressive development of new policies and procedures, and enhanced training, support and supervision of staff.

The changes had positive impacts for residents of the service including the development and implementation of comprehensive individual plans that incorporated behaviour management plans where necessary.

DADHC had, and continues to have, a significant involvement and has an action plan for monitoring and supporting the service. The plan was developed in consultation with the service and targets their policies, procedures and service systems. The service and DADHC amended the action plan to incorporate the suggestions we made in our preliminary inquiry report.

In our final report we made recommendations to the service about systemic and structural issues as well as specific issues relating to the care of individuals whose circumstance we reviewed during the inquiry. The service has reported to the Ombudsman that it is well on the way to implementing our recommendations.

Official community visitors who visit the service have confirmed that the quality of care offered by the service has shown continuous improvement.

Kirsteen Banwell, an investigation officer in our community services division, joined the office when the Community Services Commission amalgamated with us

Reviewing people in care

We review the care and circumstances of children, young people and people with a disability who are in the full time care of government services, funded, licensed and authorised non-government services, and fee for service agencies where an individual client agreement is in place. In December 2002 this jurisdiction was expanded to include residents of licensed boarding houses and to enable reviews of the situation of groups of people in care as well as individuals.

How we conduct our reviews

A review looks into all relevant aspects of a person's life and care circumstances. It may be done on our own initiative or at the request of others, including family members and Official Community Visitors. We report to the relevant Minister and the service provider and make recommendations, if necessary, on how the lives of the people we review could be improved.

We use our powers to conduct group reviews if a group of people share similar characteristics, even though they may be in the care of different services, or are being cared for by a particular service provider. Group reviews have two elements – individual reviews and reports on the circumstances of each person in the group, and a separate report about any identified systemic service provision issues.

We monitor the extent to which service providers implement the recommendations from our reviews. We obtain reports from the services and seek direct feedback from the people in care, their families and any other key people. We then report to the relevant Minister. To ensure that services for people in care are improved over the longer term, we generally monitor for a minimum of six months - sometimes longer if the care needs of the person are complex.

Reviews conducted in 2002-2003

Last year we did 83 reviews of people in care. This included 34 new reviews and 49 reviews carried forward from 2001-2002.

Figure 52: In-care reviews conducted

In-care setting	Number of people reviewed
Services provided by DoCS	42
Services provided by funded or licensed non-government out-of-home care services	15
Funded or licensed non-government disability services	14
Disability services provided by DADHC	12
Total	83

Of the individual reviews conducted, 67 (81%) were of children and young people, including 17 with a disability, and the remaining 16 (19%) were reviews of adults with a disability. Included in the total reviews we handled were:

- three group reviews of a total of 15 children and young people in non-government, fee for service OOHC services - initiated in response to complaints we received and concerns raised by Official Community Visitors
- a group review of 10 people with a disability transferred from licensed boarding houses to community accommodation under DADHC's Boarding House Reform Strategy
- a group review of 23 children under five years of age entering the out-of-home care system
- ongoing monitoring of three of the 15 children reviewed as part of a group review of Aboriginal children in the out-of-home care system in 2001.

During the year, we finalised 60 individual reviews and one group review. Twenty three reviews, mainly of individuals as part of group reviews, are current and we are monitoring the implementation of recommendations from 17 individual reviews and three group reviews.

Reviews of children and young people in care

A group review of 23 children under five in out-of-home care

We initiated this review to examine the out-of-home care (OOHC) arrangements for children under five. Children of this age are generally placed with relatives or in family-based foster care and there is limited external monitoring of their circumstances. We were also interested to see whether the *Children and Young Persons (Care and Protection) Act 1998* was achieving its objectives of ensuring the safety, welfare and wellbeing of children and young people.

In consultation with the children's court, we randomly selected 23 children under five years of age who had recently been placed under the parental responsibility of the Minister for Community Services following care applications at the three busiest Children's Courts – St James, Port Kembla and Campbelltown. Seventeen DoCS community services centres were responsible for planning the care of the 23 children selected.

Individual review reports and recommendations for these children were completed by the end of 2002. The reviews identified a number of critical issues about the out-of-home care service system.

- Even though the children's needs for permanency were considered, in the majority of cases the care planning process focussed on protection and placement issues, with little consideration of the children's individual needs or how the care plan goals would be met once they were placed.
- Services failed to consult adequately with carers at the planning stage. This meant valuable opportunities were missed to identify and plan for the individual and developmental needs of the children.
- Delays in the transfer of case management responsibilities between DoCS community services centres, the absence of 'handover' meetings and the non-involvement of carers in these meetings worked against timely support for placements and effective partnerships with carers. In some instances, this led to placements being jeopardised.
- Many carers and families, where restoration was planned, reported a lack of information about the care plan and support for the placements particularly in their early stages.
- More than 50% of the children did not have an allocated caseworker and over 33% received no home visit within six months of the final care order. Even where home visits occurred, they were generally unplanned or reactive.

Case study 99

We reviewed the care and circumstances of a sister and her two brothers as part of our 'under five' group review. They were subject to a two year care order allocating parental responsibility to the Minister. A short term order was made with a view to the children being restored to their parents' care.

We identified significant concerns about DoCS' case management, planning and casework for these children. Neither the children nor their parents or foster carers had allocated caseworkers, there had been no active casework since the court order was made, and the children had not been assessed or monitored in their foster care placement. We made recommendations for improvements in relation to these issues.

Our monitoring shows that DoCS has now reviewed the children's care. They have also implemented strategies to support and monitor the children's parents and to address the accommodation, domestic violence and substance abuse issues that resulted in the children entering care. DoCS have also reported that they intend to extend the current care orders for a further six months so that they can monitor the progress of the restoration plan.

We will continue to monitor DoCS' action until final decisions are made about the three children's restoration or long-term foster care.

Case study 100

We reviewed the situation of five young people placed by DoCS in an OOHC fee for service out-of-home care provider. Each of the young people had experienced multiple placements and required intensive support for behavioral and other needs.

The reviews were initiated following issues raised by Official Community Visitors about the quality of care in the service.

Our reviews identified significant gaps in the service provider's systems and their direct care of residents. Some of these included:

- inadequate policies and procedures for staff recruitment, training, support and supervision
- lack of development and implementation of plans to meet the needs of individual residents, including their educational, health, medical and social needs
- a poor response to critical incidents, including the management of challenging behaviour
- inadequate and inaccurate reporting to DoCS about the status and progress of the young people in care.

The reviews also identified significant issues about DoCS' case management, monitoring and review of these placements and a lack of clarity about the respective roles and responsibilities of DoCS and the service provider.

We made recommendations to the service and to DoCS about the individual care provided to the residents of the service, the systemic and direct care issues within the service, and DoCS' overall management and review of placements.

DoCS have since advised that they have stopped placing children and young people in the service pending a full review of the service's capacity to provide a satisfactory quality of care and support.

We had significant concerns about DoCS' policies and procedures and the inconsistencies in determining whether to allocate a caseworker to support and supervise the new placements. As a result some placements broke down, opportunities for permanency decisions were lost, contact and access arrangements deteriorated and, in some instances, children did not receive the services necessary for their developmental needs.

At the end of our review, we concluded that the community cannot yet be satisfied that the care and protection system is working in the best interests of young children requiring services. DoCS acknowledged the out-of-home care system was not at a point where best practice was achievable and pointed to the funding enhancement over the next five years as an opportunity to build greater capacity in the system.

We have made a number of recommendations about DoCS' out-of-home care systems, policies, procedures and practices and will monitor the extent of their implementation throughout 2003-2004.

Service level group reviews

During the year, we completed group reviews of children and young people in two fee for service out-of-home care service providers. An additional group review in a third fee for service provider is current. The services involved have all provided care and support to children and young people placed by DoCS and subject to Children's Court orders, and also to children and young people with disabilities placed by DADHC in voluntary care arrangements.

These reviews enabled us to report on the care and circumstances of individual residents and highlight systemic service provision problems. These problems were taken up in our 'Inquiry into individual funding agreements'. As a result, DoCS is now reviewing their system for developing and implementing header agreements and individual funding agreements in fee for service and other care agencies.

Following up our review of Aboriginal children and young people in care

This year we continued to monitor DoCS' implementation of recommendations from a group review of 15 Aboriginal children and young people in care conducted by the former commission.

DoCS advised that a number of factors had affected their capacity to report fully on strategies to implement these recommendations. These factors included the implementation of their new client information system, the establishment of a strategic Aboriginal unit, budgetary issues and the ongoing proclamation of the out-of-home care sections of the *Children and Young Persons (Care and Protection) Act*.

Case study 101

We conducted a review of the circumstances of a brother and his sister. Both children are under the parental responsibility of the Minister until they are 18 years of age and have been with the same foster carer since they entered care in 1999. DoCS supervise their care.

The children's mother made numerous complaints to DoCS and the Ombudsman about DoCS' arrangements for the care of her children, the decision to limit her contact with them and the failure to restore the children to her care. In view of the frequency of her complaints and the questions they raised about the children's care and case management, we decided that a review was the best way to find out what was in the children's best interests.

We found that the foster placement was meeting the children's needs and the DoCS decision not to restore them to their mother had been made with proper consideration of the relevant information. Psychological assessments found that the children were attached to their foster carer who had taken positive steps to overcome several identified shortcomings in their care. We also found DoCS had taken appropriate steps to supervise the children's contact with their birth family but that, unfortunately, their mother was unable to cooperate fully with the quite reasonable boundaries set by DoCS.

We recommended that DoCS ensure the children's files contained all relevant reports, convene a case planning meeting as a priority, and assess whether the children's contact with an older sibling required supervision. DoCS accepted and implemented our recommendations.

Case study 102

In 2002 we investigated a complaint about the care of a young man within a non-government fee for service out-of-home care provider. While we were investigating the complaint, he was moved to a second fee for service agency. We reviewed his care and circumstances in the second agency because the complaint raised substantial concerns about his case management by DoCS and his ongoing care in fee for service residential care agencies that provided 1:1 supervision and support.

The young man entered care in 1997 and is under the parental responsibility of the Minister. He is 14 years of age. He first came to DoCS' attention in 1993 when his mother requested temporary care after reports of risk of harm. Since that time he has had over 32 out-of-home care placements.

The young man has extremely complex and distinct needs. Psychological assessments have identified that he has significant learning disabilities and oppositional behaviours that are likely to have a long-term deleterious effect if not addressed. The number of placements he has experienced is indicative of the limited number of specialist placement opportunities in NSW for young people with very challenging behaviour.

Our review found that DoCS' recent case planning for the young man had been genuine and vigorous and that DoCS and the residential service were working closely with each other. Improvements in his health and wellbeing reflected this.

We acknowledged the good work of DoCS and the residential care agency and recommended maintaining the young man's placement as it appeared to address his need for permanency and reflect an understanding of his behaviour. Our only concern was about his social isolation in the 1:1 individualised residential setting and his need for community access.

Reviews of people with a disability

Group review of ex-boarding house residents

During 2002-2003 we conducted a group review of the circumstances of ten people with a disability and high, complex needs. They had been relocated from five different boarding houses to community accommodation under the Boarding House Reform Strategy funded through DADHC. Our review assessed the progress of the seven men and three women after their transition to community accommodation. The age range of those reviewed was 35-75 years, with a majority being over the age of 60. They had a range of disabilities, some with dual diagnoses.

The experience for most people living in boarding houses before the introduction of the reform strategy was largely a negative one. Boarding house residents have traditionally been a group marginalised from society with minimal, if any, access to day programs, no security of tenure in their accommodation and rarely anyone to advocate for them. Health care services are generally inadequate and there is limited opportunity for residents to develop social or living skills. As part of the review, we:

- prepared reviews and reports of the individual circumstances of the ten people in light of the Disability Services Act and Disability Standards in Action
- conducted focus groups with the five service providers
- surveyed 17 services involved in providing accommodation and recreation services to people relocated under the reform strategy - response rate 94%
- analysed information provided by DADHC about the 324 people relocated under the reform strategy and the results of an independent evaluation of the program.

We are currently preparing a final group review report and recommendations. Overall, the lives of those we reviewed improved as a result of their move to community accommodation and most prefer their new living environment.

Generally, they now have better access to community supports, more participation in decision-making about their individual service plans, and more opportunity to develop independent living skills. However, the review highlighted a number of ongoing concerns for the people reviewed and, by implication, for those that still live in the boarding house system. These concerns included:

- Poor documentation about residents - such as their family background and medical history - and poor transfer of what information is known as people move from one boarding house to another. This lack of information restricts the capacity of service providers to properly assess and address their needs.
- Lack of access to mental health and allied health services – there are few programs that target significant health problems such as smoking, obesity and nutrition problems.
- The difficulty in finding general practitioners in local areas who understand the health needs of people who have a disability and high, complex needs.

A monthly staff meeting

Inquiring into, monitoring and promoting quality services

The Ombudsman has a key role under CS-CRAMA in promoting changes in the community services sector that will benefit the lives of consumers and improve the service delivery system.

In performing our inquiry, monitoring and service review functions we:

- consult with community service stakeholders
- gather information and analyse developments across the community services sector
- respond to systemic issues within program areas and the community services sector as a whole.

We also actively monitor the implementation of the recommendations we make.

Inquiries under s.11 CS-CRAMA

The Ombudsman is empowered under s.11 of CS-CRAMA to inquire into matters affecting service providers and consumers. These inquiries may be about one community service program area, specific consumer groups or matters affecting a number of program areas. We focus particularly on matters affecting consumers who are most vulnerable and make recommendations for improving the delivery of community services. We worked on two inquiries in 2002-2003.

Individual funding arrangements in out-of-home care

Individual funding arrangements (IFAs) are financial arrangements used by DoCS to purchase out-of-home care services for individual children or young people from a non-government provider on a fee for service basis.

Our aim was to identify the impact of IFAs on the delivery of out-of-home care and the consequences for the children and young people who receive services through these arrangements. We found that the framework for administering IFAs was lacking in a number of key areas including selection and monitoring processes, case management and planning. We recommended a range of strategies to address these issues.

Supported accommodation assistance program (SAAP)

We continued our major inquiry into the policies and procedures of SAAP services that underpin decisions on eligibility, access and exiting. We are focusing on the implications of these decisions for people who are homeless and have high and complex needs.

Over 400 agencies are funded by SAAP in NSW to provide short-term support and accommodation to people who are homeless. Last year these agencies provided services to approximately 26,000 people.

Monitoring and reviewing

We monitor and review the delivery of community services both generally and in particular areas. Our work involves liaison and intelligence gathering, analysing policy and legislative issues affecting community services, and providing advice to government policy makers, service providers and other stakeholders. We also research current issues in the delivery of community services to identify any areas that may warrant further action by us.

This year, we did background research and liaison work on family support services, children's services and services for:

- children with disabilities in out-of-home care
- people with acquired brain injury
- people with disabilities who are ageing.

We also began monitoring issues raised in the substitute care inquiry conducted in 2000 by the former commission.

Policy development and advice

We use our monitoring and review work to help us provide advice on promoting improvements in the delivery of community services and the rights and best interests of service receivers.

During 2002-2003 we made submissions to:

- the inquiry into child protection by the Legislative Council Standing Committee on Social Issues

- DADHC, in relation to their draft 'Standards in action' for service providers working with children, young people and their families
- DoCS, in relation to documentation for administering individual funding arrangements
- the Parliamentary Committee for Children and Young People, in relation to the child death review team legislation, the child death review team's 'Fatal assaults' report and the inquiry into education in out-of-home care
- the Children's Guardian, in relation to substitute care standards for children with disabilities and a proposed audit and review tool and program.

Monitoring our recommendations

To make sure our work has a positive effect on service delivery, we monitor how well agencies accept and implement the recommendations we make.

We use a 'recommendations' database, which we updated this year, to keep track of our recommendations and agencies' responses to them.

In 2002-2003, we finished monitoring recommendations made in the 2000 report by the former commission called 'Voices of children and young people in foster care'. We found that our recommendations aimed at improving outcomes for children and young people in government and non-government foster care had been mostly accepted, with many being fully implemented.

Working with others to promote quality services

We work with others in the community services sector to canvass views on issues identified through our monitoring activities and to promote service improvement. This year, we were involved in a number of public initiatives.

Agencies building connections

In July 2002, we co-sponsored a forum with Uniting Care Burnside and the Association of Children's Welfare Agencies on children and young people with disabilities in out-of-home care. The aims of the forum included establishing principles of good practice in out-of-home care for children and young people with a disability, and identifying innovative and collaborative models. Over 100 people attended the forum, representing people with disabilities and their families, government and non-government agencies and academics.

Culturally and linguistically diverse communities consultation project

We also continued our joint consultation project with the Disability Council of NSW. This project is designed to inform the Disability Council and the Ombudsman about the service needs of people with disabilities and their carers, barriers to accessing services, and how people solve problems with the services they receive.

This year we completed consultations with people from Arabic-speaking communities and began consultations with Greek-speaking communities.

Consultations with ACROD

ACROD is the peak body in NSW representing non-government disability service providers. During the year, the Deputy Ombudsman (CSD) and our staff met with ACROD members in six regional areas to discuss service improvement issues in disability services, essential components of quality-focussed practice and barriers to achieving them. We developed a briefing paper for the consultations and meetings were held in Wollongong, Dubbo, North Coast, Deniliquin, Hunter/Central Coast and Sydney. ACROD provided the infrastructure support and 122 service workers from 70 disability services attended the meetings.

We have held follow-up meetings with the chairs of ACROD regional and divisional committees and an issues paper is being prepared as a starting point for further consideration by stakeholders.

Reviewing deaths

Before December 2002, the former commission reviewed the deaths of people with a disability in residential care. On amalgamation, a formal death review function was legislated to cover the deaths of:

- all people with a disability in care
- all people living in licensed boarding houses
- certain children and young people, including
  - children in care
  - children reported to DoCS within three years of their death, or children whose siblings have been reported
  - children who may have died from abuse or neglect
  - children in detention at the time of their death.

The State Coroner also has an expanded role to examine the deaths of children and people with a disability, as set out above, and from December 2002 all such deaths must be reported to the coroner via the police. Service providers are also required to report the deaths of people with a disability in care or in licensed boarding houses to DADHC. They then send the details to our office.

We focus on examining systemic issues surrounding these deaths, reviewing trends and patterns in deaths, and making recommendations about policies and practices that may prevent or reduce untimely deaths and increase the safety of children and people with a disability. We also provide ongoing education and information for service providers and other stakeholders.

The Ombudsman's work in the area of reviewable deaths will be fully reported in a separate annual report to Parliament - under the legislation the relevant reporting period is a calendar year. The first of these reports, for the calendar year 2003, will be published in 2004.

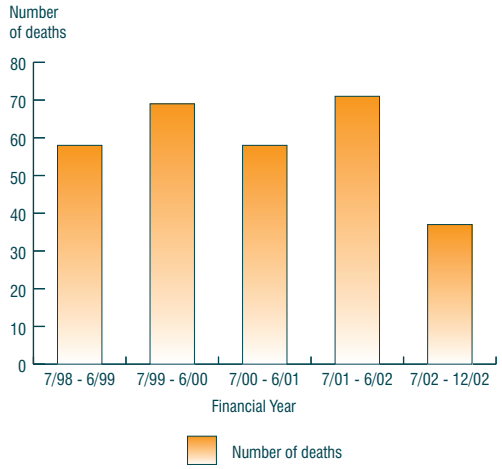
To assist the Ombudsman perform these reviewable death functions, two expert advisory committees have been established – one for reviewable disability deaths and one for reviewable child deaths. Details of the members of these committees are included later in this section.

Reviewable disability deaths

From July to December 2002, DADHC notified us of the deaths of 37 people. Twenty three people (62%) were male and fourteen (38%) were female.

Six people were aged 18 years and younger, five were aged between 20-39 years, sixteen were aged between 40-59 years, and seven were 60 years and over (see figure 54). Fifty five review cases were assessed and finalised. This included notifications from the previous reporting period.

Figure 53: Deaths each year

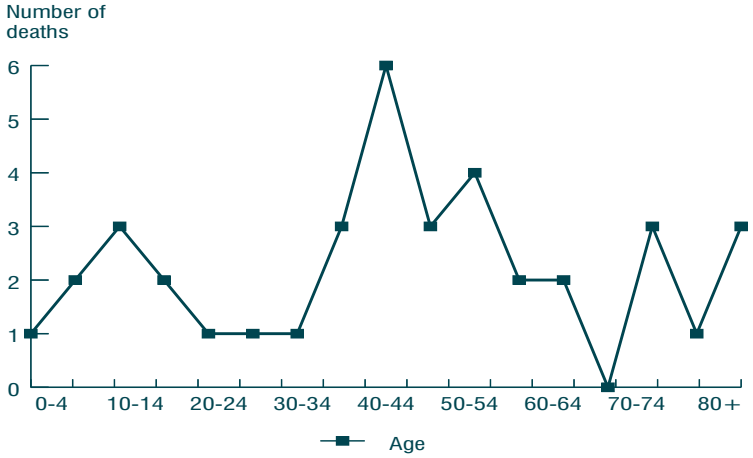


Please note: this graph illustrates the number of deaths of people with a disability reported since July 1998 when the former commission began reviewing disability deaths in care. The figures for 2002-2003 include reported deaths known at 31 December 2002. A full report for the calendar year 2003 will be produced in 2004.

Monitoring Mannix Centre services

Between July 1998 and February 2001 eight children and young people died at the Mannix Children's Centre, a non-government service at Liverpool. They had high support needs and complex medical conditions associated with their disabilities. The deaths were reported to the former commission and, in response, the commission undertook a systemic review of the circumstances of the deaths. This resulted in a public report, 'Young Deaths, children and young people with disabilities in care - a review of the deaths of eight children and young people'.

Figure 54: Age at death



The report showed that the medical, health, developmental and physical needs of the eight children had not been addressed adequately by the service before their deaths.

The Ombudsman is closely monitoring the recommendations of the 'Young Deaths' report and we are completing an audit of the health care needs of residents currently living at Mannix.

Over the past 12 months, there have been a number of changes at Mannix. DADHC has assumed management responsibility for the service, there has been an increase in onsite therapy services, and an announcement that the service will be devolved and residents moved into new services.

Promoting service improvement – 'The Right to Good Health' seminar

In November 2002, the former commission and the NSW Council for Intellectual Disability co-hosted a seminar at Parliament House to examine the health needs of people with intellectual disabilities. Over 200 people attended.

The keynote speaker, Professor Nicholas Lennox from the University of Queensland, spoke of the generally poor communication between general practitioners and patients with intellectual disability and the poor liaison between health and disability services. He highlighted the need for people with intellectual disability to have better access to oral health services, vision and hearing assessment and early diagnostic services including respiratory medicine and nutrition services. The conference also heard from NSW Health and DADHC about recent initiatives in nutritional health and the development of health assessment programs.

The recommendations from the seminar have been followed up by the development of a 'position statement' by a number of key stakeholders including the former commission, peak disability and non-government organisations.

A framework for a national and state strategy to provide medical practitioners and other health professionals with a set of health guidelines for better practice has also been discussed.

Joint training with the State Coroner

We conducted seven seminars across NSW with staff from the Coroner's Office to tell non-government disability service providers about the new requirements for reporting deaths in their services. These deaths are now examinable by the coroner and must be reported to the police and DADHC.

We spoke to 275 people representing over 90 services throughout the Sydney metropolitan area and in regional locations such as Newcastle, Shellharbour, Coffs Harbour, Tamworth, Mittagong and Orange. The seminars covered areas of particular interest for service providers including organ donation and next of kin's right to object to autopsy and tissue retention.

Many services indicated they would talk to families about the changes and review their policies and procedures as a result of the new information.

Reviewable disability deaths advisory committee

- Mr Bruce Barbour: Ombudsman and Chair of the Committee
- Mr Robert Fitzgerald: Deputy Ombudsman (CSD) and Deputy Chair of the Committee
- Dr Helen Beange: Clinical Lecturer, Faculty of Medicine, University of Sydney
- Ms Linda Goddard: Course Coordinator, Bachelor of Nursing, Charles Sturt University
- Dr Alvin Ing: Senior Staff Specialist, Respiratory Medicine, Bankstown-Lidcombe Hospital and Senior Visiting Respiratory Physician, Concord Hospital
- Dr Martin Kennedy: Consultant Medical Specialist and Director, Calvary Rehabilitation and Geriatric Service, Sydney.
- Dr Cheryl McIntyre: General practitioner at Inverell, seeing many people with developmental delay as part of her general practice
- Ms Anne Slater: Physiotherapist; has worked in paediatric disability for over 30 years, currently at Allowah Children's Hospital.
- Dr David Williams: Acting Director, Department of Neurology and Clinical Senior Lecturer in Medicine, University of Newcastle
- Dr Rosemary Sheehy: Geriatrician/Endocrinologist, Central Sydney Area Health Service
- Mr Michael Bleasdale: Director, NSW Council for Intellectual Disability, consultant and trainer assisting services to ensure their practices meet the needs of people with a disability.

Members of the reviewable disability deaths advisory committee

Case study 103

A 27 year old woman drowned in a bath. She had a moderate intellectual disability, epilepsy and autism and was unable to communicate verbally. The staff of the group home in which she lived had decided that, because her right to privacy was important, the woman would be allowed to bath alone but be checked every five minutes.

The staff had met with the parents and assured them that their daughter was always supervised during her baths. In the 12 months before her death the woman had had two seizures, both of which occurred in the bath and required emergency admission to hospital for observation. Critical incident reports were not completed on these occasions and her parents were not informed. On the evening when she died, the woman was put in the bath by a staff member who then went to watch TV with other residents, leaving her unattended and out of sight. Some time later, the second staff member on duty found the woman under the water. She was removed from the bath, CPR was started and an ambulance called. Resuscitation was unsuccessful and she was pronounced dead. The coroner found that she had died of drowning.

We have made a number of recommendations to DADHC for service improvement related to the safety of people with epilepsy during water-based and other high risk activities, file documentation and staff training.

Reviewable child deaths

The Ombudsman's expanded role in reviewing the deaths of certain children started in January 2003. This function used to rest with the child death review team, administered by the Commissioner for Children and Young People. Around one-third of children's deaths are subject to coronial inquiry and fall into the category of deaths reviewable by the Ombudsman. It seems likely that the Ombudsman will review up to 120 child deaths each year.

The Registrar of Births, Deaths and Marriages notifies us of every child's death. One of our first tasks is to assess whether it is a reviewable death under our legislation. Between January and June 2003 we were notified of 245 child deaths and assessed 48 as being within our jurisdiction. Our jurisdiction over a further 67 deaths is yet to be determined as we are waiting for further information from the coroner. Our screening identifies the risk of harm factors and child protection service involvement with the deceased and their families. We also review specific cases to examine child protection intervention and practice.

From the data supplied to us by the Registrar of Births, Deaths and Marriages, we found that the deaths of 12 children had not been notified to the coroner as required. We have now reported these deaths and the coroner is investigating the circumstances of death.

The reviewable child deaths advisory committee provides advice on complex child death cases, child protection policy and child health practices.

Reviewable child deaths advisory committee

- Mr Bruce Barbour: Ombudsman and Chair of the Committee
- Mr Robert Fitzgerald: Deputy Ombudsman (CSD) and Deputy Chair of the Committee
- Dr Judy Cashmore: Honorary Research Associate, University of NSW with an extensive academic research background in child protection and out-of-home care
- Dr Ian Cameron: Chief Executive Officer, NSW Rural Doctors Network
- Dr Michael Fairley: Head, Department of Child and Adolescent Mental Health, Prince of Wales Hospital and Sydney Hospital
- Dr Jonathan Gillis: Senior Staff Specialist in Intensive Care and Chairman, Division of Critical Care and Diagnostic Services, The Children's Hospital, Westmead
- Dr Bronwyn Gould: Medical practitioner with special interest in child protection medicine
- Ms Pam Greer: Aboriginal representative, community worker, trainer and consultant
- Dr Ferry Grunseit: Consultant Paediatrician, former Chair of the NSW Child Protection Council and NSW Child Advocate
- Assoc Professor Jude Irwin : Head, School of Social Work and Policy Studies, University of Sydney
- Ms Alice Silva: Aboriginal representative. Aboriginal Senior Consultant for Disability Services, Department of Ageing, Disability and Home Care
- Ms Toni Single: Senior Clinical Psychologist, Child Protection Team, John Hunter Hospital, Newcastle
- Ms Tracy Sheedy: Registrar, St James Children's Court with a strong interest and legal expertise in child protection law.

Members of the reviewable child deaths advisory committee

Case study 104

One death was of a four month old baby boy, the fourth child of a mother who was a sole carer at the time of his birth. His mother and siblings had a ten-year history of child protection intervention from DoCS and risk of harm for the baby was reported to DoCS before his birth.

There were significant risk factors present in the family including poor parenting, physical abuse, alcohol and other drug use, physical disability, domestic violence, financial stress and lack of basic needs. A number of agencies had provided intermittent family and disability support but the family was inconsistent in engaging with these services.

After the boy's birth, the family received services from DoCS, NSW Health and family support services. The baby died at home but a cause of death has not yet been determined. The coroner is still investigating.

Although our review of the baby's death is not complete, we have already identified a number of problems. There was no comprehensive assessment of cumulative risk factors for the baby and no other professional assessments by any of the agencies involved with the family.

Strategies to address risk of harm and support for the family were poorly documented and services were poorly coordinated. We also found no record of a protection plan for the baby.

Case study 105

A young person committed suicide at the age of 15. At the time of his death, he was living at home with both parents and three siblings. He did not attend school and was recently unemployed. DoCS received three risk-of-harm reports about the boy and his siblings in the year before his death. All reports related to domestic violence and alcohol and other drug use within the family. The mother and children were, from time to time, living in overcrowded and unsuitable accommodation where the children were allegedly exposed to further domestic violence and drug use.

The boy's father had been charged with assault and was the subject of an apprehended domestic violence order at the time of the boy's death. Health records showed that the boy presented at the local hospital accident and emergency department on three occasions in the two years before his death with injuries relating to alleged assaults. He had a history of offending behaviour and was known to be using marijuana and alcohol in the year before his death.

We found that each of the three risk-of-harm reports to DoCS was unallocated and closed without further assessment or investigation due to 'lack of resources and higher priorities'. There appeared to be minimal involvement with this young person and his family by any of the key agencies.

Coordinating official community visitors

The role of Official Community Visitors

The role of Official Community Visitors is to monitor and protect the interests of children, young people and people with disabilities living in residential care or licensed boarding houses.

Official Community Visitors are directly responsible to the Minister for Community Services. They are appointed, on the recommendation of the Ombudsman, for an initial term of three years with the option of being reappointed for a maximum of six years.

There were 23 visitors at the start of the reporting year. During the year, four visitors left and seven new visitors joined the scheme. The 2003-2004 year begins with 26 Official Community Visitors. The increase in numbers is because licensed boarding houses are now visitable services.

A visitor's objectives are to:

- inform the Minister, Ombudsman and Deputy Ombudsman (CSD) about the quality of services
- promote the legal and human rights of residents
- identify issues raised by residents
- provide information
- help resolve complaints.

They have legislative authority to enter and inspect a service at any reasonable time, talk in private with any resident or person employed at the service and inspect any document relating to the operation of the service. Our role is to coordinate the scheme and make sure that:

- visiting resources go to those in care who are most vulnerable
- visitors are well supported in their role – we consult with them regularly about this
- issues raised by visitors about the residential care system are addressed.

Targeting resources to the most vulnerable residents

During 2002-2003, there was a 14.5% increase in the number of services eligible for visiting by visitors – from 1,014 services in July 2002 to 1,161 services at the end of June 2003. This included 62 licensed boarding houses.

The recurrent budget for the scheme in 2002-2003 was $677,000, plus an enhancement of $92,000 to incorporate licensed boarding houses into the scheme. Resources were also allocated to provide training, support and consultation opportunities for visitors.

Services are allocated a minimum of two visits per year. Additional visiting resources are allocated on the basis of two risk factors:

- the age of residents - more visits go to services where children and young people live
- the number of residents per service - more visits go to services with a lot of residents.

The significant increase in the number of new residential services in 2002-2003 is expected to continue into the coming year. It will renew the pressure on us to review our approach to allocating visiting resources.

Figure 53 provides an overview of the level of visiting undertaken by visitors in 2002-2003. Fifty eight or 2% fewer visits were conducted than in the previous year. This was due to a combination of factors including difficulties in reallocating visits when visitors leave the scheme before their appointment term ends. The delay in completing recruitment for new visitors for licensed boarding houses meant that only some of those services had initial visits during May and June 2003.

In the table, activity hours refer to time spent at visits, reporting to services, talking to families, attending meetings and monitoring service responses to issues raised by visitors. The average time spent on visit-related activities was about three hours per visit, although overall there was less time available for visitors to follow-up issues.

Figure 55: Visits to services 1 July 2002 to 30 June 2003

Target group of services	No of services	No of residents	Visits 2001-02	Visits 2002-03	Activity hours 2002-03
Children and young people	94	233	222	259	987
Children and young people with disabilities	57	191	163	189	563
Children, young people and adults with disabilities	43	290	147	166	488
Adults with disabilities	967	6,013	2,464	2,324	6,841
Total	1,161	6,727	2,996	2,938	8,879

Recording, analysing and using information

Visitors raise issues directly with service providers and encourage them to resolve issues locally. They check with residents, monitor how services respond to issues and report the results to the Minister for Community Services and the Ombudsman. The database systems we maintain to support the scheme contain a vast amount of information reported by visitors about the quality of services provided to people in full-time care.

Figure 54 shows that visitors reported 2,849 issues during 2002-2003. Some services address an issue as soon as it is brought to their attention, although some issues may be complex and take longer to resolve. Unfortunately, some services are unable or unwilling to take the necessary action and ongoing work is needed to improve the rate of resolution.

Official Visitor Metty Cassimatis (far right) talks to residents and staff at one of the disability services she visits regularly

Figure 56: Key issues reported by visitors

Target group of services (number of services)	Number of issues	Average number of issues per service	Number of issues resolved (% of issues)	Key issues identified
Children and young people (94)	494	5.3	270 (55%)	• Inadequate response to meeting residents' needs • Inadequate attention to residents' safety • Poor condition of premises and facilities
Children and young people with disabilities (57)	200	3.5	76 (38%)	• Inadequate response to meeting residents' needs • Inadequate attention to residents' safety • Inadequate behaviour management
Children, young people and adults with disabilities (43)	127	3.0	37 (29%)	• Inadequate attention to health, nutrition and hygiene • Inadequate attention to residents' privacy • Poor management responsibility
Adults with disabilities (967)	2,028	2.1	744 (37%)	• Inadequate response to meeting residents' needs • Inadequate attention to health, nutrition and hygiene • Poor condition of premises and facilities
Total (1,161)	**2,849**	**2.5**	**1,127 (40%)**	

Supporting visitors

Visitors work alone and the nature of the work can be stressful and demanding. We use various mechanisms to support visitors, especially when they are dealing with complex service issues. During the year, some of these activities included:

- visitor conferences in October 2002 and June 2003 for training and networking
- a two-day induction for seven new visitors in June 2003, including linking them with more experienced visitors as mentors
- coordinating a representation of visitors to discuss systemic service issues with the Minister in October 2003
- a briefing for visitors to out-of-home-care services for children and young people about changes to DoCS
- consultation with visitors through four regional groups
- five newsletters to visitors to promote the exchange of good practice ideas and updates about the sector.

To promote stakeholder understanding of the visitor scheme we:

- published and distributed a fact sheet about the visitor scheme to services and other stakeholders
- provided detailed reports to area directors of DADHC about issues visitors have identified in their services
- gave presentations to service staff and families about the role of visitors
- handled calls from service staff and families who had queries about the role of visitors or wanted to contact a visitor.

Improving the operation of the scheme

We continually try to improve the effectiveness of the visitor scheme and promote improvements to services for people in full-time care. Some of our initiatives during the year included:

- consulting with visitors to identify and implement additional evaluation mechanisms to complement those being routinely used to monitor the performance of the scheme
- monitoring the revised communications systems between visitors and the Ombudsman.

Priorities for 2003-2004

Our priorities for 2003-2004 include:

- undertaking visits to all licensed boarding houses in NSW
- looking at ways to incorporate feedback from stakeholders about the operation of the scheme
- continuing to manage the imbalance between the demand for visiting, an increasing number of visitable services and the available resources.

For more information about the activities of Official Community Visitors, please see their Annual Report 2002-03 which is available from our office.

At a 'Rights Stuff' workshop for consumers of Home and Community Care Services. We ran 21 of these workshops during the year.

Educating and informing the sector and community

The Ombudsman has a legislative function to promote and assist the development of standards for the delivery of community services and the legal and human rights of service receivers. We do this by:

- providing practical advice, information and education for consumers about problem-solving and making complaints
- educating service providers about standards for the delivery of community services, effective problem solving and complaints handling
- promoting the role of the Ombudsman in community services and informing stakeholders about what we do.

Working with consumers

This year we ran a new consumer education program called 'The Rights Stuff'. It was targeted at consumers of home and community care (HACC) services – both people with a disability and older people. This program has two key elements.

- Workshops to inform participants of their rights as HACC consumers, to give them tools to solve problems with their service provider and, where necessary, to make complaints. A total of 21 workshops were held – 10 in regional areas of NSW and 11 in the Sydney metropolitan area.
- A publication called 'The Rights Stuff Toolkit' developed as a workshop or stand-alone information resource for people using HACC services. We have distributed about 1,500 toolkits this year.

Working with service providers

Our work with service providers includes workshops on complaint handling, seminars for licensees of boarding houses and information sessions on the new requirements for reporting deaths.

Promoting good complaints handling

During 2002-2003 we delivered ten workshops across NSW on 'Resolving consumer complaints'. These workshops provide front-line staff in non-government services with strategies to handle consumer complaints effectively and confidently.

We also delivered four 'Establishing effective complaint systems' workshops. These are designed for service managers and provide them with the skills and knowledge to implement effective systems for handling complaints in community services. This workshop will have a new format from July 2003.

Licensed boarding houses

Sixty two licensed, private-for-profit boarding houses in NSW with a population of 1,100 residents came within the Ombudsman's jurisdiction in December 2002. This meant that the boarding houses became visitable by Official Community Visitors, deaths of residents were reviewable, complaints could be made about the conduct of licensed boarding houses and about those providing services, and the situation of residents could be reviewed.

During March-June 2003, we conducted a series of eight information seminars throughout NSW for licensees of boarding houses, and the various service providers who have contact with residents, about the potential impact of the Ombudsman and Official Community Visitors on their services.

The seminars were well attended by 130 people. We also held meetings with the Residential Care Association of NSW, the peak body for boarding house licensees.

Reporting deaths of people with a disability in care

Together with the coroner, we conducted information seminars for non-government disability service providers about the new requirements for reporting deaths in their services.

For more information, please see the previous section on reviewable deaths.

Explaining our role

Informing the community about the role of the Ombudsman in community services is important because it promotes an understanding of our work and improves access to our services.

After the merger of the former commission with the NSW Ombudsman in December 2002, we started a community information program for key stakeholders.

This program included:

- disseminating information resources on our expanded role in community services
- providing articles for a range of community sector newsletters
- sending targeted mailouts to community services interagencies across NSW
- running eleven information seminars – six in regional areas and five across Sydney, reaching around 600 people.

We are also available to talk to community and consumer groups about the role and work of the Ombudsman in community services generally, or in relation to specific issues or program areas. During the year, we spoke to 23 groups and had information stalls at three community events – the St George Migrant Information Day, Seniors Week Expo and the Family Support Services Association annual conference.

Staff in our inquiries section.

Appeals

Witness protection

Witness Protection Act 1995

The Ombudsman has the power to hear appeals arising from the exercise of certain powers under the *Witness Protection Act 1995*. We are also responsible for handling complaints from people who are participating in the program.

The Act gives the NSW Commissioner of Police the power to refuse someone entry to the witness protection program or to terminate their participation in it. The person directly affected by such a decision can appeal to our office. The Ombudsman must determine an appeal within seven days of receiving it and any decision we make replaces that of the Commissioner. This is our seventh full year in this role and we determined two appeals this year.

Complaints usually relate to management practices and personality conflicts between participants and their case officers. Due to the ongoing and unique relationship between the participants on the program and the officers responsible for their protection, we usually take an informal approach to resolving these issues. In some cases our staff negotiate with the commander of the state protection group to refine procedures that generate recurring complaints. The management of the program has become more sophisticated over the years.

One of the original provisions of the *Witness Protection Act* was that it must be reviewed after five years of operation. The responsible Minister was required to assess whether the Act's policy objectives were still valid and whether its terms were still appropriate for achieving those objectives. Following the review, the Minister made a number of recommendations for amendments to the Act which we supported.

The *Witness Protection Amendment Act 2002* commenced on 19 August 2002. The Act made a number of changes to the role of the Ombudsman in the witness protection program.

- The period within which the Ombudsman has to determine an appeal under the Act was extended from 72 hours to seven days.
- The Commissioner may temporarily suspend a participant from the program. An affected person may appeal against this decision to us and we have seven days to determine these appeals.
- If we confirm the Commissioner's decision to terminate or suspend a person from the program but despite reasonable attempts we cannot locate the person to tell them of our decision, termination or suspension nevertheless takes effect when we inform the Commissioner that we have been unable to locate the person.

Child Protection (Offenders Registration) Act 2000

The *Child Protection (Offenders Registration) Act 2000* came into effect in October 2001. The Act requires people convicted of certain offences against children to provide personal information to the NSW Commissioner of Police. This information is then included on a register of offenders believed to pose a risk to the safety of children.

If a person required to provide this information is a current or past participant in the witness protection program, or is about to leave the program, the Commissioner may make an order allowing them to provide the information in writing to a police officer authorised by the Commissioner. Other people are generally required to report to a police station in person.

If the Commissioner does not make such an order, the affected person may appeal to the Ombudsman. This year we did not handle any appeals of this nature.

Reform

This section gives details of the work we have done to contribute to policy reform in NSW. We provide advice to agencies, make submissions and put forward proposals on a range of topics relating to public administration.

Advice

This year we provided advice to a number of agencies on a variety of topics, including:

- Tasmanian Government on its review of administrative appeal processes and in particular a public complaints information and referral service
- Public Sector Standards Commission of WA about the *Public Interest Disclosure Act 2003* (WA)
- Duncan Gay MLC on the statutory requirement for MPs to have written consent of constituents in order to make a complaint on a person's behalf
- University of Tasmania on the nature and incidence of cases of genetic discrimination
- Better Service Delivery Program on its draft complaint procedures
- Energy & Water Ombudsman on the profile of water complaints received by the Ombudsman
- Hornsby Shire Council on the applicability of sanctions in its Code of Conduct
- Shires Association of NSW on its proposal for Ombudsman to award costs arising from unmeritorious complaints
- Victorian Energy & Water Ombudsman on the NSW system for handling public transport complaints
- Gosford City Council on its complaint profile
- Warringah Council on its revised Code of Conduct
- Emeritus Professor Maurice Daly (Warringah Council Public Inquiry) on the complaint profile of Warringah Council
- Lismore City Council on its draft Difficult Customers (Access to Service) Policy
- Griffith City Council on its proposed customer service policy
- Uralla Shire Council on the need for review of the pecuniary interest provisions of the *Local Government Act*
- North Sydney Council on its policy and procedures relating to public access to documents and information
- NSW Fisheries on the probity and equity issues arising from implementation of the proposed Oyster Lease Application and Allocation Procedure
- Department of Corrective Services on their policy and procedures for the use of force
- Department of Corrective Services on the feasibility of introducing 'smartcards' into the NSW correctional system
- NSW Aboriginal Land Council senior staff about governance issues.
- Commission for Children and Young People (CCYP) on requests by employers for the withdrawal of notifications from the employment screening register

Comments and recommendations

We also provided comments and input to:

- the review of the contribution of the Inspector General of Corrective Services to the state's correctional system
- a Cabinet Minute on proposals for the transfer of functions of the Inspector General of Corrective Services
- the Minister for Justice on the Crimes (Administration of Sentences) Further Amendment Bill 2002
- the review by the Department of Corrective Services of operational policy and procedures for segregation and protective custody
- the policy review of certain provisions of the Commonwealth Telecommunications (Interception) Act 1979
- the Network of Government Agencies - Gay, Lesbian, Bisexual and Transgender Issues, convened by the Attorney-General's Department
- an Attorney-General's Department steering committee that commissioned important research on the issue of homophobic violence against gay men and lesbians in NSW.

Submissions

During the year we made submissions to:

- The Ministry for Police about the review of the *Police Act*. Our submission suggested a number of amendments to the Act to clarify the operation of the police complaints system.
- Privacy NSW on Draft Guidelines on 'Privacy and People with Decision-Making Disabilities'
- NSW Law Reform Commission on review of *Community Justice Centres Act 1983*
- Ministry of Police on the review of *Law Enforcement (Controlled Operations) Act 1997*
- Department of Community Services during the community consultation process on the draft Children's Services Regulation 2003 – two submissions
- Legislative Council Standing Committee on Social Issues, in relation to the Inquiry into Child Protection
- Department of Disability, Ageing and Home Care, in relation to their draft Standards in Action for service providers working with children, young people and their families
- Parliamentary Committee for Children and Young People, in relation to:
  - Child deaths review team legislation
  - Child deaths review team's 'Fatal Assaults' report
  - Inquiry into education in out-of-home care.
- The Children's Guardian, in relation to:
  - substitute care standards for children with disabilities
  - proposed audit and review tool and program.

Discussion papers

As part of our monitoring of the *Police Powers (Drug Premises) Act*, we distributed a public discussion paper to obtain information about the implementation by police, of the provisions in the Act. Some of the issues about which the discussion paper sought feedback were:

- whether the implementation of the Act was successful in targeting drug supply
- how police and courts were defining 'drug houses' under the Act
- the operation of the provisions reversing the 'onus of proof' for some offences in the Act
- whether there were any unnecessary difficulties in proving offences under the Act
- the reasons given by police for making 'reasonable directions' under the Act
- the appropriateness of particular types of directions given by police
- whether there was any evidence that police were targeting particular groups, when implementing the Act.

We issued a discussion paper on service improvement issues in disability services as a basis for consultation with ACROD members in six regional areas.

Offering apologies

In last year's annual report (page 139) we noted that the consultation draft of the Civil Liability Amendment (Personal Responsibility) Bill 2002 included provisions addressing apologies.

This Bill was passed and the relevant provisions of the Act came into force on 6 December 2002. As of that date, an apology does not constitute an admission of liability, and will not be relevant to the determination of fault or liability, in connection with civil liability of any kind. In addition, evidence of an apology is not admissible in a court hearing as evidence of fault or liability, other than in relation to the categories of civil liability excluded by s 3B of the *Civil Liability Act 2002*.

We have issued fact sheets to various organisations within our jurisdiction providing advice about giving apologies, including how to word them. They also give information about the circumstances in which apologies are not protected by the Act. Copies of these fact sheets can be accessed on our website at www.ombo.nsw.gov.au/publications.

Following discussion at the Working With Children Check Guidelines Review working party, it was agreed that a small group would prepare material to guide agencies in the gathering and assessment of evidence and to provide advice to agencies regarding important issues in the conduct of investigations, such as 'the right to silence'. The working party comprised two members of our child protection team and a chief investigator from DET. Several drafts were prepared and assessed by agencies including the Commission for Children and Young People, the Catholic Commission for Employment Relations and the Association of Independent Schools.

Access and equity

We are committed to having in place an effective access and equity program to make sure that our services are accessible to all members of the public and to disadvantaged groups in particular. It is essential that our office is accessible to anyone who needs our services and any barriers are identified and eliminated.

One of our corporate goals is to be accessible and responsive. Some of the strategies we use to achieve this goal include:

- identifying and targeting people with special needs
- consulting peak groups and key referral agencies and developing protocols for ongoing communication
- participating in community events and forums
- making presentations to and developing an outreach program for target groups
- developing and distributing appropriate and effective information
- developing and implementing training and information programs for agencies in our jurisdiction
- minimising cultural, linguistic and physical barriers to accessing our services.

We have an access and awareness plan that provides an overall framework for all our access and equity activities. During the year we reviewed this plan, adopting a 'going back to the basics' approach.

After considerable internal consultation we developed a draft 'access and equity action plan', shifting from 'awareness' to 'equity' to better reflect our legislative obligations and our focus of removing barriers and facilitating access for persons who would otherwise be disadvantaged. At the time of writing, our draft access and equity plan is near completion. We will report on its implementation in next year's report.

One concern is the tendency for each of our core business teams to duplicate work in this area. To minimise this duplication and better coordinate our outreach activities, our staff work together to deliver information about our services to a range of community groups rather than focus on a particular target group. This means that we can maximise our visits to regional centres and ensure that the greatest number of people receive information about various aspects of the work of the Ombudsman.

In this section we give details of the work we have done during 2002–2003 to improve the accessibility of our services to children and young people, people in detention, Aboriginal people, ethnic communities, people in rural areas, people with a disability and women. We also report on our implementation of a range of government policies and the work of our public relations and publications unit in promoting access to and awareness of our office.

Inquiries

Our reception and inquiries staff are the office's front door for most members of the public. Most inquiries are received by phone but an increasing number are received by email. Some people visit our office in person for advice.

We regularly call upon our own multilingual staff or use the Telephone Interpreter Service when responding to inquiries from people who speak languages other than English. People with hearing impairments can access our inquiry service using the TTY number.

The expansion of the office's jurisdiction, particularly in the area of community services, has meant that our inquiries staff have had to become familiar with a wide array of additional agencies and issues.

Inquiries can cover a huge range of matters, not all of which are within our jurisdiction. Tenancy problems with the Department of Housing, neighbourhood disputes, police complaints, fair trading issues, council complaints and immigration queries can be part of an inquiry officer's normal day.

We increased the number of inquiry staff and made some changes to the structure of the area. These changes have enabled us to focus on quality assurance and improvements in the standard and timeliness of our inquiries and reception services. All inquiries staff have been trained in conducting interviews, frontline complaint handling skills and dealing with people with challenging behaviour.

Many callers are angry, frustrated and confused about who can help them. We can often assist by explaining who they need to speak to, how government agencies work, and how best to raise their concerns. If the matter is within our jurisdiction, an inquiry officer may call an agency to try to resolve a minor matter quickly. We regularly do this for inmates and young people in juvenile justice centres.

Our inquiries staff are able to detect trends in inquiries received and inform our investigative staff of possible systemic issues requiring attention. This year we identified problems in certain correctional centres and fine processing issues involving the IPB and SDRO. We subsequently raised these issues with the agencies concerned. Our inquiries staff also referred a small number of inquiries to more senior staff to be accepted as oral complaints, requiring more formal action by the office. This tends to occur where the caller is an inmate or young person, has difficulty in writing to our office, or if prompt action is required.

Our policy on dealing with the public is also being revised and clearer procedures developed to guide staff in dealing with callers and visitors to the office. Information on other agencies, their protocols and contact details has been revised and centrally recorded. All inquiries staff now have internet access from their desktop. This gives them ready access to information and referral options on a wide range of matters. New telephone system software has reduced the time for calls to be transferred to inquiry staff. The software also provides improved reporting capacity on trends in call numbers and duration. This will provide valuable information to guide further improvements in this front line area of our work.

Children and young people

We work with young people and youth workers to provide information, support and training about the role of our office and the complaint process. This year we have worked with a variety of organisations including community based centres, peak youth advocacy bodies, agencies providing youth services, local councils, universities and the Department of Education and Training. We have attended a number of meetings of student representative councils.

We have adopted a proactive approach to address issues concerning police and young people. We also promote awareness of our child protection role and educate agencies that have a legislative obligation to report matters to us about what they have to do. Some highlights of our work in 2002–2003 include:

- visiting children's services in regional NSW to provide information sessions and conduct workshops on our role and agencies' responsibilities in child protection
- conducting workshops and information sessions for agencies that provide services for children including Department of Health, Department of Community Services, Department of Ageing, Disability and Home Care, child care centres, local councils, disability services and agencies providing substitute residential care
- making presentations on the role and functions of the Ombudsman and the complaint process to youth workers and young people including Ryde Youth Workers Interagency and welfare students at Ultimo TAFE College
- part-funding the Child Protection Learning and Development Coordination Unit which has been set up to promote an interagency approach to child protection training in NSW
- consulting with youth workers during our visits to regional areas on local issues involving youth and police
- conducting an audit of the handling of child protection allegations at two juvenile justice centres.

Training and information sharing is an important part of our work, especially in the child protection area. This year, we changed our focus from providing short briefings and information sessions about our role to providing more in-depth training about specific issues. We provided education and training for a range of organisations on the notification and appropriate handling of child abuse investigations, risk management of child abuse allegations and the development of child protection policies and procedures.

To support our training program, we have developed a number of fact sheets for agencies outlining their responsibilities when dealing with an allegation of child abuse against an employee. These fact sheets are available on our web site. We also gave presentations about our child protection role at a number of conferences. The audience included legal officers, community visitors and workers from government and non-government agencies. The Ombudsman spoke at the Catholic Schools Conference about our child protection role and the responsibilities of Catholic schools.

It is often difficult for young people in detention to make complaints. To help them access our services, we visited juvenile justice centres and talked to staff and young people. We also took complaints and tried to resolve issues there and then. This year we also audited the systems of two juvenile justice centres for the prevention and handling of child abuse allegations against employees. We made a number of recommendations to assist them to improve their systems.

Please see the 'Police', 'Corrections' and 'Child protection' sections for more details.

People in detention

We continue to visit correctional centres around the state. Our primary reason for visiting places of detention is to take complaints from inmates and to resolve simple issues quickly and effectively. Our presence also allows us to speak with staff and develop their understanding of our role. We gain first-hand knowledge about what is happening which allows us to keep pace with the ever-changing correctional environments. This direct communication often has a positive impact on our ability to more easily resolve inquiries and complaints without the need for formal investigation. Sometimes, however, we identify issues that warrant investigation rather than quick resolution.

Our decision about which centres we include in our annual visit program is partly influenced by the inquiries and complaints we receive. When we plan our visits program we also consider other things, like the opening of new units or the start of new programs.

We are at the moment evaluating our visits program and the work we undertake at each centre, looking at how we can best use the time we are there.

Figure 57: Ethnic Affairs Priority Statement

Key result area	Initiative	Time frame	Intended outcome
Planning	• Developing a three year access and equity action plan which includes strategies specifically designed for improving access by culturally and linguistically diverse communities	Sep 2003	• The new Access and Equity Plan is practical and reflects the needs of linguistically and culturally diverse communities
	• Conduct a full review of our EAPS action plan	Dec 2003	• The new EAPS plan includes strategies in all specified key areas
Social justice	• Working closely with peak ethnic community organisations to identify needs of culturally and linguistically diverse communities • Providing training to ethnic community workers on complaint handling to improve access to our services by the communities • Developing effective communication strategies to raise awareness of the role of the office	Ongoing	• Increased community awareness • Improved access to our services for culturally and linguistically diverse people
Community harmony	• Providing cross cultural training to our front line and other staff • Participating in cultural activities and festivals	Ongoing	• Increased community awareness • Improved understanding of community needs

This year, we made 25 visits to 18 correctional centres. We also made 16 visits to juvenile justice centres to inspect facilities and records, and to talk to detainees and staff. We have also revised our inmate complaint form and translated sections of the form into Arabic, Korean, Vietnamese, Spanish and Chinese languages.

Please see the 'Corrections' section for more details.

Culturally and linguistically diverse communities

Our work with culturally and linguistically diverse communities has been focused on informing the community of the Ombudsman's new role in community services, and providing training to community workers on the complaint process. Some highlights include:

- distributing information about the new role of the Ombudsman to ethnic community organisations and migrant resource centres
- making presentations to ethnic community workers and groups including the Al Zahra Muslim Women's Association, the Arabic women's group at South East Neighbourhood Centre, the social workers' network at Auburn Hospital, Khmer community workers and the community legal centres network
- providing training on the role and functions of our office and the complaint process to the Auburn Multicultural Interagency and the Parramatta Multicultural Interagency
- participating in the St George Migrant Information Day, Multicultural Carnival and Western Sydney Water Festival, and Campbelltown Festival of Cultures
- translating our information sheet into Arabic and Chinese
- participating in a series of consultations with people with disabilities and their carers from Arabic and Greek backgrounds about their experiences in using community services and barriers to accessing these services
- briefing staff and parents from a school with a large proportion of NESB students about our role in child protection.

As a designated agency under the Ethnic Affairs Priority Statement (EAPS) program, we are required to develop an EAPS plan. This plan identifies our strategies to improve our services to the diverse community of NSW. We report to the Community Relations Commission on the implementation of this plan and we must detail our progress in our annual report.

This year we commenced a review of our EAPS strategies as part of our overall review of our access and equity program. We will develop a new EAPS action plan to reflect the new directions set out in the Community Relations Commission's green paper 'Cultural Harmony, the next decade'.

Aboriginal communities

We visited regional areas and met with Aboriginal legal services, Aboriginal land councils, health services and local Aboriginal organisations, police Aboriginal liaison officers, domestic violence liaison officers and youth liaison officers, and members of Aboriginal communities. We held consultation meetings with representatives from government and non-government organisations, both Aboriginal and non-Aboriginal, to provide information about our role and functions and to discuss local concerns.

Some highlights of our work in 2002–2003 include:

- conducting audits on the implementation of the strategies set out in the NSW Police Aboriginal Strategic Direction 2002-2006 at five police local area commands
- visiting and consulting with regional Aboriginal communities including Armidale, Coolangatta, Cowra, Dubbo, Gunnedah, Gordon, Kempsey, Lismore, Namatijira Haven, Nambucca Valley, Nimbin, Nowra, Orange, Port Macquarie, Tamworth and Tweed Heads

- working with police, Aboriginal legal services and other Aboriginal organisations to address policing issues affecting local Aboriginal communities
- liaising with Aboriginal legal services about issues arising in correctional centres
- making presentations at the police Aboriginal Community Liaison Officers' conference
- networking and participating in joint activities with the Aboriginal Out of Home Care Secretariat of the Department of Aboriginal Affairs
- visiting correctional centres and juvenile justice centres and speaking to Aboriginal staff, inmates and inmate delegates on issues concerning Aboriginal people in custody.

Joanne Scott (third from left) with Wiradjuri elders Aunty Joyce Hampton (left), Aunty Edna Andrew and Aunty Isabelle Reid (right) during the 2003 NAIDOC celebrations at the Ashmont resource centre in Wagga Wagga.

This year we continued to work closely with NSW Police on a wide range of issues concerning Aboriginal communities. Our main focus has been to conduct audits of police local area commands in relation to their implementation of the NSW Police Aboriginal Strategic Direction 2002-2003. The audit consisted of surveys, interviews of police officers, service providers and members of Aboriginal communities, focus group discussions and examination of relevant police policies and protocols, as well as our complaint records. We have completed audits at Shoalhaven, Richmond, Mid North Coast, Canobolas and Oxley local area commands. The areas were chosen as there have been high rates of police contact with Aboriginal communities and significant Aboriginal justice issues. At the end of each audit, we debriefed the commanders and discussed our findings with them.

For more details about our work with Aboriginal communities, please see the 'Police' section.

Regional outreach

Last year staff from our various teams visited over 40 major towns and regional centres across NSW. We conducted community consultations, made presentations on the role of our office and our procedures to agencies and community groups, provided training courses to agencies on complaint handling, ran policy workshops for agencies that provide services to children, inspected correctional centres and juvenile justice centres, and held information stalls at the annual Ag-Quip in Gunnedah.

In an effort to maximise the use of our resources and coordinate our regional outreach activities, our teams worked together and combined core work with activities that aimed to raise awareness. For example, our police team members while meeting with regional police, also held public meetings and community consultations involving local businesses, people with disabilities, people from a culturally and linguistically diverse background and people who work with young people.

We recognise the disadvantages people outside Sydney may face in accessing our services. Our strategies to minimise any such disadvantage include a free call service where people outside Sydney can call us for the cost of a local telephone call. We include our free call number and our web and email addresses in all regional telephone directories. We also use local media to promote our visits and encourage people to make their complaints online or via email. We send information brochures to all community legal centres across the state and make this information available on our website.

People with a disability

The NSW Government Disability Policy Framework requires agencies to have a Disability Strategic Plan that identifies how they plan to improve services to people with a disability in the following priority areas: physical access, promoting positive community attitudes, training of staff, information about services, employment in the public sector and complaints procedures.

During 2002–2003 we undertook a range of initiatives to improve access for people with disabilities. Some highlights include:

- liaising with disability advocacy groups and peak disability organisations on key issues for people with disabilities
- visiting disability organisations in regional areas, providing information about the role of our office and discussing issues concerning the relationship between police and people with disabilities
- participating in a series of consultations with people with disabilities and their carers from Arabic and Greek communities about their experiences in using community services and barriers to access
- conducting workshops for consumers of Home and Community Care services about tips for making a complaint and solving problems about poor service provision

Figure 58: Implementation of our Disability Strategic Plan

Priority area for action	Goals/targets	Reporting year strategies	Outcomes/achievements
Physical access	Ensuring that our office and any other locations we use are accessible to people with a disability	Undertake an access audit of the whole office using external experts	• We conducted a review of our premises. We identified some areas of concern and made changes. We improved accessibility including lowering door access readers, installing mirrors at the corners of corridors, changing desk configurations and providing specialised equipment. • On our public access floor we have toilet facilities for people with a disability. • The building has wheelchair access (ramp and lift) and tactile ground surface indicators near all staircases, ramps and escalators. • The tenant directory is a well-lit area with tenant details in a reasonably sized font. There are some details in Braille.
Promoting positive community attitudes	Actively promote people with disabilities as valuable members of the community	Working in partnership with peak organisations to promote positive community attitudes	• We promote people with disabilities as valuable members of the community by including positive images of people with a disability and using appropriate languages in our publications. • We participated in community forums such as the International Day of People with Disability, giving a speech on issues and challenges for people with a disability. • We conducted tips for making complaint workshops for consumers of Home and Community Care services.
Training of staff	Staff are trained and competent in providing services for people with a disability	Conduct disability awareness training for staff	• We include a session on 'working with people with a disability' in our investigation skills training course. • Our staff attended forums and seminars on disability issues.
Information about the services	Our office and the services we provide are accessible to people with a disability		• Information about our services is available in a range of alternative formats including large print, Braille and tapes. This information will be reviewed and updated in the next 12 months. • We have a Compic poster for people with intellectual disability. The poster will be reviewed and updated in the next 12 months. • We are currently reviewing our website to ensure that it is both usable and accessible.
Employment in the public sector	To employ more staff who have a disability		• We participated in an employment program for a person with a disability and are exploring similar programs for the future. • 8% of our staff have a disability, with 2.7% requiring work related adjustments.
Complaints procedure	Our office and the services we provide are accessible to people with disabilities	Develop strategies to let people with disabilities know about the complaint and compliment policy	• Complaint handling is one of our core functions. We have used various strategies to inform people with disabilities of our role and services and how to make a complaint. • We have an internal complaints and compliments policy. We also inform people who use our services about how to make complaint about us. • We have participated in consultations with people with disabilities and their carers about their experiences in using community services including barriers to access.

- conducting workshops on risk management and child protection policy development to agencies that provide services to children with disabilities
- completing our audit program of the systems that schools for special purposes have to prevent and handle allegations or convictions of child abuse against employees
- providing training on working with people with a disability to staff as a part of our investigation skills training
- providing employment opportunities for people with disabilities.

We continued to build and maintain ongoing liaison with disability advocacy groups and peak disability organisations such as the Department of Ageing, Disability and Home Care, People with Disability, ACROD, and the Spastic Centre and to discuss key issues for people with disabilities.

We have worked with a number of disability organisations to raise awareness of our role and functions and to discuss issues regarding the relationship between police and people with disabilities.

For the session on working with people with a disability in our investigation skills training, we engaged people with a disability to co-present.

We have provided a placement and employment opportunity for a person with a disability and are currently exploring a scholarship scheme for other such opportunities.

We have also modified some of our office space to accommodate new staff members with disabilities, including improving wheelchair access and modifying individual workstations to ensure that they have appropriate facilities.

Figure 58 above reports on the implementation of our Disability Strategic Plan.

Figure 59: Action Plan for Women – progress report

Objective	What we have done/are doing
Reduce violence against women	• We have conducted audits of six police local area commands regarding their work with Aboriginal communities. The policing response to domestic violence and sexual violence is an important aspect of police efforts to work more effectively with Aboriginal victims, witnesses and offenders. Our audit reports include detailed feedback from Aboriginal residents and other sources about how well the command is targeting Aboriginal family violence and sexual abuse, and ideas for further improvement. • In response to a critical audit report in one rural area, the local commander appointed an experienced domestic violence liaison officer to a high-need location, moved a trial to target repeat domestic violence offenders to that area, and developed a victim referral protocol to improve police links with other agencies in the town.
Promote safe and equitable workplaces that are responsive to all aspects of women's lives	• We have adopted flexible working conditions including flexible working hours, part-time and job share arrangements, and leave for family responsibilities. We also promote a harassment free workplace.
Maximise the interests of women	• We have no specific strategies for this objective.
Improve the access of women to educational and training opportunities	• We have given women in our office educational and training opportunities to further their careers.
Promote the position of women	• We have a diverse and skilled workforce. Women make up 72% of total staff and 68% of staff above grade six. All of our team managers are women and one of our six statutory officers is a woman. • We employ people on merit. Of our new recruits 78% are women. • We participate in activities celebrating International Women's Day and published fact sheets to inform women of our role and functions.

Women

Our access and equity activities relating to women focused on existing networks and programs to promote the profile of our office and improve the access of women to our services. Some highlights of our work this year include:

- participating in the International Women's Day celebrations by holding an information stall at Belmore Park in Sydney, and sending information brochures to organisers of celebration events in both regional and metropolitan areas to be distributed to women
- making presentations to women's organisations and groups including the Muslim Women's Association and Arabic Women's Group in South East Sydney
- providing information packages to the 'Women on Wheels' tour group for distribution to rural women.

We also implemented a range of initiatives to meet the objectives of the NSW Government's Action Plan for Women. Figure 60 above gives details of our progress.

Public relations and publications

Our public relations and publications unit coordinates our access and awareness activities and develops, with core business teams, supporting materials such as brochures, guidelines and fact sheets.

During the year we continued to work closely with community groups such as disability organisations and the multicultural workers network. We reviewed our access and awareness strategies and developed a draft three-year access and equity action plan. We reviewed a range of our written material and updated it. Specifically we have:

- published two special reports to Parliament on the police complaints system and police practice in using speedometers and issuing speeding fines
- published a discussion paper on the *Police Powers (Drug Premises) Act 2002*
- published Enforcement Guidelines for Councils
- revised our general information brochure
- developed six inserts on specific areas of our work to complement our general information brochure
- published a set of four fact sheets on our new functions in community services and the role of our Community Services Division
- published a set of four fact sheets to explain amendments to the *Civil Liability Act 2002* on the offering of apologies
- published a general information sheet in the Chinese and Arabic languages

A list of all our recent reports and publications is at the end of this report.

Speeches and presentations

The following are some of the major speeches and presentations given by our staff this year. The list includes speeches and presentations given by staff of the former Community Services Commission prior to its amalgamation with the Ombudsman.

July 2002

Robert Fitzgerald, Community Services Commissioner spoke at a social policy breakfast organised by Wesley Mission on social policy issues. He also gave an address at a seminar organised jointly by the Community Services Commission, Uniting Care Burnside and ACWA on 'continuum of care for children and young people with disabilities in out of home care'.

August 2002

Jennifer Agius, Senior Investigation Officer, gave a presentation at the annual Official Visitors Conference on the role and functions of the Ombudsman.

Greg Andrews, Assistant Ombudsman (General), spoke at the ICAC forum for universities 'Degrees of Transparency — Corruption Resistance in NSW Universities'. He identified the main types of complaints made to our office about universities and the critical issues emerging from those complaints.

Anne Barwick, Assistant Ombudsman (Children and Young People) gave presentations to the Christian Schools Association and District Superintendents of the Department of Education and Training.

Andrew O'Brien, Youth Liaison Officer, gave a presentation to Family Advocacy and another presentation to the Ryde youth workers interagency meeting about the role of the office.

Geoff Briot, Senior Investigation Officer, participated in a 'hypothetical' at the Australian Society of Archivists National Conference. The scenario involved attempted destruction of records, a protected disclosure and a leak to the media about environmental contamination of publicly owned land on which a childcare centre had been erected.

Lisa Du, Public Relations Officer, gave a presentation on the role and functions of the Ombudsman to the Arabic Women's group at South East Neighbourhood Centre.

Wayne Kosh, Investigation Officer, gave a speech to the Pittwater Branch of Rotary about the role of the Ombudsman.

Robert Fitzgerald spoke at the Excellence in Youth Awards, organised by the Baulkham Hills Shire Council. He also gave an address at the state conference of the NSW Neighbourhood Aid Association Inc.

September 2002

Bruce Barbour, Ombudsman, spoke at the Catholic Schools Conference about our child protection role and the responsibilities of Catholic schools.

Steve Kinmond, Assistant Ombudsman (Police) gave a presentation to Internal Investigators at Westmead on the expectations of this office when assessing investigations.

Anne Barwick and ***Greg Williams, Legal Officer***, gave a presentation to the Department of Education Child Protection Investigation Directorate on the use of restraint.

Anne Barwick gave a presentation to the Ombudsman Child Protection Forum on trends and patterns in child abuse notifications.

John Davies, Senior Investigation Officer, made a joint presentation with the Department of Local Government to the ICAC about our local government jurisdiction.

Robert Fitzgerald gave a keynote address at the annual conference of the Association of Children's Welfare Agencies on 'More than a safety net – a network of safeguards in child and family services'. He also addressed the Local Community Services Association annual conference on 'Building capacity – a vital challenge to community services', and addressed the annual general meetings of the Foster Care Association (NSW) Inc and the St George Community Services Inc.

Margaret von Konigsmark, Senior Review Officer (Disability Deaths) presented a paper at the national conference of the Australian Cerebral Palsy Association entitled 'Nutrition-related issues arising from the deaths of people with cerebral palsy and intellectual disability'.

October 2002

Bruce Barbour opened the Community Visitors Conference organised by the Community Services Commission.

Anne Barwick gave a presentation to Aboriginal out of home care managers.

Eileen Graham, Community Liaison Officer, gave a presentation at the Community Visitors Conference about our office's child protection role.

Oliver Morse, Investigation Officer, gave a talk to the State Rail Authority complaint handling unit on appropriate standards of complaint handling.

Sheila O'Donovan, Senior Inquiry Officer, made a presentation to the social workers at St Josephs Private Hospital at Auburn, on our role.

John Davies gave a talk about our local government jurisdiction to the Environmental Defenders Office.

November 2002

Anne Barwick gave a presentation to representatives of the principals of schools for special purposes and Primary Principals Association (Department of Education and Training).

Simon Cohen, Legal Officer, gave a presentation to student police officers in Richmond.

Daryn Nichols and ***Opal Kiang, Assistant Investigation Officers***, gave a presentation at the Buddhist temple at Bonnyrigg, at the request of City Watch, on the role of the Ombudsman and the police complaints system. They provided advice on interpreters and translators for complainants.

David Watson, Investigation Officer, gave a seminar on Freedom of Information to NSW Young Lawyers.

Eileen Graham presented a workshop on developing a child protection policy at Far North Coast TAFE Child Protection Conference.

Robert Fitzgerald spoke at a seminar on Government and Human Services, organised by the Department of Human Services, Premiers and Cabinet in Melbourne, on relationships in formal service systems.

Margaret von Konigsmark presented a paper at the annual conference of the Australian society for the Study of Intellectual Disability entitled 'The need for responsive palliative care – issues identified by the NSW Disability Death Review Team'. She also presented a paper at the NSW Paediatric Dieticians Special Interest Group on reviewable disability death issues.

December 2002

Robert Fitzgerald delivered a speech at the 9th National Conference on Unemployment in Newcastle entitled 'Unemployment: A Common Responsibility'.

Katy Knock, Project Officer, Terry Chenery, Investigation Officer, and ***Steven Murray, Project Manager***, spoke to the quarterly meeting of the Aboriginal Justice Advisory Council on our legislative review role in relation to non-association orders and criminal infringement notices.

Cath Mullane, Coordinator, Reviewable Child Death Project Team, gave a presentation to the Australian Association of Social Workers Hospital Managers Meeting at Cumberland Hospital on the amended legislation and changes to reviews of child deaths in NSW.

Simon Cohen gave a presentation to student police officers in Goulburn and to a NSW Police internal investigators' course in Westmead.

Carolyn Campbell-McLean, Education and Training Officer, CSD, gave a speech at an event for the International Day of People with Disability on issues and challenges for people with a disability.

February 2003

Chris Wheeler, Deputy Ombudsman, gave a presentation on receiving accreditation under the Australian standard for information security (AS7799) at a records and document management forum held by NSW Business Link.

Simon Cohen gave a presentation to the NSW Police Leadership Development Program in Parramatta.

Anne Barwick and ***Laurel Russ, Investigation Officer***, spoke at the Aboriginal Out of Home Care Conference in Port Macquarie.

Robert Fitzgerald spoke at a Benevolent Society Centre for Social Leadership seminar on 'Taking action in the social sector'. He also addressed the Board of the Sylvanvale Handicapped Children's Centre about service management issues.

March 2003

Monica Wolf, Manager, Policy and Community Education, CSD, gave a presentation to the Aged and Community Services Association of NSW & ACT on the role of the NSW Ombudsman in community services.

Anne Barwick gave a presentation to the ANZALA (Australia & New Zealand Education Law Association) Twilight Conference and presented at the Schools with Special Purpose conference.

Robert Fitzgerald addressed the 4th National Health Care Complaints Conference on 'Effective complaints handling'.

April 2003

Lisa Du gave a presentation on the role and functions of the Ombudsman at the Auburn Multicultural Interagency.

Sheila O'Donovan and ***Michelle Chung, Project Officer, Police Team***, gave a talk to Al Zahra Muslim Women's Association, organised through the Rockdale Council Community Relations Officer on the functions of the NSW Ombudsman in police complaints.

Robert Fitzgerald gave an address at the Anglicare Victoria Conference on 'Rethinking community services: from problem solving to building capacity'. He also addressed the National Homelessness Conference in Brisbane about 'Homelessness and the changing social welfare context'; and was a member of a panel discussion at a National Institute for Governance conference in Melbourne.

May 2003

Wayne Kosh gave a presentation on the role and functions of the Ombudsman at the Roseville Probus Club for Men and Women.

Greg Williams gave a presentation to the Church Law Reform Conference in Sydney.

Robert Fitzgerald gave an address about community and disability services at the TAFE Sydney Institute Welfare Graduation Ceremony.

June 2003

Robert Fitzgerald spoke at the St Vincent de Paul Society National Homeless Persons Seminar on homelessness issues.

Lisa Du gave a presentation on the role and functions of the Ombudsman to the Parramatta Multicultural Interagency.

Wayne Kosh gave a presentation on the role and functions of the Ombudsman to welfare students at the Ultimo TAFE.

Sheila O'Donovan gave a presentation on the role and functions of the Ombudsman to the Local Government Association Network in Lismore.

Corporate support

This section gives details of our work in the corporate support area. The corporate support team includes personnel, financial services, public relations and publications, information and records management, information technology (IT) and library services.

Our corporate support team aims to:

- provide efficient and effective support to the core activities of the office
- make the most effective use of resources
- maximise productivity and staff development and ensure a healthy, safe, creative and satisfying work environment
- increase parliamentary and community awareness of the role, function and services offered by the Ombudsman
- maximise the use of information technology and introduce appropriate technology to increase productivity and accessibility.

This year our corporate support team faced many challenges. Every section of the team was involved in the amalgamation of the Community Services Commission (former commission) with this office. We had to integrate the former commission's IT systems, payroll, leave and other personnel functions as well as transferring its financial assets and liabilities. We were also responsible for the physical relocation of staff, furniture and equipment.

We continued to use technology to improve our performance this year. We started to catalogue our library holdings in our new enterprise document management system (EDMS). When this project is finished, it will allow staff to search and retrieve all the information we hold from one repository.

Our corporate team grew in size this year. In addition to corporate staff of the former commission being welcomed into our team, we employed a temporary analyst/programmer to assist with the integration of the former commission's databases. We also created a position of librarian as part of the ongoing improvement of our information systems.

The 2003–2004 reporting year will also be a busy one. We will need to ensure that new business systems such as the EDMS and the Police Complaints Case Management System are working well and meeting expectations. Work will also continue on the integration of the former commission's systems and technology.

Personnel

Personnel services include recruitment, leave administration, payroll and occupational health and safety (OH&S).

Our key achievements for 2002–2003 included:

- integrating the former commission's payroll, leave and other personnel systems with our systems
- an audit of all leave records of former commission staff
- occupational health and safety training for all managers and supervisors and ergonomic training for all staff.

Next year we will review a range of personnel policies including working from home, induction and performance management.

Staff

As at 30 June 2003, we had a full-time equivalent staff number of 168 (see figure 10 in 'Where we are now: a snapshot'). Staff numbers are expressed in terms of full-time equivalent, so the actual number of part-time staff is not reflected in the table. Staff on leave without pay are not included in this figure.

Figure 60: Chief and Senior Executive Service

	2002	2003
SES Level 4	1	2
SES Level 2	3	3
CEO*	1	1
Total	5	6

** CEO position listed under section 11A of the Statutory and Other Offices Remuneration Act 1975, not included in Schedule 3A of the Public Sector Management Act 1988*

Chief and Senior Executive Service

Our office has six senior positions – the Ombudsman, two Deputy Ombudsman and three Assistant Ombudsman. A woman currently holds one of those positions. There was an increase in the number of senior positions during 2002–2003 because of the amalgamation. Please see figure 60 for details of the levels of senior positions.

Wage movements

Public servants were awarded a 4% pay increase effective 3 January 2003.

Executive remuneration

In its annual determination, the Statutory and Other Officers Remuneration Tribunal awarded increases to our statutory officers. The Deputy Ombudsman and our three Assistant Ombudsman were awarded a 4.3% increase effective 1 October 2002. The Ombudsman's remuneration increased by 1.3%.

Figure 61 details the Ombudsman's remuneration, which includes salary, superannuation and annual leave loading.

Figure 61: Executive remuneration

Position	Ombudsman
Occupant	Bruce Barbour
Total remuneration package	$251,326
$ Value of remuneration paid as a performance payment	Nil
Criteria used for determining total performance payment	NA

The Ombudsman's performance statement

As the Ombudsman is not responsible to an individual Minister, there is no formal one-on-one review of his performance. However, the Ombudsman regularly appears before the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission to answer questions about the performance of our office.

Personnel policies

As mentioned last year, the *Public Sector Management and Employment Act 2002* was passed by Parliament in June 2002. This Act sets out the basis of employment and the framework for many of the working conditions of public servants including our staff. The Act has been progressively implemented with many of the new provisions starting during 2002–2003. As provisions have been commenced, we have reviewed our processes and policies, making changes as appropriate.

A further change in conditions occurred in December 2002 when the Industrial Relations Commission of NSW approved variations to the conditions of employment award. As a result we have reviewed some of our processes and policies and made changes where necessary.

As a public sector agency, we have little scope to set working conditions and entitlements for staff. The Public Sector Management Office (PSMO), a division of the Premier's Department, is the employer for this purpose and negotiates conditions and entitlements with the relevant union. However, we have a joint consultative committee (JCC) that meets regularly to discuss how we might develop local policies or implement public sector policies.

In 2002-2003 the major policy negotiated through the JCC was a new co-lateral flexible working hours agreement. In December 2002, the PSMO and the Public Service Association (PSA) approved an interim agreement in anticipation of a formal agreement being reached. We are still negotiating with the PSA and the PSMO about the final form of the agreement.

We also started to review existing work practices for working from home and to formalise a working from home policy. We are also reviewing our performance management policy and practices.

Training and development

Last year we developed our own internal investigations training program covering topics such as the Ombudsman's powers, investigation planning and risk management, the gathering of evidence and interviewing techniques. In 2002-03 we trialled this course, reviewing structure, content and delivery methods. We identified some areas of the training package that needed refinement and this work is being done. We are planning to offer this training in 2003-2004. Over time all relevant staff will be required to attend.

A significant training program was also conducted as part of the introduction of the EDMS. All staff had initial training on the new system and follow up refresher training a few months later. Funds were provided from the EDMS project for this program.

We also implemented an occupational health and safety program which all staff were required to attend. For details, please see 'Occupational health and safety' below.

A comprehensive external training program for IT staff continued this year. The aim of this program is to strengthen our IT skills to accreditation standards, particularly in security specific technologies.

A number of managers and staff representatives were trained in job analysis and job evaluation.

An important aspect of our staff training and development is the provision of study assistance. During 2002–2003, 18 members of staff used study leave provisions to undertake tertiary education courses.

Figure 62: Percentage of total staff by employment basis

Employment basis	Total staff number	Subgroup as % of total staff in each category: Resp (%)	Men (%)	Women (%)	Subgroup as estimated percent of total staff in each employment category: ATSI (%)	Ethnic (%)	ESL (%)	Dis (%)	Dis adj (%)
< $28,710									
$28,710 - $37,708	11	100		100		55	36	18	9.1
$37,709 - $42,156	9	100	22	78		89	67	11	
$42,157 - $53,345	41	100	24	76		22	17	5	
$53,346 - $68,985	82	100	23	77	3.7	16	11	6	4.9
$68,986 - $86,231	27	100	37	63	3.7	15	11	4	
> $86,231 (non SES)	11	100	64	36		9	9	18	
> $86,231 (SES)	5	100	80	20				20	
Casual									
Total	**186**	**100**	**28**	**72**	**2.2**	**22**	**16**	**8**	**2.7**

Resp – Respondents
ATSI – Aboriginal people and Torres Strait Islander people
Ethnic – People from racial, ethnic, ethno-religious minority groups
ESL – People whose language first spoken as a child was not English
Dis – People with a disability
Dis adj – People with a disability requiring work-related adjustmen

Workers compensation

We participate in the NSW Treasury Managed Fund, a self-insurance scheme for the NSW public sector. We have strategies to minimise our workers compensation claims including workplace inspections and the provision of a counselling service. Our claims have been generally limited to one or two per year.

Performance Indicator Workers compensation claims

	01/02		02/03	
	Fund*	Ombudsman	Fund*	Ombudsman
No. of claims	10,471	2	12713	8
No. of staff	180,851	115	193,266	125
No. of claims per staff	0.058	0.017	0.066	0.064
Average cost per claim	$4,791	$1,342	$5,595	$2,122
Average cost per staff	$277	$23	$368	$136

**NSW Treasury Fund's comparative statistical analysis as at 31 March 2002 and 31 March 2003 respectively*

Interpretation

This performance indicator compares our performance with the overall performance of all participants in the NSW Treasury Managed Fund. As can be seen, we made eight workers compensation claims in the reporting period, up from two claims the year before. We have a number of strategies to minimise accidents in the workplace, which are detailed in the occupational health and safety section of this report. A significant number of the claims lodge involve accidents outside the Office, mostly on journeys to and from work.

The performance indicator 'Workers compensation claims' shows a comparative statistical analysis of workers compensation claims and compares our performance with the overall performance of all participants in the NSW Treasury Managed Fund. This analysis does not include the period between March and June 2003, but we received 5 claims during that quarter.

Occupational health and safety (OH&S)

This year we continued our focus on OH&S. We undertook a comprehensive training program for managers and supervisors so that they would better understand their responsibilities under the legislation. We also provided ergonomic training to staff and had an external occupational health specialist assess workstations, computer placement and lighting. This assessment highlighted the need to upgrade some office equipment and change the work practices of some staff.

We conducted workplace inspections, including ergonomic assessment of workstations as well as general hazard identification. Staff that have been trained in safety audits conducted these inspections. We continued the upgrading of our workstations purchasing new workstations that are ergonomically sound, make better use of the available space and give staff more privacy.

We held briefings on our employee assistance program, a free 24-hour counselling service for staff and their families. This program helps to solve both work and personal problems that if not dealt with could impact on job performance.

Figure 63: Percentage of total staff by employment basis

		Subgroup as % of total staff in each category					Subgroup as estimated % of total staff in each employment category		
Employment basis	**Total staff number**	**Resp (%)**	**Men (%)**	**Women (%)**	**ATSI (%)**	**Ethnic (%)**	**ESL (%)**	**Dis (%)**	**Dis adj (%)**
Permanent full-time	108	100	32	68	2.8	20	15	7	2.8
Permanent part-time	25	100		100		28	28	4	4.0
Temporary full-time	31	100	32	68	3.2	29	16	6	
Temporary part-time	16	100	13	88		19	13	6	6.3
Contract - SES	5	100	80	20				20	
Contract - Non-SES	1	100	100					100	
Training positions									
Retained staff									
Casual									
Total	**186**	**100**	**28**	**72**	**2.2**	**22**	**16**	**8**	**2.7**

Resp – Respondents
ATSI – Aboriginal people and Torres Strait Islander people
Ethnic – People from racial, ethnic, ethno-religious minority groups
ESL – People whose language first spoken as a child was not English
Dis – People with a disability
Dis adj – People with a disability requiring work-related adjustmen

We have a number of other programs that help us to meet our health and safety obligations.

- Hepatitis vaccinations — staff who visit correctional centres are vaccinated against Hepatitis A and B.
- Eye examinations — our staff spend a lot of time using computers and this can lead to eyestrain. We organise an eye examination for all staff every two years so that any potential problems can be detected.
- Flu shots — like many organisations, we have previously experienced high absenteeism during the flu season so for the third year we organised flu shots for staff. About 50% of staff participated in the program.

We also reviewed our emergency evacuation procedures, including the selection and training of new wardens.

Equal employment opportunity

We are committed to the principles of EEO and have a program that includes policies on performance management, grievance handling, harassment-free workplace and reasonable adjustment.

A sound information base

We achieved a 100% response rate from staff to our EEO survey giving us a sound information base about the composition of our workforce.

Ensuring staff views are heard

We provide mechanisms for staff to contribute their views about the planning and management of the office. Members of staff are involved in business planning and raise issues through our joint consultative committee.

EEO outcomes included in agency planning

EEO accountabilities are included in business plans, performance agreements and work plans.

Fair policies and procedures

We continued to promote flexible work practices including part-time work, working from home and use of family and community service leave.

Needs-based program for EEO groups

We provided training and development opportunities for EEO groups.

Managers and staff informed, trained and accountable for EEO

Our induction program for new staff includes a section on EEO and our performance agreements and work plans include EEO accountabilities. We are currently developing a supervisor's manual that details all supervisory responsibilities including information on sound EEO practices.

A workplace culture displaying fair practices and behaviours

We have consultative arrangements in place and grievance policies. We are committed to providing a workplace free of harassment.

Improved employment access and participation by EEO groups

We offer traineeships to improve the employment access and participation of young people.

Performance Indicator
Trends in the representation of EEO groups

			Ombudsman		
EEO Group	Government Target	Public sector 00/01	00/01	01/02	02/03
Women	50%	56%	66%	67%	72%
Aboriginal and Torres Strait Islander people	2%	1.4%	3.0%	3%	2%
People whose language first spoken as a child was not English	20%	14%	15%	16%	16%
People with a disability	12%	7%	7%	7%	8%
People with a disability requiring work related adjustment	7%	1.9%	2.3%	1.5%	3%

** figures for 2001-2002 not available at time of writing.*

Interpretation

We exceed the government benchmark for employment of women and have achieved the benchmark for the employment of Aboriginal or Torres Strait Islander people. We have slightly higher representation than the public sector as a whole for people with a disability, people with a disability requiring a work related adjustment and people whose first language is not English, but we fall behind the Government benchmark in all these categories.

The representation of women, people with a disability and people with a disability requiring adjustment has improved since the last reporting period, mainly due to the amalgamation of staff from the Community Service Commission. There has been a decrease in the representation of Aboriginal or Torres Strait Islander people although the number of employee remains the same. We need to focus on improving strategies for employing people with a disability.

A diverse and skilled workforce

Members of our staff come from a variety of backgrounds and experience. Figures 62 and 63 show the gender and EEO target groups of staff by salary level and employment basis, that is, permanent, temporary, full-time or part-time.

The government has established targets for the employment of people from various EEO categories. Measurement against these targets is a good indication of the success or otherwise of our EEO program. The performance indicator 'Trends in the representation of EEO groups' compares our performance to the rest of the public sector and to government targets.

Industrial relations

Joint Consultative Committee

The JCC is made up of representatives of staff, management and the Public Service Association (PSA). They meet to discuss issues of mutual concern including policy development.

During 2002-2003, the JCC discussed a range of matters including the negotiated public sector pay award that provides a 16% pay increase to staff over three and a half years, the amalgamation and the new co-lateral flexible working hours agreement.

Part-time work

The office promotes part-time work. On 30 June 2003, 41 members of staff or 22% were employed on a part-time basis.

Grievance procedure

We have a grievance procedure designed in accordance with the provisions of the Industrial Relations Act 1996. No formal grievances were lodged during 2002–2003.

Trainee/apprentices

We currently employ no trainees or apprentices.

Financial services

Financial services include budgeting, management reporting, accounts payable and purchasing.

Our key achievements for 2002–2003 include:

- the integration of the former commission into our accounting structure

Performance Indicator
Trends in the distribution of EEO groups

		Ombudsman			
EEO Group	Benchmark or Target	99/00	00/01	01/02	02/03
Women	100%	86%	89%	90%	86%
Aboriginal and Torres Strait Islander people	100%	n/a	n/a	n/a	n/a
People whose language first spoken as a child was not English	100%	n/a	78%	79%	83%
People with a disability	100%	n/a	n/a	n/a	n/a
People with a disability requiring work related adjustment	100%	n/a	n/a	n/a	n/a

Interpretation

A distribution index of 100 indicates that the centre of the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicated that the EEO group is less concentrated at the lower levels. Where n/a appears, the sample was not sufficient to draw a conclusion. The Distribution Index is automatically calculated by the software provided by ODEOPE.

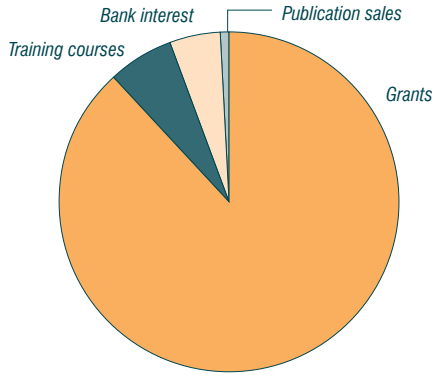
- a revision of the chart of accounts which significantly reduced the number of cost centres and line items
- an unqualified audit report.

Next year we will be updating our accounting manual and reviewing the classification and recording of our fixed assets. We will also implement our new chart of accounts.

Revenue

Most of our revenue comes from the government in the form of a consolidated fund appropriation. The government also makes provision for our superannuation and long service leave liabilities. There is a breakdown of revenue generated, including capital funding and acceptance of employee entitlements in figure 8 in 'Where we are now: a snapshot'.

Figure 64: Revenue from other sources

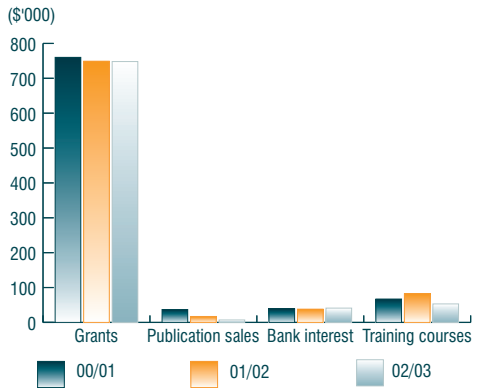


Grants	$748,000
Publication sales	$7,000
Bank interest	$41,000
Training courses	$53,000
Total	$849,000

Our appropriation was increased by $2,853,000. The majority of this, $2,293,000, was the result of the amalgamation. We also received funding for new functions and other miscellaneous items.

We generated additional revenue of $101,000 through the sale of publications, bank interest and fee for service training courses for other public sector agencies. See figures 64 and 65.

Figure 65: Revenue from other sources – Three year comparison



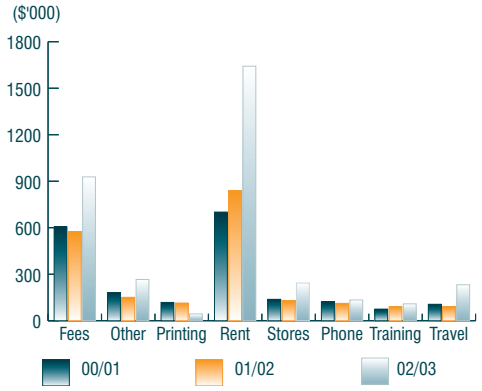
The PCCM project continued during the year, funded by a $710,000 grant from the Premier's Department. We also received $38,000 funding from the Department of Juvenile Justice for our review of the *Children (Criminal Proceedings) Act 1987*.

Expenses

Most of our revenue is spent on employee-related expenses. These include salaries, superannuation entitlements, long service leave and payroll tax. Last year we spent more than $11.7 million on employee-related expenses.

The day to day running of the office including rent, postage, telephone, stores, training, printing and travel costs over $3.67 million. Depreciation of equipment, furniture and fittings and other office equipment was $514,000. For more details please see figure 9 in 'Where we are now: a snapshot' and figure 66.

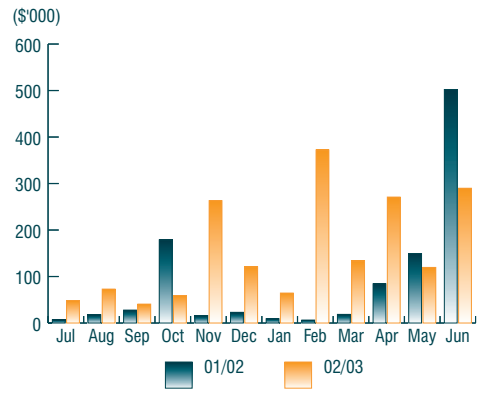
Figure 66: Expenses - Three year comparison



Stores expenditure

Figure 67 shows our stores expenditure during the year. Stores include asset purchases such as office and computer equipment, furniture and fixtures and consumables such as stationery. A significant proportion of our stores expenditure is related to asset purchases. These types of purchases can cause fluctuations in the level of expenditure between months and between years.

Figure 67:Stores expenditure – two year comparison



Funds granted to non-government community organisations

We did not grant any funds to any non-government community organisations.

Controlled entities

We have no controlled entities.

Credit card use

We do not have any corporate credit cards.

Assets

Major assets

Our major assets are listed below in figure 68.

Figure 68: Major assets

Description	01/02	Acquisition	Disposal	02/03
File servers (mini computer)	21	5	5	21
Hub	13	2		12
Personal computers	22	7		22
Printers	12	4	6	6
Photocopiers	3	4	2	5

Land disposal

We do not own and did not dispose of any land or property.

Major works in progress

After a number of years in development, the PCCM project was completed this year. The Ombudsman's component of the overall project budget was $1.7 million. These funds were provided for acquisition and development of hardware and software, data migration from legacy systems and security infrastructure. Ongoing recurrent funding has been provided for maintenance and other ongoing costs.

Minor works

A number of minor works were completed during the year. As a consequence of the amalgamation, modifications to our fit out were made, including new workstations. Other minor works included the purchase of IT-related equipment, the purchase of library shelving and replacing a number of damaged compactuses.

Liabilities

We have two sources of liabilities – creditors who are owed money for goods and services they provide and staff who are owed accrued leave entitlements.

There was an increase in our liabilities as at 30 June 2003. Employee entitlements increased significantly because we became responsible for leave entitlements of staff of the former commission. Amounts owing to trade creditors increased by $398,000.

Consultants

During the year we used one consultant to provide expert advice and assistance in the category of management services. The total cost of this consultancy was $12,433 so there was no individual consultancy equal to or in excess of $30,000.

Accounts payable policy

We have an accounts payable policy that states that all accounts must be paid within the agreed terms or within 30 days of receipt of invoice if terms are not specified. We notify suppliers of the policy in writing when we place orders with them for goods and services. For accounts on hand at 30 June 2003, please see figure 69.

Figure 69: Aged analysis of accounts on hand at the end of each quarter

	Sep 2002	Dec 2002	Mar 2003	Jun 2003
Current (ie within due date)	$106,051	$95,204	$69,712	$35,016
Less than 30 days overdue	$1,714	0	$165	0
Between 30 days and 60 days overdue	$473	0	0	0
Between 60 days and 90 days overdue	0	$2,409	$473	0
More than 90 days overdue	0	$99	$99	0
Total accounts on hand	$108,238	$97,793	$70,449	$35,016

Performance Indicator Accounts paid on time

Quarter	Target	% paid on time	Amount paid on time	Total amount paid
September 2002	98%	89.88%	$771,670	$858,514
December 2002	98%	72.51%	$1,058,740	$1,460,137
March 2003	98%	90.58%	$1,509,391	$1,666,291
June 2003	98%	99.47%	$1,980,398	$1,990,966
Total	98%	89.03%	$5,321,099	$5,975,908

Interpretation

We aim to pay all accounts within the vendors credit terms at least 98 percent of the time. We did not meet our target paying only 89.03% within the terms set by the vendor. We had some problems with the printing of new cheque stationery, which affected the payment of accounts in the December 2002 quarter. We also found an increasing number of invoices reached the office after the expected date of payment. In these circumstances, it is impossible to pay within the terms specified. To a certain extent, the results are outside our control. We also questioned a number of invoices and disputed amounts with vendors. Payment was delayed until these disputes were resolved.

We regularly review our payment policy and aim to pay all accounts within the vendor credit terms 98% of the time. During 2002-2003 we only paid 89% of our accounts on time. Please see the performance indicator 'Accounts paid on time' for details.

We have not had to pay any penalty interest on outstanding accounts.

Value of leave

The value of recreation (annual) leave and extended (long service) leave owed for all staff for the 2001–2002 and 2002–2003 financial years is shown in figure 70.

Figure 70: Value of recreation and long service leave

	01/02	02/03
Recreation leave	$541,310	$845,634
Long service (extended) leave	$1,116,152	$318,225

Risk management

The NSW Treasury Managed Fund encourages agencies to improve their performance in a range of areas including prevention of claims, education and the adoption of risk management principles. Our goal is to improve our performance in this area continually, with specific focus on overall risk management policy, OH&S and fleet management.

Further details on our risk management and internal control program relating to our core functions may be found in 'How we operate'.

Workers compensation

To limit the number of workers compensation claims, we actively promoted a safe work environment through workplace inspections and providing a counselling service.

Fleet management

We have a small motor vehicle fleet of four vehicles. The performance indicator 'Insurance claims for motor vehicle accidents' provides data on the number of claims made to our insurer, the NSW Treasury Managed Fund, as a result of motor vehicle accidents. The fund average represents all public sector claims.

Financial based internal audit

We use an accounting firm to undertake the financial based internal audit function. This internal audit consists of:

- an audit of internal controls within the accounting, payroll and leave functions
- a review of our statutory obligations such as the calculation and treatment of payroll tax and fringe benefits tax
- a review of the financial statements before submission to the Auditor-General.

We have also been addressing a range of risk management issues including internal control, corruption prevention, fraud control, office security, disaster recovery and preventative maintenance of equipment. We finalised an information security policy and a business continuity plan.

Performance Indicator
Insurance claims for motor vehicle accidents

	01/02		02/03	
	Fund*	Ombudsman	Fund*	Ombudsman
No. of claims	2,650	2	2,499	0
No. of vehicles	20,521	3	21,912	3
No. of claims per vehicle	0.129	0.667	0.114	0
Average cost per claim	$3,018	$1,040	$2978	0
Average cost per staff	$390	$693	$340	0

**NSW Treasury Fund's comparative statistical analysis as at 31 March 2002 and 31 March 2003 respectively*

Interpretation

This performance indicator compares our performance with the overall performance of all participants in the NSW Treasury Managed Fund. We had no claims during the year. This is down from the previous year.

Public relations

Our public relations unit is responsible for coordinating our access and equity program, managing media relations and producing publications. We have reported in 'Access and equity ' on our implementation of access and awareness strategies and in publications. The following details are about the non-access and awareness work of the public relations unit.

Our key achievements of 2002-2003 include:

- successful media campaigns for the release of two special reports to Parliament, as well as our 2000-2001 annual report
- a silver medal for our 2001-2002 annual report in the Australasian Annual Report Awards
- successful media campaigns to promote our regional visits
- dealing with over 180 inquires from both print and electronic media
- a review of our website and developing a plan to build a new integrated website.

Information and records management

Our information and records management program has helped us better manage our information and records. Our records staff are also responsible for file creation, maintenance, archiving and disposal.

Staff of the office at a briefing on the role and functions of the Children's Guardian by Susan Nicolson (standing) and Toni Mulholland (sitting far left)

Our key achievements for 2002–2003 include:

- developing and implementing an enterprise document management system (EDMS)
- implementing a corporate keyword thesaurus for cataloguing the library collection
- developing and implementing best practice business rules
- continuing the review of our records disposal authorities.

Next year we will roll out the EDMS to the division whose staff were not included in the original scope of the project. We will also finalise our records disposal authorities, develop a library collection policy and review the implementation of the EDMS.

Enterprise Document Management System

One of the Police Complaints Case Management (PCCM) projects was the implementation of an enterprise document management system (EDMS) in our police team. Seeing the advantages of such a system, we sought and were given funding to extend it throughout the office. The EDMS project commenced in 2001-2002 with the preferred vendor being selected in May 2002.

During the reporting year considerable resources were invested in this project. A significant number of staff were involved in developing policies or procedures or attending a series of focus groups to assist the vendor tailor the product to our needs. The general team was chosen to pilot the EDMS prior to its roll out throughout the office. During the pilot, the EDMS was further fine tuned to ensure that it suited our business needs. An extensive training program was provided to all staff.

Expected disruption to business processes was minimal due to careful project management and a proactive change management strategy. Staff quickly adapted to the new system and the enhanced search capabilities of the product have already led to noticeable productivity gains for many staff.

The EDMS still needs to be integrated with the two principal case management systems used by the community services division.

Library

Our library was redesigned and fitted out with new shelving and furniture. A new library database and office-wide subject thesaurus was developed and implemented using the EDMS. A contractor was engaged to catalogue the existing library collection and a part-time librarian position was created.

Disposal Authorities and Archiving

We regularly send completed files to an offsite storage facility, as we do not have the space to keep these files at our premises. During 2002–2003 we continued to send complaint files as well as personnel, accounting and other administrative records offsite.

Records disposal authorities are the legal means by which we manage documents that cease to be of administrative value to us. We began a review of our existing disposal authorities, which will be submitted to State Records for approval.

Information technology

IT includes help desk/user support, network administration, information and computer systems security, and information and data analysis.

Our key achievements for 2002–2003 include:

- accreditation under the Australian Information Security Standard AS7799
- integration of former commission systems and staff into our network
- a storage area network (SAN) to achieve a scalable storage and backup system to address the emerging storage requirements
- a major upgrade of core system file servers and desktop computers.

This year we continued to review our information security policies and procedures because of the requirements of the PCCM project and our need to access police information.

Our IT team – from left – Mani Maniruzzaman, Geoff Pearce, Marianna Adzich, Stan Waciega, Bao Nguyen, David Begg and John McKenzie.

We looked at physical security arrangements as well as network security and the security of our information holdings. We also implemented new core system file servers and a SAN to consolidate network storage and backup facilities. We also provided IT infrastructure to incorporate the information storage and other IT business systems that were used by the former commission.

Next year we will need to consolidate the infrastructure and systems developed under the various PCCM projects.

Security accreditation – AS/NZS 7799

The Ombudsman began a project in 2002 to review and enhance information security management. The initiative was in direct response to an agreement that the Ombudsman made in 2001 to the Police Complaints Case Management (PCCM) partners that we would work towards substantial compliance with the Information Security Standard. As well, in 2002 the Premier directed that all public sector agencies were to be compliant with the Information Security Standard AS/NZS 7799 by 2003.

Having achieved substantial compliance with the standard by mid 2002 the Ombudsman decided to pursue full accreditation. SAI Global (Standards Australia) conducted a pre-certification audit of the Ombudsman's Information Security Management Systems in November 2002 and certification was granted on 9 December 2002. The Ombudsman was the first fully certified agency in both the government and non-government sectors in Australia to achieve accreditation. Since that time three other NSW Government agencies have achieved accreditation.

The security review project included extensive perimeter security enhancements, training for key personnel, policy redevelopment, staff education and installation of significant security infrastructure hardware and software. The project succeeded through the combined effort and goodwill of management and staff.

Police complaints case management system (PCCM)

During the year, our IT team continued their involvement in a number of PCCM-related projects. The project has now finished. However, participating agencies will need to work closely to ensure that the benefits of the project are realised.

Security - Intrusion Monitoring

Our accredited Information Security Management system requires staff employed to manage these systems to have sufficient skills and training to equip them to manage the technology and to address the complexities of issues that may arise. Key IT staff undertook an extensive IT security related training program during the year. Further training will occur in 2003-2004. Until such time as staff were appropriately trained and key systems implemented, some security related services were outsourced. Many of these services are now being performed in-house, so that by the end of the reporting year we had become largely self sufficient in terms of information security management.

Geoff Pearce, Manager Information Technology who has been with the office since 1986.

Storage Area Network

We acquired the components of a Storage Area Network (SAN) in June 2002. The SAN was implemented in July and August 2002 to achieve a scalable storage and backup system to address the emerging storage requirements of the EDMS and to consolidate a number of small storage arrays that had grown incrementally over a number of years.

Our storage needs post amalgamation was another of the drivers for a SAN implementation.

The SAN project was implemented successfully and on time and is capable of addressing our data storage and backup needs for three to five years.

Electronic service delivery

We have implemented an electronic service delivery program to meet the government's commitment that all appropriate government services be available electronically by December 2001. We provide an online complaints form, an online publications order form as well as a range of information brochures on our website.

General management

Research and development

We were involved in a number of research projects in 2002–2003, as part of our legislative review function. Please see 'Legislative reviews'.

Overseas travel

No staff member travelled overseas during the reporting year.

Code of conduct

Our code of conduct provides practical guidance to staff in the performance of their duties and in handling situations that may present ethical conflicts. It sets out basic principles

that members of staff are expected to follow and prescribes specific conduct in areas central to the exercise of the Ombudsman's functions and powers. We only made minor changes to the code during the year. These changes updated references to legislation and cross referenced the code to other Ombudsman policies.

Privacy and Personal Information Protection Act

Our office has established a privacy management plan as required by the Privacy and Personal Information Protection Act 1998. This year we had no request for an internal review under Part 5 of that Act.

Environmental issues

All organisations have an impact on the environment. This impact includes generating emissions and waste and using resources such as water and energy. To monitor and ultimately reduce our impact, we have put in place a number of environmental programs including an energy management program and a waste reduction and purchasing strategic plan.

The owners of our building have also been proactive in improving the environmental performance of the building and have achieved significant results in water conservation, energy savings and reduction of CO_2 emissions.

Performance Indicator
Petrol consumption

	95/96	00/01	01/02	02/03
Petrol (L)	4,296	3,042	4,276	5,330
Total GJ	147	104	146	182
Total cost ($)	3,098	2,900	3,343	4,303
Distance travelled (km)	53,018	32,108	47,719	65,190
MJ/distance travelled (km)/annum	2.77	3.24	3.06	2.8

Interpretation

We are committed to reducing total energy consumption where cost effective and feasible. Under the government's Energy Management Policy, we are required to establish benchmarks and report on the progress of meeting the government's environmental outcomes. Electricity and petrol are the major types of energy used. This table shows petrol usage for the last four financial years and for the baseline year of 1995/1996.

We have significantly reduced our petrol consumption in terms of litres used per person, cost per person and gigajoules per person. The number of litres used has increased from the base year and the last reporting year, however, this is due to staff travelling more as indicated by the increase in kilometres travelled.

Energy management

In 1998, the Premier announced the government's energy management policy. This policy committed each agency to sustainable energy use, lower greenhouse gas emissions, improved environmental outcomes and better financial performance.

The policy outlined specific agency responsibilities including:

- establishing performance goals and reporting on outcomes in the annual report
- reporting energy consumption to the Department of Energy at the end of each year
- adopting best practice in procurement of new assets.

Developing our goals

We reviewed our activities and identified that the energy we use is mainly electricity and fuel in our cars. Our energy management targets are to:

- reduce total energy consumption, where cost effective and feasible, by 25% of the 1995 level by 2005
- include 6% green power in electricity use when available under contract
- purchase or lease personal computers which comply with SEDA's energy star requirement
- include energy efficiency as an additional selection criteria for the purchase of any equipment
- include an appropriate energy management/ environmental module in employee induction
- implement an employee education program.

Benchmarking

The government's policy requires each agency to establish benchmarks. The baseline year is 1995–1996. Our reporting is compared to this baseline.

Petrol consumption

During 2002–2003 there was an increase in the litres of petrol we used. This is accounted for by the increase in the kilometres travelled.

Electricity consumption

Total electricity use increased by 32% over the previous year. However, our staff number increased by 53%. Our energy consumption per person, compared to last year, decreased by 14%.

Using the indicators established by the Ministry of Energy and Utilities, our electricity use has decreased. However, we are still above our base line figures set in 1995-96. This is due to our increased floor space, additional staff and the 24-hour air conditioning system in our computer room.

Future direction

The focus of our energy management program for the coming year will be a continuation of a staff awareness program.

Other environmental programs

Waste reduction

We have a waste reduction and purchasing strategic plan that was submitted to the Environmental Protection Authority (EPA) in June 1998. The focus of our plan has been on waste reduction and avoidance and increasing the purchase of recycled content products.

Reducing generation of waste

To reduce the amount of paper and toner we use, we have promoted email as the preferred internal communication tool. We also provided duplex trays for all the printers and instructed staff on double-sided copying. Of the 50 toner cartridges purchased all were recycled.

Resource recovery

We recycled approximately 1.7 tonnes of paper. We also recycled glass, plastic and aluminium.

The use of recycled material

We use 100% recycled content copy paper and our letterhead and envelopes are printed on recycled content paper. Approximately 80% of our printed material is printed on either recycled, acid free or chlorine free paper. We purchase recycled content product when feasible and cost effective.

Water usage reduction

The building owners have implemented a water saving strategy throughout the building.

Performance Indicator
Energy consumption

	95/96	00/01	01/02	02/03
Electricity (kWh)	133,630	229,653	259,938	352,703
Kilowatts converted to gigajoules	481.07	827	935.90	1,270
Total Cost ($)	16,254	22,782	27,070	38,489
Occupancy (people)	69.7	117.2	122.5	186
Area (m^2)	1,438	1,836	3,133	3,133
MJ/occupancy (people)/annum	6,872	7,066	7,926	6,938
MJ/Area (m2)/annum	335	450	307	405
M2/person	20.54	15.69	25.79	17.12

Interpretation

We are committed to reducing total energy consumption where cost effective and feasible. Under the Government's Energy Management Policy, we are required to establish benchmarks and report on the progress of meeting the government's environmental outcomes. Electricity and petrol are the major types of energy used.

This table shows electricity use for the last three financial years and for the baseline year of 1995/1996. We have increased our electricity consumption however this can be explained by the increase in floor space, additional staff and the 24 hour air conditioning system in our computer room.

Financial statements

GPO BOX 12
SYDNEY NSW 2001

INDEPENDENT AUDIT REPORT

OMBUDSMAN'S OFFICE

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Ombudsman's Office:

(a) presents fairly the Office's financial position as at 30 June 2003 and its financial performance and cash flows for the year ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

(b) complies with section 45E of the *Public Finance and Audit Act 1983* (the Act).

The opinion should be read in conjunction with the rest of this report.

The Ombudsman's Role

The financial report is the responsibility of the Ombudsman. It consists of the statement of financial position, the statement of financial performance, the statement of cash flows, the program statement-expenses and revenues, the summary of compliance with financial directives and the accompanying notes.

The Auditor's Role and the Audit Scope

As required by the Act, I carried out an independent audit to enable me to express an opinion on the financial report. My audit provides *reasonable assurance* to members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing and Assurance Standards and statutory requirements, and I:

- evaluated the accounting policies and significant accounting estimates used by the Ombudsman in preparing the financial report, and
- examined a sample of the evidence that supports the amounts and other disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Ombudsman had failed in his reporting obligations.

My opinion does *not* provide assurance:

- about the future viability of the Ombudsman's Office,
- that the Ombudsman's Office has carried out its activities effectively, efficiently and economically,
- about the effectiveness of its internal controls, or
- on the assumptions used in formulating the budget figures disclosed in the financial report.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office are not compromised in their role by the possibility of losing clients or income.

R J Sendt
Auditor-General

SYDNEY
25 September 2003

NSW Ombudsman

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STATEMENT BY THE OMBUDSMAN

Pursuant to Section 45F of the Public Finance and Audit Act 1983 I state that:

(a) the accompanying financial statements have been prepared in accordance with the provisions of the Public Finance and Audit Act 1983, the Financial Reporting Code for Budget Dependent General Government Sector Agencies, the applicable clauses of the Public Finance and Audit (General) Regulation 2000 and the Treasurer's Directions;

(b) the statements exhibit a true and fair view of the financial position and transactions of the Office; and

(c) there are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

B. A Barbour

Bruce Barbour
Ombudsman

19 September 2003

Ombudsman's Office

Statement of Financial Performance
For the Year Ended 30 June 2003

	Notes	Actual 2003 $'000	Budget 2003 $'000	Actual 2002 $'000
Expenses				
Operating expenses				
Employee related	2(a)	11,691	10,029	8,817
Other operating expenses	2(b)	3,598	2,098	2,098
Maintenance		75	82	183
Depreciation and amortisation	2(c)	514	350	267
Total expenses		15,878	12,559	11,365
Less:				
Retained revenue				
Sale of goods and services	3(a)	7	70	29
Investment income	3(b)	41	36	38
Grants and contributions	3(c)	748	710	749
Other revenue	3(d)	53	0	82
Total retained revenue		849	816	898
Gain on disposal of non-current assets	4	6	0	1
Net cost of services	19	15,023	11,743	10,466
Government contributions				
Recurrent appropriation	5(a)	13,599	11,026	9,611
Capital appropriation	5(b)	1,097	557	358
Acceptance by the Crown Entity of employee benefits and other liabilities	6	1,210	485	916
Total government contributions		15,906	12,068	10,885
Surplus for the year		883	325	419
Non-owner transaction changes in equity		0	0	0
Total revenues, expenses and valuation adjustments recognised directly in equity		0	0	0
Total changes in equity other than those resulting from transactions with owners as owners	16	883	325	419

The accompanying notes form part of these statements

Ombudsman's Office

Statement of Financial Position
At 30 June 2003

	Notes	Actual 2003 $'000	Budget 2003 $'000	Actual 2002 $'000
Assets				
Current assets				
Cash	8	1,224	695	729
Receivables	9	166	116	116
Other	10	272	92	192
Total current assets		1,662	903	1,037
Non-current assets				
Plant and Equipment	11	3,094	2,901	1,984
Total non-current assets		3,094	2,901	1,984
Total assets		4,756	3,804	3,021
Liabilities				
Current liabilities				
Payables	12	821	97	262
Provisions	13	1,156	920	727
Other	14	84	112	112
Total current liabilities		2,061	1,129	1,101
Non-current liabilities				
Other	15	294	303	337
Total non-current liabilities		294	303	337
Total liabilities		2,355	1,432	1,438
Net assets		2,401	2,372	1,583
Equity				
Accumulated funds	16	2,401	2,372	1,583
Total equity		2,401	2,372	1,583

The accompanying notes form part of these statements

Ombudsman's Office

Statement of Cash Flows
For the Year Ended 30 June 2003

	Notes	Actual 2003 $'000	Budget 2003 $'000	Actual 2002 $'000
Cash flows from operating activities				
Payments				
Employee related		(10,605)	(9,540)	(8,188)
Other		(4,308)	(2,111)	(2,157)
Total payments		(14,913)	(11,651)	(10,345)
Receipts				
Sale of goods and services		66	70	116
Interest received		43	36	36
Other		1,314	710	820
Total receipts		1,423	816	972
Cash Flows from Government				
Recurrent appropriation		13,599	11,026	9,611
Capital appropriation		1,097	557	358
Cash reimbursements from the Crown Entity		620	485	399
Net cash flows from government		15,316	12,068	10,368
Net cash flows from operating activities	19	1,826	1,233	995
Cash flows from investing activities				
Proceeds from sale of leasehold improvements, plant and equipment and infrastructure systems		6	0	1
Purchases of leasehold improvements, plant and equipment and infrastructure systems		(1,571)	(1,267)	(1,079)
Net cash flows used in investing activities		(1,565)	(1,267)	(1,078)
Net increase/(decrease) in cash		261	(34)	(83)
Opening cash and cash equivalents		729	729	812
Cash transferred in as a result of administrative restructuring		234	0	0
Closing cash and cash equivalents	8	1,224	695	729

Ombudsman's Office

Program Statement - Expenses and Revenues
For the Year Ended 30 June 2003

	Program 1*		Program 2*		Program 3*		Program 4*		Not Attributable		Total	
Agency's expenses and revenues	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**
Expenses												
Operating expenses												
Employee related	4,378	3,978	2,981	2,630	2,155	2,209	2,177				11,691	8,817
Other operating expenses	1,387	959	851	646	590	493	770				3,598	2,098
Maintenance	30	94	19	49	13	40	13				75	183
Depreciation and amortisation	193	109	143	88	100	70	78				514	267
Total expenses	5,988	5,140	3,994	3,413	2,858	2,812	3,038				15,878	11,365
Retained revenue												
Sale of goods and services	(3)	(7)	(3)	(13)	(1)	(6)					(7)	(26)
Investment income	(15)	(15)	(11)	(12)	(8)	(10)	(7)				(41)	(37)
Grants and contributions	(710)	(745)	(38)	(2)		(2)					(748)	(749)
Other revenue	(10)	(3)	(31)	(82)	(5)	(1)	(7)				(53)	(86)
Total retained revenue	(738)	(770)	(83)	(109)	(14)	(19)	(14)				(849)	(898)
Gain/(loss) on disposal of non-current assets									6	1	6	1
Net cost of services	5,250	4,370	3,911	3,304	2,844	2,793	3,024		(6)	(1)	15,023	10,466
Government contributions**									(15,906)	(10,885)	(15,906)	(10,885)
Net expenditure (revenue) for the year	5,250	4,370	3,911	3,304	2,844	2,793	3,024		(15,912)	(10,886)	(883)	(419)

** The name and purpose of each program is summarised in Note 7.*

*** Appropriations are made on an agency basis and not to individual programs. Consequently, government contributions must be included in the 'Not Atributable' column.*

Ombudsman's Office

Summary of Compliance with Financial Directives For the Year Ended 30 June 2003

	2003				2002			
	Rec* $'000	Exp* $'000	Cap* $'000	Exp** $'000	Rec* $'000	Exp* $'000	Cap* $'000	Exp** $'000
Original budget appropriation/expenditure								
Appropriation Act	10,905	10,905	557	557	9,326	9,326	358	358
Additional appropriations	0	0	0	0	0	0	0	0
s 21A PF&AA - special appropriation	0	0	0	0	0	0	0	0
s 24 PF&AA - transfers of function between departments	2,293	2,293	0	0	0	0	0	0
s 26 PF&AA - Commonwealth specific purpose payments	0	0	0	0	0	0	0	0
	13,198	13,198	557	557	9,326	9,326	358	358
Other Appropriations/expenditure								
Treasurers advance	481	481	540	540	378	285	0	0
s 22 - expenditure for certain works and services	0	0	0	0	0	0	0	0
Transfers from another agency (s 25 of the Appropriation Act)	0	0	0	0	0	0	0	0
Total appropriations/expenditure/net claim on consolidated fund	13,679	13,679	1,097	1,097	9,704	9,611	358	358
Amount drawn down against appropriation		13,599		1,097		9,611		358
Liability to consolidated fund		0		0		0		0

The Summary of Compliance is based on the assumption that Consolidated Fund moneys are spent first (except where otherwise identified or prescribed).
The Liability to Consolidated Fund represents the difference between the 'Amount Drawndown against Appropriation' and the 'Total Expenditure/Net Claim on Consolidated Fund.

Rec = Recurrent Appropriation*
Exp = Expenditure/Net Claim on Consolidated Fund*
Cap = Capital Appropriation*
*Exp** = Expenditure/Net Claim on Consolidated Fund*

Ombudsman's office

Notes to the Financial Statements For the Year Ended 30 June 2003

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a)Reporting entity

The Ombudsman's office, as a reporting entity, comprises all the activities of the office.The reporting entity is consolidated as part of the NSW Total State Sector Accounts.

On the 3rd July 2002, the Community Services Legislation Amendment Bill 2002 was assented to, which amended the Community Services (Complaints, Reviews and Monitoring) Act 1983 to abolish the Community Services Commission (CSC) and confer its functions on the NSW Ombudsman. On the 1st December 2002, the operations, assets and liabilities of the Commission were transferred to the Ombudsman's office. The expenses and revenues for the CSC prior to 1st December 2002 are reported in Note 7 and the assets and liabilities transferred from the CSC to the office are reported in Note 17.

(b) Basis of accounting

The office's financial statements are a general purpose financial report, which has been prepared on an accruals basis and in accordance with:

- applicable Australian Accounting Standards;
- other authoritative pronouncements of the Australian Accounting Standards Board (AASB);
- Urgent Issues Group (UIG) Consensus Views;
- the requirements of the Public Finance and Audit Act and Regulations; and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2)(n) of the Act.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed.

In the absence of a specific Accounting Standard, other authoritative pronouncements of the AASB or UIG Consensus View, the hierarchy of other pronouncements as outlined in AAS 6 "Accounting Policies" is considered.

The financial statements are prepared in accordance with the historical cost convention.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

Accounting policies are consistent with those of the previous year.

(c) Revenue recognition

Revenue is recognised when the office has control of the good or right to receive, it is probable that the economic benefits will flow to the office and the amount of revenue can be measured reliably. Additional comments regarding the accounting policies for the recognition of revenue are discussed below.

(

i) *Parliamentary appropriations and contributions from other bodies*

Parliamentary appropriations and contributions from other bodies (including grants and donations) are generally recognised as revenues when the office obtains control over the asset comprising the appropriations and contributions. Control over said appropriations and contributions is normally obtained upon receipt of cash.

An exception to the above is when appropriations remain unspent at year-end. In this case, the authority to spend the money lapses and generally the unspent amount must be repaid to the Consolidated Fund in the following financial year. As a result, unspent appropriations are accounted for as liabilities rather than revenue. The office had no such liability in the 2002/2003 reporting year.

(ii) Sale of goods and services

Revenue from the sale of goods and services comprises revenue from the provision of products or services ie user charges, sale of publications/reports etc. These are recognised as revenue when the office obtains control of the assets that result from them.

(iii) Investment income

Interest revenue is recognised as it accrues.

(d) Employee benefits and other provisions

(i) *Salaries and wages, annual leave, sick leave and on-costs*

Liabilities for salaries and wages (including non-monetary benefits), annual leave and vesting sick leave are recognised and measured in respect of employees' services up to the reporting date at nominal amounts based on the amounts expected to be paid when the liability are settled.

Unused non-vesting sick leave does not give rise to a liability, as it is not considered probable that sick leave taken in the future will be greater than the entitlements accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(ii) Accrued salaries and wages reclassification

As a result of the adoption of Accounting Standard AASB 1044 "Provisions, Contingent Liabilities and Contingent Assets", accrued salaries and wages and on-costs has been reclassified to "payables" instead of "provisions" in the Statement of Financial Position and the related note disclosures, for the current and comparative period. On the face of the Statement of Financial Position and in the notes, reference is now made to "provisions" in place of "employee entitlements and other provisions". Total employee benefits (including accrued salaries and wages) are reconciled in Note 13 "Provisions".

Ombudsman's office

Notes to the Financial Statements For the Year Ended 30 June 2003

(ii) Long service leave and superannuation

The office's liabilities for long service leave and superannuation are assumed by the Crown Entity. The office accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of employee benefits and other liabilities".

Long service leave is measured on a short-hand basis. The nominal method is based on the remuneration rates at year-end for all employees with five or more years of service. It is considered that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurer's Directions. The expense for certain superannuation schemes (ie Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

(e) Insurance

The office's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for government agencies. The expense (premium) is determined by the Fund Manager based on past experience.

(f) Accounting for the goods and services tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where:

- the amount of GST incurred by the office as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the acquisition of an asset or as part of an item of expense.
- receivables and payables are stated with the amounts of GST included.

(g) Acquisition of assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the office. Cost is determined as the fair value of the assets given as consideration plus the costs incidental to the acquisition. Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition. (See also assets transferred as a result of an administrative restructure (Note 17)).

Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction. Where settlement of any part of cash consideration is deferred, the amounts payable in the future are discounted to their present value at the acquisition date. The discount rate used is the incremental borrowing rate, being the rate at which a similar borrowing could be obtained.

(h) Plant and equipment

Plant and equipment costing $5000 and above individually are capitalised.

(i) Revaluation of physical non-current assets

Physical non-current assets are valued in accordance with the "Guidelines for the Valuation of Physical Non-Current Assets at Fair Value" (TPP 03-02). This policy adopts fair value in accordance with AASB 1041 from financial years beginning on or after 1 July 2002. There is no substantive difference between the fair value valuation methodology and the previous valuation methodology adopted in the NSW public sector.

Where available, fair value is determined having regard to the highest and best use of the asset on the basis of current market selling prices for the same or similar assets. Where market selling price is not available, the asset's fair value is measured as its market buying price ie the replacement cost of the asset's remaining future economic benefits. The agency is a not for profit entity with no cash generating operations.

Each class of physical non-current assets is revalued every five years and with sufficient regularity to ensure that the carrying amount of each asset in the class does not differ materially from its fair value at reporting date. As yet, no revaluation of assets under this guideline has occurred.

(j) Depreciation/amortisation of non-current physical assets

Depreciation/amortisation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the office.

All material separately identifiable component assets are recognised and depreciated over their shorter useful lives, including those components that in effect represent major periodic maintenance.

Depreciation/amortisation rates used are:

Computer equipment	33.33%
Office equipment	20.00%
Furniture & fittings	10.00%
Leasehold improvements	Life of Lease Contract

The Community Services Commission used different depreciation rates for its assets as follows:

Computer hardware	25.00%
Computer software	20.00%
Office equipment	25.00%

The office has continued to use those rates for those assets transferred from the Commission upon its abolition.

(k) Maintenance and repairs

The costs of maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

(l) Leased assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits. Where a non-current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the inception of the lease. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the Statement of Financial Performance in the periods in which they are incurred. Lease incentives received on entering non-cancellable operating leases are recognised as a lease liability. This liability is reduced on a straight-line basis over the lease term.

(m) Receivables

Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectable debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred.

(n) Other financial assets

"Other financial assets" are generally recognised at cost.

(o) Other assets

Other assets including prepayments are recognised on a cost basis.

(p) Equity transfers

The transfer of net assets between agencies as a result of an administrative restructure, transfers of programs/functions and parts thereof between NSW public sector agencies are designated as a contribution by owners by NSWTC 01/11 and are recognised as an adjustment to "Accumulated Funds". This treatment is consistent with Urgent Issued Group Abstract UIG 38 "Contributions by Owners Made to Wholly Owned Public Sector Entities".

Transfers arising from an administrative restructure between government departments are recognised at the amount at which the asset was recognised by the transferor government department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

(q) Payables

These amounts represent liabilities for goods and services provided to the Office and other amounts, including interest. Interest is accrued over the period it becomes due.

(r) Budgeted amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year and with any adjustments for the effects of additional appropriations, s 21A, s24 and/or s26 of the Public Finance and Audit Act 1983.

The budgeted amounts in the Statement of Financial Performance and the Statement of Cash Flows are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Statement of Financial Position, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward amounts per the audited financial statements (rather than carried forward estimates).

2	Expenses	2003 $'000	2002 $'000
(a)	**Employee related expenses**		
	Salaries and wages (including recreation leave)	9,772	7,355
	Superannuation	843	595
	Long service leave	318	284
	Workers compensation insurance	68	37
	Payroll tax and fringe benefit tax	641	509
	Payroll tax on superannuation	49	37
		11,691	8,817
(b)	**Other operating expenses**		
	Auditors remuneration – audit or review of the financial reports	21	18
	Operating lease rental expenses – minimum lease payments	1,643	837
	IT Leasing - minimum lease payments	207	130
	Insurance	15	12
	Consultants	12	20
	Fees	688	406
	Telephones	134	112
	Stores	243	128
	Training	109	91
	Printing	44	114
	Travel	232	91
	Books, periodicals and subscriptions	44	46
	Advertising	31	27
	Energy	36	28
	Motor vehicle	29	21
	Postal and courier	32	17
	Other	78	0
		3,598	2,098
(c)	**Depreciation and amortisation expenses**		
	Depreciation		
	Plant and equipment	394	221
	Amortisation		
	Plant and equipment	120	46
		514	267

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

3	Revenues	2003 $'000	2002 $'000
(a)	**Sale of goods and services**		
	Sale of Publications	5	15
	Other	2	14
		7	29
(b)	**Investment income**		
	Bank interest	41	38
		41	38
(c)	**Grants and contributions**		
	Police complaints case management (PCCM)	710	743
	Review of the Children (Criminal Proceedings) Act	38	0
	Trainee salary subsidy (ATS/career start)	0	6
		748	749

Conditions on contributions

The Ombudsman's participation in the PCCM project is funded by a grant from the Premier's Department. Although this grant is recognised as retained revenue, the Ombudsman has limited discretion over its use as it is solely for the purposes of the PCCM project. The Ombudsman is required to provide expenditure details to the PCCM Steering Committee to ensure that funds are appropriately spent.

(d)	**Other revenue**		
	Workshops and conferences	53	82
		53	82

4	Gain/(loss) on disposal of non-current assets		
	Gain/(loss) on disposal of plant and equipment and infrastructure systems		
	Proceeds from disposal	6	1
	Written down value of assets disposed	0	0
	Gain on sale of non current assets	6	1

5	Appropriations	2003 $'000	2002 $'000
(a)	**Recurrent appropriations**		
	Total recurrent drawdowns from Treasury (per Summary of Compliance)	13,599	9,611
		13,599	9,611
	Comprising:		
	Recurrent appropriations(per Statement of Financial Performance)	13,599	9,611
	Total	**13,599**	**9,611**
(b)	**Capital appropriations**		
	Total capital drawdowns from Treasury (per Summary of Compliance)	1,097	358
		1,097	358
	Comprising:		
	Capital appropriations (per Statement of Financial Performance)	1,097	358
	Total	**1,097**	**358**

6 Acceptance by the crown entity of employee entitlements and other liabilities

The following liabilities and/or expenses have been assumed by the Crown Entity or other government agencies

Superannuation	843	595
Long service leave	318	284
Payroll tax	49	37
	1,210	916

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

7 PROGRAMS/ACTIVITIES OF THE AGENCY

(a) Program 1: Resolution of complaints about police

Objectives:
Oversight and scutinise the handling of complaints about the conduct of police. Promote fairness, integrity and practical reforms in the NSW Police Service

Description:
Keep under scutiny Police Service systems, investigate complaints, report and make recommendations for change

(b) Program 2: Resolution of local government, public authority and prison complaints and review of freedom of information complaints

Objectives:
Resolve justified complaints and protected disclosures about the administrative conduct of public authorities and local councils. Promote fairness, integrity and practical reforms in New South Wales public administration

Description
Conduct investigations, audits and monitoring activities. Report and make recommendations for change

(c) Program 3: Resolution of child protection related complaints

Objectives:
Scrutiny of complaint handling systems and monitoring of the handling of notifications of alleged child abuse

Description:
Keep under scrutiny systems in place to prevent and investigate allegations of child abuse, investigate complaints, make recommendations for change.

(d) Program 4: Resolution of complaints about and the oversight of the provision of community services.

Objectives
Provide for independent monitoring of community services and programs, keep under scrutiny complaint handling systems and provide for and encourage the resolution of complaints. Review the deaths of certain children and people with a disability to formulate recommendations for the prevention or reduction of deaths of children in care, children at risk of death due to abuse or neglect, children in detention and correctional centres or disabled people in residential care

Description:
Monitoring of, and providing for resolution of complaints about, community services and programs. Reviewing the causes of death of certain children and persons with a disability. Reporting and making recommendations for change. Program 4 was transferred to the Office on 1 December 2002 following the abolition of the Community Services Commission. The following summarises the expenses and revenues, recognised by the Community Services Commission up to the date of abolition and by the office from the date of transfer to year end, for the reporting period.

	CSC* Jul 02 -Nov 02	Office# Dec 02 -Jun 03	2003 Program	2002 Program
Expenses				
Operating expenses				
Employee related	1,278	2,126	3,404	3,014
Other operating expenses	457	770	1,227	1,065
Maintenance	8	13	21	25
Depreciation and amortisation	34	78	112	73
Total Expenses	**1,777**	**2,987**	**4,764**	**4,177**
Retained Revenue				
Sale of goods and services	(12)		(12)	(17)
Investment income	(5)	(7)	(12)	(14)
Other revenue		(8)	(8)	
Total Retained Revenue	**(17)**	**(15)**	**(32)**	**(31)**
Gain / (loss) on disposal of non-current assets		(87)	(87)	
Net Cost of Services	**1,760**	**2,885**	**4,645**	**4,146**

** CSC = Community Services Commission*
 # Office = Ombudsman's Office

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

8 Current assets - cash	2003 $'000	2002 $'000
Cash at bank and on hand	1,224	729
	1,224	729

For the purposes of the Statement of Cash Flows, cash includes cash on hand and at bank.

Cash assets recognised in the Statement of Financial Position are reconciled to cash at the end of the financial year as shown in the Statement of Cash Flows as follows:

Cash (per Statement of Financial Position)	1,224	729
Closing cash and cash equivalents (per Statement of Cash Flows)	1,224	729

9 Current assets - receivables		
Transfer of leave	23	
Workshops	18	
Sale of goods and services	6	6
Bank interest	22	19
Gst receivable	97	91
	166	116

Management considers all amounts to be collectable and as such, no provision for doubtful debts has been established

10 Current assets - other assets	2003 $'000	2002 $'000
Prepayments		
Salaries and wages	12	
Maintenance	73	50
Prepaid rent	114	113
Subscription/Membership	10	10
Training	8	2
Motor Vehicle	1	1
Employee assistance program	11	
IT Leasing	39	16
Other	4	
	272	192

11 Non-current assets - plant and equipment		
At cost	5,006	3,448
Accumulated depreciation at cost	(1,912)	(1,464)
Total plant and equipment at net book value	3,094	1,984

Reconciliations

Reconciliations of the carrying amounts of each class of plant and equipment at the beginning and end of the current and previous financial years are set out below

	Plant & equipment		Total	
2003	**2003 $'000**	**2002 $'000**	**2003 $'000**	**2002 $'000**
Carrying amount at start of year	1,984	1,172	1,984	1,172
Additions	1,571	1,079	1,571	1,079
Acquisitions through administrative restructuring	111		111	
Disposals	(122)	(17)	(122)	(17)
Depreciation/amortisation for the year	(514)	(267)	(514)	(267)
Depreciation/amortisation writeback on disposal	122	17	122	17
Other - adjustment to accumulated depreciation – administrative restructuring	(58)	16	(58)	16
Carrying amount at end of year	**3,094**	**2,000**	**3,094**	**2,000**

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

12 Current liabilities - payables

	2003 $'000	2002 $'000
Trade creditors	469	71
Accrued salaries	350	167
Payroll tax	0	11
Fringe benefit tax	2	2
Superannuation	0	11
	821	262

13 Current liabilities - employee entitlements

Recreation leave	846	541
Annual leave loading	140	78
Payroll tax on recreation and long service leave	163	103
Workers compensation on recreation leave	7	5
Aggregate employee entitlements	1,156	727

14 Current liabilities - other

Department of Juvenile Justice Advance payment review of Section 19 of the Children(criminal proceedings) Act	50	78
Lease incentive	34	34
	84	112

15 Non-current liabilities - other

Department of Juvenile Justice Advance payment review of Section 19 of the Children(criminal proceedings) Act	113	122
Lease incentive	181	215
	294	337

16 Changes in equity

	2003 $'000	2002 $'000
Balance at the beginning of the financial year	1,583	1,164
Increase in net assets from equity transfers	(65)	0
Surplus for the year	883	419
Balance at the end of the financial year	2,401	1,583

17 Increase in net assets from equity transfers

Responsibilty assumed for Community Services Commission (CSC)

Assets transferred from CSC

Cash	234
Receivables	6
Other	19
Plant & equipment	53
	312

Liabilities transferred from CSC

Payables	54
Provisions	323
	377
Increase in net assets from administrative restructuring	(65)

18 Commitments for expenditure

Operating lease commitments

Future non-cancellable operating lease rentals not provided for and payable		
Not later than one year	1,735	1,527
Later than one year and not later than five years	6,194	5,732
Later than five years	1,836	1,778
Total (including GST)	9,765	9,037

Operating lease payments are charged to the statement of financial performance in the periods in which they are incurred.The total operating lease commitments of $9,765,000 includes GST input tax credits of $888,000 that are expected to be recoverable from the Australian Tax Office.

Ombudsman's Office

Notes to the Financial Statements For the Year Ended 30 June 2003

19 Reconciliation of cash flows from operating activites to net cost of services

	2003 $'000	2002 $'000
Net cash used on operating activities	1,826	995
Cash flows from government / appropriations	(15,316)	(9,969)
Acceptance by the Crown Entity of employee benefits and other liabilities	(590)	(916)
Depreciation	(514)	(267)
Decrease/(increase) in provisions	(105)	(99)
Increase/(decrease) in receivables	44	16
Increase/(decrease) in prepayments and other assets	60	(75)
Decrease/(increase) in creditors	(505)	13
Decrease/(increase) in other liabilities	71	(165)
Net gain (loss) on sale of non-current assets	6	1
Net cost of services	(15,023)	(10,466)

20 Restricted assets

	2003 $'000	2002 $'000
Police Complaints Case Management system funds	0	0
Department of Juvenile Justice	163	201
	163	201

The Ombudsman received funding of $200,585 in the form of an advance payment from the Department of Juvenile Justice to cover the costs of the Ombudsman's review of the operation and effect of Sect 19 of the Children (Criminal Proceedings) Act for the financial years to June, 2005.At year end, $163,000 were unspent, the project is to continue for a further two years.

21 Budget review

Net cost of services

There was a variation of $3.2m between the budgeted net cost of services and actual. This variation was largely due to the Community Services Commission (CSC) amalgamating with the Ombudsman on 1 December 2002. The unspent portion of the CSC budget was transferred to the Ombudsman. In addition, funding was provided to the Ombudsman to review a range of police powers.

Assets and Liabilities

Current assets were larger than budget. The CSC's cash reserves of $234,000 were transferred to the Ombudsman. Receivables and prepayments were also larger than budget. Non current assets increased mainly due to funding being provided to integrate the CSC into the Ombudsman's office. Liabilities have increased compared to budget. Employee provisions are higher as a result of the Ombudsman accepting responsibility for the entitlements of CSC staff.

Cash flows

Cash flows are higher than budget mainly due to the additional expenses associated with the CSC amalgamating with the Ombudsman.

End of audited financial documents

Appendices

Appendix A: Police complaints profile

Category	Declined	Adverse finding	No adverse finding	Conciliated/ other	Total
Abuse/rudeness					
Other	113	13	92	28	246
Other social prejudice	11	0	6	0	17
Racist	14	1	15	4	34
Traffic Rudeness	21	0	4	6	31
Total	159	14	117	38	328
Admin wrong conduct					
Cell/premises conditions	1	0	0	0	1
Child abuse related	0	0	0	1	1
Deficient investigation	13	21	6	0	40
Deficient management	18	54	16	2	90
Delay in correspondence	3	0	0	0	3
Inappropriate permit/license	3	0	0	0	3
Other	26	7	29	4	66
Summons/warrant/order	5	2	1	2	10
Whistleblower	1	0	2	0	3
Total	70	84	54	9	217
Assault					
No physical/mental injury	13	3	50	0	66
Physical/mental injury	107	26	269	4	406
Total	120	29	319	4	472
Breach of rights					
Fail provide/delay	30	6	54	7	97
Fail return property	35	2	18	4	59
Unreasonable treatment	85	16	118	44	263
Total	150	24	190	55	419
Criminal conduct					
Bribery/extortion	67	1	34	2	104
Consorting	25	10	68	0	103
Conspiracy/cover up	78	11	103	3	195
Dangerous/culpable driving	6	3	1	0	10
Drug offences	38	10	67	0	115
Fraud	9	4	13	0	26
Murder/manslaughter	3	0	2	0	5
Other	34	11	49	1	95
Perjury	31	1	22	0	54
Sexual assault	12	6	30	0	48
Telephone tapping	1	0	0	0	1
Theft	48	5	66	0	119
Total	352	62	455	6	875

Appendix A: Police complaints profile (continued)

Category	Declined	Adverse finding	No adverse finding	Conciliated/ other	Total
Inadvertent wrong treatment					
Admin matter arising	1	0	0	0	1
Property damage	5	2	12	1	20
Total	6	2	12	1	21
Information					
Fail notify/give information	42	32	64	11	149
Inappropriate access to information	13	46	57	1	117
Inappropriate disclosure of information	62	17	120	12	211
Provide false information	43	42	60	9	154
Total	160	137	301	33	631
Investigator/prosecution misconduct					
Disputes traffic infringement notice	86	0	3	0	89
Fabrication	66	3	32	0	101
Fail review prosecute	1	0	0	0	1
Fail to prosecute	35	15	32	12	94
Faulty invest/prosecution	257	69	128	41	495
Forced confession	3	0	0	0	3
Suppress evidence	9	3	5	0	17
Unjust prosecution (non-traffic)	16	0	11	4	31
Total	473	90	211	57	831
Other misconduct					
Breach police regulations	53	233	135	6	427
Drink on duty	4	5	8	0	17
Fail to identify/wear number	9	0	10	2	21
Fail to take action	182	27	92	53	354
Faulty policing	6	1	2	2	11
Misuse office	16	17	51	5	89
Other	37	14	17	6	74
Sexual harassment	1	8	9	3	21
Threats/harassment	176	23	201	49	449
Traffic/parking	14	21	23	6	64
Total	498	349	548	132	1527
Stop/search/seize					
Faulty search warrant	3	1	11	0	15
Strip search	5	1	5	1	12
Unjust search/entry	28	2	27	13	70
Unnecessary force/damage	22	2	101	16	141
Unreasonable arrest/detention	39	5	68	15	127
Total	97	11	212	45	365
Summary of allegations					
Total	2085	802	2419	380	5686

Appendix B: Summary total of complaint determinations*

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Departments and Authorities	111	24	128	136	134	126	10	114	258	24	160	70	2	0	1	1	5	1304
Freedom of Information	16	2	4	5	1	3	0	9	34	6	57	2	0	3	0	0	3	145
Prisons	14	2	10	46	50	33	4	34	62	20	29	21	0	0	1	0	0	326
Local government	19	16	91	90	75	59	5	136	158	8	82	50	0	0	0	2	0	791
Outside jurisdiction	558	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	558
Total	718	44	233	277	260	221	19	293	512	58	328	143	2	3	2	3	8	3142

** excludes complaints about NSW police, complaints received under Part 3A of the Ombudsman Act (child protection function) and complaints received after 1 December 2002 about community services*

Key

Assessment Only

1 Outside Jurisdiction

2 Trivial/remote/insufficient interest/commercial matter

3 Right of appeal or redress

4 Substantive explaination or advice provided

5 Premature, referred to agency

6 Investigation declined on resource/priority grounds/ concurrent representation

7 Premature, second tier review referral

Preliminary or informal investigations

8 Substantive advice, information provided without formal finding of wrong conduct

9 Advice/explanation provided where no or insufficient evidence of wrong conduct

10 Further investigation declined on grounds of resource/priority

11 Resolved to Ombudsman's satisfaction

12 Resolved by agency prior to our intervention

13 Concilliated/mediated

Formal investigations

14 Resolved during investigation

15 Investigation discontinued

16 No adverse finding

17 Adverse finding

18 Total

Appendix C: Public sector agencies – Summary of complaint determinations*

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Aboriginal Housing Office	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Adult & Community Education, Board Of	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Ambulance Service Of NSW	3	0	0	1	1	1	1	0	3	0	0	1	0	0	0	0	0	11
Anti-Discrimination Board	0	0	0	3	1	0	0	4	0	1	0	0	0	0	0	0	1	10
Attorney General's Department	5	0	0	2	0	0	0	1	2	0	0	0	0	0	0	0	1	11
Australian Music Examinations Board	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Board of Studies	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	3
Central Coast Area Health Service	0	0	1	0	0	2	0	0	1	0	0	0	0	0	0	0	0	4
Central Sydney Area Health Service	1	0	3	0	2	0	0	0	1	0	0	0	0	0	0	0	0	7
Charles Sturt University	0	0	0	0	0	3	0	0	2	0	0	1	0	0	0	0	0	6
Consumer, Trader & Tenancy Tribunal	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Country Energy	0	2	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Cowra Local Aboriginal Land Council	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Crime Commission	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Dental Board of Nsw	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Department of Aboriginal Affairs	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2
Department of Ageing, Disability & Home Care (until 1/12/2002)	2	0	0	1	0	0	0	2	1	0	2	1	0	0	0	0	0	9
Department of Agriculture	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	3
Department of Commerce	1	0	1	1	1	1	0	1	2	0	3	0	0	0	0	0	0	11
Department of Community Services (until 1/12/2002)	10	2	4	4	10	8	1	17	38	2	17	6	0	0	0	0	0	119
Department of Education And Training	20	2	2	10	13	9	0	6	15	2	7	6	0	0	0	0	0	92
Department of Fair Trading	5	0	2	1	6	2	0	8	2	0	1	0	0	0	0	0	0	27
Department of Gaming & Racing	1	0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	0	4
Department of Health	3	0	4	2	2	2	0	0	5	0	2	1	0	0	0	0	0	21
Department of Housing	4	3	9	7	20	18	5	15	29	3	27	14	0	0	0	0	0	154
Department of Industrial Relations	0	0	0	1	0	0	0	0	3	0	0	0	0	0	0	0	0	4
Department of Information Technology & Management	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	3
Department of Land And Water Conservation	2	1	1	3	4	6	1	3	4	0	0	1	0	0	0	0	0	26
Department of Lands	1	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	4
Department of Local Government	0	0	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0	4
Department of Mineral Resources	0	0	0	0	0	0	0	1	0	0	3	1	0	0	0	0	0	5
Department of Public Works And Services	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Department of Sport And Recreation	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Department of State And Regional Development	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Sustainable Natural Resources	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Department of Transport	0	0	0	4	0	1	0	1	6	0	2	3	0	0	0	0	0	17
Department of Urban & Transport Planning	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	2
Director Public Prosecutions	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Dust Diseases Board	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Energy Australia	0	1	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Environment Protection Authority	0	0	1	2	0	0	0	2	2	0	1	1	0	0	0	0	0	9
Fire Brigades, NSW	3	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5

Appendix C: Public sector agencies – summary of complaint determinations (continued)

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
First State Superannuation Trustee Corporation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Greater Murray Health Service	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	2
Greyhound Racing Authority	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Guardianship Tribunal	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Health Care Complaints Commission	0	0	0	0	0	1	1	0	4	0	1	0	0	0	0	0	0	7
Healthquest	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Heritage Council of NSW	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Heritage Office	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Housing Appeals Committee	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Hunter Area Health Service	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	4
Hunter Water Corporation Limited	0	0	1	2	0	0	0	1	0	0	0	0	0	0	0	0	0	4
Illawarra Area Health Service	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Illawarra Local Aboriginal Land Council	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Independent Commission Against Corruption	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Infringement Processing Bureau	0	0	16	11	7	10	0	6	18	0	28	10	0	0	0	0	0	106
Integral Energy	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Jali Local Aboriginal Land Council	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Land & Property Information NSW	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Legal Aid Commission	2	0	5	2	2	0	0	0	2	0	3	0	0	0	0	0	0	16
Lord Howe Island Board	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Macquarie Area Health Service	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Macquarie University	0	1	0	0	0	2	0	0	3	1	0	0	0	0	0	0	0	7
Medical Appeals Board	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Mid North Coast Area Health Service	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Mid Western Area Health Service	1	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	4
Mine Subsidence Board	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Motor Accidents Authority	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Museum of Applied Arts & Sciences	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
National Parks & Wildlife Service	2	0	0	2	2	0	0	1	3	0	3	2	0	0	0	0	0	15
National Parks Service	2	1	1	0	0	0	0	0	4	0	1	0	0	0	0	0	0	9
New England Area Health Service	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	4
Northern Rivers Area Health Service	1	0	3	0	0	2	0	0	1	1	0	0	0	0	0	0	0	8
Northern Sydney Area Health Service	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
NSW Aboriginal Land Council	0	0	0	0	0	1	0	0	0	3	1	0	0	0	0	0	0	5
NSW Fisheries	1	0	1	0	2	1	0	1	2	1	1	0	0	0	0	0	0	10
NSW Lotteries	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
NSW Medical Board	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Office of State Revenue	2	0	2	7	0	0	0	0	7	0	6	0	0	0	0	0	0	24
Pacific Power	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3
Pillar Administration	1	0	0	1	0	0	0	2	2	0	2	2	0	0	0	0	0	10
Planning NSW	1	0	0	2	1	1	0	7	3	0	2	0	0	0	0	0	0	17
Premier's Department	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Privacy NSW	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	2
Protective Commissioner	5	0	0	1	1	2	0	1	2	0	1	0	0	0	0	0	0	13
Psychologists Registration Board	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Public Guardian	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Public Trustee	3	0	0	0	2	0	0	0	1	0	4	0	0	0	0	0	0	10
Rail Infrastructure Corporation	0	0	0	1	0	1	0	1	3	1	0	0	0	0	0	0	0	7
Registrar of Aboriginal Land Rights Act	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Registry of Births, Deaths And Marriages	0	0	0	0	1	0	0	1	0	0	3	2	0	0	0	0	0	7
Rental Bond Board	0	0	0	0	1	0	0	0	1	0	1	0	0	0	0	0	0	3
Roads And Traffic Authority	3	1	11	10	20	12	0	7	9	1	8	4	0	0	0	0	0	86

Appendix C: Public sector agencies – summary of complaint determinations (continued)

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Rural Assistance Authority	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	3
Rural Fire Service	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0	0	3
Rural Lands Protection Board	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	3
Sheriffs Office	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
South Eastern Sydney Area Health Service	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
South Western Area Health Service	0	0	0	0	2	2	0	0	1	0	0	0	0	0	0	0	0	5
Southern Area Health Service	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2
Southern Cross University	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	2
State Authorities Superannuation Trustee Corporation	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
State Contracts Control Board	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
State Debt Recovery Office	0	0	15	19	5	7	0	8	14	1	10	5	0	0	0	0	0	84
State Electoral Office	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
State Emergency Service	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
State Forests	0	0	0	0	1	1	1	0	1	0	0	0	0	0	0	0	0	4
State Library of NSW	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
State Rail Authority of NSW	0	3	3	10	4	4	0	2	3	0	5	5	1	0	0	0	0	40
State Rescue Board of NSW	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
State Transit Authority of NSW	0	0	0	2	2	3	0	0	4	0	4	1	1	0	0	0	1	18
State Valuation Office	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Sydney Catchment Authority	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Cricket & Sports Ground Trust	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Harbour Foreshore Authority	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Sydney Opera House	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Ports Corporation	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Water Corporation	0	1	5	0	0	0	0	3	2	0	0	0	0	0	0	0	0	11
Transport Co-ordination Authority	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
University of New England	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
University of New South Wales	0	0	0	3	1	1	0	0	2	1	1	0	0	0	0	0	0	9
University of Newcastle	0	1	0	1	0	2	0	0	1	0	0	0	0	0	0	0	1	6
University of Sydney	1	1	1	4	2	1	0	0	2	0	0	0	0	0	0	0	0	12
University of Technology	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
University of Western Sydney	1	0	0	0	0	1	0	0	2	0	2	0	0	0	0	0	0	6
University of Wollongong	1	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	3
Upper Hunter Weeds Authority	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Valuer General	0	0	2	0	1	1	0	0	1	2	0	0	0	0	0	0	0	7
Vocational Education Training & Accreditation Board	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Waterways Authority	1	0	0	0	1	0	0	3	2	0	0	0	0	0	0	1	0	8
Wentworth Area Health Service	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Western Sydney Area Health Service	1	1	2	0	2	0	0	0	1	0	0	0	0	0	0	0	0	7
Workcover Authority	2	0	1	2	2	3	0	1	6	0	1	0	0	0	0	0	0	18
Total	111	24	128	136	134	126	10	114	258	24	160	70	2	0	1	1	5	1304

**This table shows the determinations made in relation to complaints about all public sector agencies other than NSW police, local councils, the Department of Corrective Services, the Department of Juvenile Justice, the Corrections Health Service, and excluding FOI complaints and complaints made under part 3A of the Ombudsman Act (child protection).*

For Key see Appendix B.

Appendix D: Local councils – Summary of complaint determinations

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Albury City Council	0	0	1	0	0	0	0	1	2	0	0	0	0	0	0	0	0	4
Armidale Dumaresq Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Ashfield Municipal Council	0	0	0	1	0	2	0	3	2	0	0	0	0	0	0	0	0	8
Auburn Council	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Ballina Shire Council	0	0	2	0	0	2	0	1	1	0	0	0	0	0	0	0	0	6
Bankstown City Council	0	0	0	0	1	0	0	3	1	1	0	1	0	0	0	0	0	7
Bathurst City Council	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	3
Baulkham Hills Shire Council	1	0	1	1	1	0	0	3	4	0	0	0	0	0	0	0	0	11
Bega Valley Shire Council	0	0	1	0	0	0	0	1	0	2	0	1	0	0	0	0	0	5
Bellingen Shire Council	0	0	1	2	1	0	0	1	1	1	1	0	0	0	0	0	0	8
Blacktown City Council	0	0	1	2	1	1	0	1	3	0	0	0	0	0	0	0	0	9
Bland Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Blayney Shire Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Blue Mountains City Council	0	1	2	1	1	0	0	3	3	0	0	0	0	0	0	0	0	11
Bombala Shire Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Botany Bay City Council	0	0	0	1	0	0	1	0	0	0	2	0	0	0	0	0	0	4
Bourke Shire Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Broken Hill City Council	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Burwood Municipal Council	0	0	0	0	0	1	0	2	1	0	0	2	0	0	0	0	0	6
Byron Shire Council	0	0	0	1	1	0	0	4	1	0	1	1	0	0	0	0	0	9
Camden Council	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	3
Campbelltown City Council	0	0	1	2	1	0	0	1	0	0	0	0	0	0	0	0	0	5
Canada Bay Council	1	0	3	3	2	0	0	1	1	0	1	0	0	0	0	0	0	12
Canterbury City Council	0	0	4	1	0	1	0	1	1	0	2	1	0	0	0	0	0	11
Carrathool Shire Council	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	3
Central Tablelands Water	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Cessnock City Council	1	0	0	0	2	0	0	3	3	0	0	0	0	0	0	0	0	9
Coffs Harbour City Council	0	0	1	1	1	0	0	2	4	0	1	0	0	0	0	0	0	10
Coolah Shire Council	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Cooma-monaro Shire Council	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Coonamble Shire Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cootamundra Shire Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Copmanhurst Shire Council	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Corowa Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Council Not Named	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Dungog Shire Council	0	0	0	0	0	1	0	2	1	0	0	0	0	0	0	0	0	4
Eurobodalla Shire Council	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	3
Fairfield City Council	0	0	0	2	1	0	0	1	1	0	2	0	0	0	0	0	0	7
Far North Coast County Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Glen Innes Municipal Council	0	1	0	1	0	1	0	0	0	0	1	0	0	0	0	0	0	4
Gloucester Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Goldenfields Water County Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Gosford City Council	1	0	2	1	4	2	0	5	3	0	3	2	0	0	0	0	0	23
Goulburn City Council	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Great Lakes Council	0	0	1	1	1	0	0	1	2	1	0	1	0	0	0	0	0	8

Appendix D: Local councils – Summary of complaint determinations (continued)

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Greater Taree City Council	0	0	4	3	1	1	0	1	1	0	1	1	0	0	0	0	0	13
Griffith City Council	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	2
Gunnedah Shire Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Gunning Shire Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Guyra Shire Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Hastings Council	0	0	0	0	0	1	0	0	3	0	2	0	0	0	0	0	0	6
Hawkesbury City Council	0	2	1	0	0	1	1	1	3	0	1	1	0	0	0	0	0	11
Holroyd City Council	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	4
Hornsby Shire Council	0	0	2	2	1	0	0	3	1	0	3	0	0	0	0	0	0	12
Hunters Hill Municipal Council	0	0	0	0	1	1	0	0	1	0	2	0	0	0	0	0	0	5
Hurstville City Council	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	3
Inverell Shire Council	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Kempsey Shire Council	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2
Kiama Municipal Council	0	0	0	0	0	2	0	0	1	0	2	0	0	0	0	0	0	5
Kogarah Municipal Council	0	1	0	2	2	0	0	1	2	0	1	1	0	0	0	0	0	10
Ku-ring-gai Municipal Council	0	1	2	0	1	0	0	3	3	0	1	2	0	0	0	0	0	13
Kyogle Shire Council	0	0	1	0	0	0	0	1	1	0	1	0	0	0	0	0	0	4
Lake Macquarie City Council	0	1	1	5	2	1	0	5	3	0	3	1	0	0	0	0	0	22
Lane Cove Municipal Council	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Leichhardt Municipal Council	1	0	1	1	0	0	0	1	1	0	2	1	0	0	0	0	0	8
Lismore City Council	0	1	0	0	2	0	0	2	2	0	0	3	0	0	0	0	0	10
Lithgow City Council	0	0	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0	3
Liverpool City Council	0	0	2	0	1	1	0	1	1	0	3	1	0	0	0	0	0	10
Maclean Shire Council	0	0	2	1	0	0	0	1	1	0	0	0	0	0	0	0	0	5
Maitland City Council	0	0	1	1	0	1	1	5	2	0	0	0	0	0	0	0	0	11
Manilla Shire Council	0	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	3
Manly Council	0	0	3	2	1	1	0	1	3	0	5	2	0	0	0	0	0	18
Marrickville Council	0	2	1	2	1	1	0	3	2	0	3	1	0	0	0	0	0	16
Merriwa Shire Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Mid Coast County Council	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Mid-western County Council	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Mosman Municipal Council	0	0	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	3
Mudgee Shire Council	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2
Mulwaree Shire Council	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	3
Murray Shire Council	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Muswellbrook Shire Council	0	0	0	0	1	0	0	3	0	0	0	0	0	0	0	0	0	4
Nambucca Shire Council	0	0	0	0	2	1	0	0	2	0	1	1	0	0	0	0	0	7
Narrabri Shire Council	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Narrandera Shire Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Newcastle City Council	2	0	2	1	2	1	0	3	1	0	0	5	0	0	0	1	0	18
North Sydney Council	1	0	1	2	0	0	0	1	2	0	1	1	0	0	0	0	0	9
Oberon Shire Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Orange City Council	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	2
Parramatta City Council	0	0	2	0	0	0	0	4	3	0	1	2	0	0	0	0	0	12
Parry Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Penrith City Council	0	0	2	2	0	0	0	2	0	0	1	0	0	0	0	0	0	7
Pittwater Council	0	0	2	0	0	1	0	0	4	0	2	0	0	0	0	0	0	9
Port Stephens Shire Council	0	0	0	3	0	0	0	3	5	0	0	0	0	0	0	0	0	11
Principal Certifying Authority	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Pristine Waters Council	0	0	0	1	1	1	0	0	0	0	1	0	0	0	0	0	0	4
Queanbeyan City Council	1	0	1	2	1	0	0	0	1	0	0	0	0	0	0	1	0	7
Randwick City Council	1	0	3	1	4	0	0	6	2	0	2	0	0	0	0	0	0	19
Richmond Valley Council	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Richmond Valley Council	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1

Appendix D: Local councils – Summary of complaint determinations (continued)

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Roads And Traffic Authority	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Rockdale Municipal Council	0	2	2	2	0	0	0	2	1	0	0	1	0	0	0	0	0	10
Ryde City Council	1	0	1	0	0	0	0	2	2	0	0	1	0	0	0	0	0	7
Scone Shire Council	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	2
Shellharbour City Council	1	0	0	1	0	2	0	1	0	0	1	0	0	0	0	0	0	6
Shoalhaven City Council	1	1	1	1	2	4	0	2	5	0	3	0	0	0	0	0	0	20
South Sydney Council	1	0	3	2	3	0	0	4	3	0	4	0	0	0	0	0	0	20
Strathfield Municipal Council	0	0	0	1	2	0	0	3	14	0	2	0	0	0	0	0	0	22
Sutherland Shire Council	0	0	6	2	1	6	1	1	2	0	3	2	0	0	0	0	0	24
Sydney City Council	1	0	1	2	2	1	0	1	4	0	0	0	0	0	0	0	0	12
Tallaganda Shire Council	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	2
Tamworth City Council	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Tumbarumba Shire Council	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Tumut Shire Council	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	3
Tweed Shire Council	0	0	1	0	1	0	0	2	3	0	2	0	0	0	0	0	0	9
Uralla Shire Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Wagga Wagga City Council	0	0	0	0	0	0	0	3	2	0	0	0	0	0	0	0	0	5
Walcha Council	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Walgett Shire Council	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
Warringah Council	0	0	2	0	2	4	0	2	2	1	0	2	0	0	0	0	0	15
Waverley Council	0	0	2	0	2	1	0	1	4	0	1	0	0	0	0	0	0	11
Wellington Council	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wentworth Shire Council	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	2
Willoughby City Council	0	0	5	0	0	2	0	0	4	0	2	0	0	0	0	0	0	13
Wingecarribee Shire Council	0	0	1	0	2	1	0	2	3	0	0	1	0	0	0	0	0	10
Wollondilly Shire Council	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2
Wollongong City Council	1	0	2	0	2	0	0	2	3	0	0	1	0	0	0	0	0	11
Woollahra Municipal Council	0	0	1	1	0	0	0	1	0	0	3	2	0	0	0	0	0	8
Wyong Shire Council	0	0	2	5	1	1	0	1	2	0	0	0	0	0	0	0	0	12
Yarrowlumla Shire Council	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
Yass Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Young Shire Council	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Total	19	16	91	90	75	59	5	136	158	8	82	50	0	0	0	2	0	791

For Key see Appendix B.

Appendix E: Corrections

*Corrections - summary of complaint determinations**

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Agency	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Australasian Correctional Management	0	2	3	2	2	1	1	1	4	2	1	0	0	0	0	0	0	19
Corrections Health Service	1	0	3	3	3	0	0	0	1	2	0	1	0	0	0	0	0	14
Corrective Services Department	10	0	4	40	43	31	2	28	53	15	26	20	0	0	1	0	0	273
Juvenile Justice, Dept Of	3	0	0	1	2	1	1	5	4	1	2	0	0	0	0	0	0	20
Total	14	2	10	46	50	33	4	34	62	20	29	21	0	0	1	0	0	326

For Key see Appendix B.

Complaints received (written and oral) about DJJ and juvenile justice centres by institution

Institution	Written	Oral	Total
Department of Juvenile Justice	6	15	21
Acmena Juvenile Justice Centre	2	19	21
Cobham Juvenile Justice Centre	0	6	6
Frank Baxter Juvenile Justice Centre	3	37	40
Kariong Juvenile Justice Centre	5	42	47
Keelong Juvenile Justice Centre	0	36	36
Orana Juvenile Justice Centre	2	14	16
Reiby Juvenile Justice Centre	0	25	25
Riverina Juvenile Justice	0	23	23
Yasmar Juvenile Justice Centre	5	37	42
Total	23	254	277

Appendix E: Corrections (continued)

Complaints received (written and oral) about correctional centres, DCS and ACM by institution

Institution	Written	Oral	Total
Australasian Correctional Management	1	1	2
Bathurst Correctional Centre	12	97	109
Berrima Correctional Centre	1	4	5
Broken Hill Correctional Centre	2	5	7
Cessnock Correctional Centre	9	41	50
Cooma Correctional Centre	0	17	17
Corrections Health Service	0	0	0
Court Escort/Security Unit	16	11	27
Department Of Corrective Services	1	0	1
Dept Of Corrective Services (DCS)	78	972	1050
Drug Dog Detector Unit	1	1	2
Emu Plains Correctional Centre	0	6	6
Glen Innes Correctional Centre	0	3	3
Goulburn Correctional Centre	16	160	176
Goulburn X Wing	0	10	10
Grafton Correctional Centre	11	94	105
Grafton Correctional Centre C Unit	0	4	4
Ivanhoe "Warakirri" Correctional Centre	0	2	2
John Morony Correctional Centre	10	74	84
Junee Correctional Centre	18	136	154
Kirkconnell Correctional Centre	6	59	65
Lithgow Correctional Centre	9	93	102
Long Bay Hospital	3	46	49
Malabar Special Programs Centre	25	232	257
Mannus Correctional Centre	0	4	4
Metropolitan Medical Transient Centre	16	61	77
Metropolitan Remand Reception Centre	23	120	143
Mulawa Correctional Centre	6	130	136
Norma Parker Correctional Centre	0	1	1
Oberon Correctional Centre	2	1	3
Parklea Correctional Centre	12	89	101
Parramatta Correctional Centre	5	26	31
Parramatta Transitional Centre	0	2	2
Periodic Detention Centres	3	8	11
Probation And Parole Service	5	13	18
Serious Offenders Review Council	0	1	1
Silverwater Correctional Centre	16	45	61
Special Purpose Prison Long Bay	1	7	8
St Heliers Correctional Centre	1	10	11
Tamworth Correctional Centre	4	18	22
Yetta Dhinnakkal (Brewarrina) Correctional Centre	0	2	2
Total	313	2606	2919

** A number of the written complaints and oral inquiries were about more than one centre.*

Appendix F: Freedom of Information – Summary of complaint determinations

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Attorney Generals Department	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	3
Baulkham Hills Shire Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Blacktown City Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Broken Hill City Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Burwood Municipal Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Cabinet Office	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Central Sydney Area Health Service	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Cessnock City Council	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Dental Board of Nsw	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Department of Ageing, Disability & Home Care	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Department of Commerce	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Department of Community Services	1	0	0	0	0	0	0	0	3	0	2	0	0	1	0	0	1	8
Department of Corrective Services	0	0	0	0	0	0	0	0	0	0	3	1	0	0	0	0	0	4
Department of Education And Training	1	0	0	2	0	3	0	1	6	2	5	0	0	0	0	0	1	21
Department of Health	0	0	0	0	0	0	0	0	1	0	2	0	0	0	0	0	0	3
Department of Information Technology & Management	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Department of Juvenile Justice	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Department of Land And Water Conservation	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Minerals & Energy	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Department of State And Regional Development	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Transport	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Environment Protection Authority	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Gosford City Council	0	1	0	0	0	0	0	0	1	0	2	0	0	0	0	0	0	4
Great Lakes Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Greater Taree City Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Greyhound Racing Authority, Nsw	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Hastings Council	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
Health Care Complaints Commission	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Healthquest	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Housing Department	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Inverell Shire Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Kiama Municipal Council	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Kogarah Municipal Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Ku-ring-gai Municipal Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Lake Macquarie City Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Lord Howe Island Board	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Macquarie University	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1	3
Maitland City Council	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Manly Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
National Parks & Wildlife Service	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
North Sydney Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Northern Sydney Area Health Service	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
NSW Fisheries	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
NSW Police	8	0	3	2	1	0	0	0	1	1	9	0	0	2	0	0	0	27

Appendix F: Freedom of Information - summary of complaint determinations (continued)

	Assessment Only							Preliminary or informal investigations						Formal investigations				Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Office Of Protective Commissioner	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pittwater Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Planning Nsw	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Pristine Waters Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Rail Infrastructure Corporation	1	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	3
Rural Lands Protection Board	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Snowy River Shire Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
South Eastern Sydney Area Health Service	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	3
South Sydney Council	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	3
State Rail Authority Of NSW	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	2
State Transit Authority of NSW	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Strathfield Municipal Council	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Sydney City Council	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Sydney Water Corporation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
University Of New England	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
University Of New South Wales	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Uralla Shire Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Waterways Authority	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Wingecarribee Shire Council	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Woollahra Municipal Council	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	16	2	4	5	1	3	0	9	34	6	57	2	0	3	0	0	3	145

For Key see Appendix B.

Appendix G: FOI annual reporting requirements

The following information is provided in accordance with our annual reporting requirements under the *Freedom of Information Act 1989*, the Freedom of Information (General) Regulation 2000 and Appendix B in the NSW Premier's Department 'FOI Procedure Manual'. Under section 9 and Schedule 2 of the FOI Act, the Ombudsman is exempt from the operation of the Act in relation to its complaint handling, investigative and reporting functions. We therefore rarely make a determination under the Act, as most applications we receive, which was the case with all but one application this year, relate to our exempt functions.

Clause 9(1)(a) and (2) of the Regulation and Appendix B of the NSW Premier's Department FOI Procedure Manual

Section A: Numbers of new FOI requests

We received seven new FOI applications in the 2002–2003 year. None from 2001–2002 were brought forward into 2002–2003. All applications were processed and completed and two were withdrawn.

FOI requests		Personal	Other	Total
A1	New (including transferred in)	7	0	7
A2	Brought forward	0	0	0
A3	Total to be processed	7	0	7
A4	Completed	5	0	5
A5	Transferred out	0	0	0
A6	Withdrawn	2	0	2
A7	Total processed	5	0	5
A8	Unfinished (carried forward)	0	0	0

Section B: What happened to completed requests?

Four of the completed applications were for documents which related to the Ombudsman's complaint handling, investigative and reporting functions. In all these matters an explanation of section 9 and our inclusion in Schedule 2 of the FOI Act was provided. In relation to the other application, access was provided to all requested documents.

FOI requests		Personal	Other
B1	Granted in full	1	0
B2	Granted in part	0	0
B3	Refused	0	0
B4	Deferred	0	0
B5	Completed*	5	0

**The figures on the line B5 should be the same as the corresponding ones on A4. All but one of these applications related to functions of the office which are excluded from the operation of the Act.*

Section C: Ministerial certificates

No ministerial certificates were issued in relation to FOI applications to the Ombudsman this year.

Ministerial certificates		No issued
C1	Ministerial Certificates issued	0

Section D: Formal consultations

No requests required consultations, formal or otherwise.

Request requiring formal consultations		Issued	Total
D1	Number of requests requiring formal consultation(s)	0	0

Section E: Amendment of personal records

We received no requests for the amendment of personal records.

Ministerial certificates		No issued
E1	Result of amendment—agreed	0
E2	Result of amendment—refused	
E3	Total	

Section F: Notification of personal records

We received no requests for notations in the period.

Requests for notification		Total
F1	Number of requests for notation	0

Section G: FOI requests granted in part or refused

No decisions to grant access in part or to restrict access were made.

Basis for disallowing or restricting access		Personal	Other
G1	s 19 (application incomplete, wrongly directed)	0	0
G2	s 22 (deposit not paid)	0	0
G3	s 25(1)(a1)(diversion of resources)	0	0
G4	s 25(1)(a) (exempt)	0	0
G5	s 25(1)(b), (c), (d) (otherwise available)	0	0
G6	s 28(1)(b) (documents not held)	0	0
G7	s 24(2)—deemed refused, over 21 days	0	0
G8	s 31(4) (released to Medical Practitioner)	0	0
G9	Total	0	0

Section H: Costs and fees of requests processed during the period

We received four application fees of $30. All four cheques were returned to the applicants.

Request requiring formal consultations		Assessed costs	FOI fees received
H1	All completed requests	$0	$80

Section I: Discounts allowed

No fees were retained and therefore the question of discounts did not arise.

Type of discount allowed		Personal	Other
I1	Public interest	0	0
I2	Financial hardship–Pensioner/Child	0	0
I3	Financial hardship–Non profit organisation	0	0
I4	Totals	0	0
I5	Significant correction of personal records	0	0

Section J: Days to process

All applications were dealt with within 21 days.

Days to process		Personal	Other
J1	0–21 days	5	0
J2	22–35 days	0	0
J3	Over 35 days	0	0
J4	Totals	5	0

Section K: Processing time

All applications were dealt with in 0–10 hours.

Days to process		Personal	Other
K1	0-10 hours	5	0
K2	11-20 hours	0	0
K3	21-40 hours	0	0
K4	Over 40 hours	0	0
K5	Totals	5	0

Section L: Reviews and appeals

No applications proceeded to internal review. Under section 52(5)(d) of the FOI Act we cannot review determinations. No applications were finalised by or indeed proceeded to the Administrative Decisions Tribunal (ADT).

		Total
Internal reviews finalised		
L1	Number of internal reviews finalised	0
Ombudsman reviews finalised		
L2	Number of Ombudsman reviews finalised	0
District Court appeals finalised		
L3	Number of ADT appeals finalised	0

Section L: Details of internal review results

		Personal		Other	
Grounds on which internal review requested		Upheld	Varied	Upheld	Varied
L4	Access refused	0	0	0	0
L5	Deferred	0	0	0	0
L6	Exempt matter	0	0	0	0
L7	Unreasonable charges	0	0	0	0
L8	Charge unreasonably incurred	0	0	0	0
L9	Amendment refused	0	0	0	0
L10	Totals	0	0	0	0

Clause 9(1)(b) and (3) of the Regulation

Dealing with the above matters took very little time and did not impact to a significant degree on our activities during the year. The preparation of our 'Statement of affairs' and 'Summary of affairs' also does not take much time and again could not be said to have impacted to any significant degree on our activities. In terms of clause 9(3)(c), (d) and (e), no major issues arose during the year in connection with our compliance with FOI requirements, and given that there could be no inquiries by us of our own determinations and there were no appeals of our decisions made to ADT, there is no information to give as specified at (d) and (e) of Clause 9.

Appendix H: Legal changes

The following Acts and Regulations had an impact on our functions this year.

Community Services Legislation Amendment Act 2002

The Act commenced on 1 December 2002 and amended the *Community Services (Complaints, Reviews & Monitoring) Act 1993* and the *Ombudsman Act 1974* to provide for the merger of the Community Services Commission (CSC) into the NSW Ombudsman. Please see the chapter on 'Community services' for more details.

Crimes (Administration of Sentences) Amendment Act 2002

Police and correctional officers who capture an escaped inmate must now bring the inmate before an authorised justice 'to be dealt with according to law'. The authorised justice may issue a warrant committing the inmate to custody

There is no longer a requirement that the victim of a serious offence needs the approval of the Parole Board to make an oral submission to the Board when the Board is considering the possible release of the offender on parole.

The Ombudsman is required to monitor the operation of the amended provisions for two years. More details may be found in 'Legislative reviews'.

Crimes (Forensic Procedures) Amendment Act 2002

The Act commenced on 1 June 2003. The Ombudsman is required to monitor the operation of the Act for a second review period from 1 June 2003 to 31 December 2004. This phase of our review will focus on forensic procedures carried out on suspects and 'volunteers'. We will also continue to monitor the use and destruction of DNA profile information and the exchange of information between police in NSW and other jurisdictions. More details can be found in 'Legislative reviews'.

Crimes Legislation Amendment (Penalty Notice Offences) Act 2002

The Act came into effect on 1 September 2002, establishing a trial scheme in which police may issue 'on-the-spot' penalty notices (known as 'criminal infringement notices' or 'CINs') for certain criminal offences. The Ombudsman is required to monitor the year long trial in twelve local area commands. More details can be found in 'Legislative reviews'.

Firearms Amendment (Public Safety) Act 2002

The Act commenced on 15 July 2002. This Act gives police the power to use a dog to carry out searches for firearms or explosives in any public place without a search warrant. The Ombudsman is required to monitor the use of these powers for two years. More details can be found in 'Legislative reviews'.

Guardianship and Protected Estates Legislation Amendment Act 2002

This Act commenced on 28 February 2003. It amended the *Guardianship Act* by permitting reviews by the Administrative Decisions Tribunal (ADT) of certain decisions of the Public Guardian as prescribed by regulation. At the time of writing, regulations prescribing the particular decisions of the Public Guardian against which an appeal can be made to the ADT were yet to be made. The availability of review by the ADT may provide an alternative and satisfactory means of redress for some complaints to our office about the Public Guardian.

The Act also amended the *Protected Estates Act* by providing that the Protective Commissioner is no longer an officer of the Supreme Court, thus removing one of the principal barriers to people bringing complaints about the Commissioner to the Ombudsman. One of the purposes for the legislative amendments articulated in the second reading speech was to enable complaints about the Protective Commissioner to be made to the Ombudsman. However, existing provisions in Schedule 1 of the *Ombudsman Act* that are still unamended mean that most complaints about the

conduct of the Protective Commissioner remain outside the Ombudsman's jurisdiction. A right of review by the ADT was also conferred in relation to certain decisions of the Protective Commissioner as prescribed by regulation. A regulation that came into effect on 16 May 2003 prescribed that any decision of the Protective Commissioner under Division 3 of Part 3 of the *Protected Estates Act* can be reviewed by the ADT. This right of review may also constitute an alternative and satisfactory means of redress for some complaints about the Protective Commissioner that fall within our jurisdiction.

Justice Legislation Amendment (Non-association and Place Restriction) Act 2001

The Act commenced on 22 July 2002. The Act amends several pieces of legislation relating to sentencing, bail and sentence administration. When imposing a sentence on a person convicted of an offence punishable by six months imprisonment or more, a court may also make a 'non-association order', prohibiting the offender from associating with a specified person or a 'place restriction order', prohibiting the offender from visiting a specified place or district. These orders take effect after the person's release from incarceration. They may also be made as a condition of bail, parole, leave or home detention.

The Ombudsman is required to monitor the effect of the Act's amendments for a two year period. More details can be found in 'Legislative reviews'.

Police Powers (Internally Concealed Drugs) Act 2001

The Act commenced on 1 July 2002. It established a regime for the carrying out of 'internal searches' on persons who are suspected of swallowing or otherwise internally concealing a prohibited drug for the purposes of supply. The Ombudsman is required to keep under scrutiny the operation of the Act for a period of two. More details can be found in 'Legislative reviews'.

Police Service Amendment (NSW Police) Act 2002

The Act commenced on 12 July 2002. It renamed the Police Service as NSW Police.

Statute Law (Miscellaneous Provisions) Act (No 2) 2002

The Act commenced on 29 November 2002. It inserted provisions into the *Ombudsman Act* that permit the Ombudsman, the Health Care Complaints Commission, the Legal Services Commissioner, the Anti-Discrimination Board and the Privacy Commissioner to enter into arrangements for the referral of complaints and the sharing of information. Arrangements were entered into between these bodies during the reporting year.

Statute Law (Miscellaneous Provisions) Act 2003

Relevant provisions of the Act commenced on 1 August 2003. These provisions amended the *Ombudsman Act* to allow the Ombudsman to disclose information and make comments to any public authority if the Ombudsman is satisfied that the information concerned is relevant to the functions or practices of the public authority and the information is not personal information. It also allows the Ombudsman to disclose information to a police officer, the Department of Community Services or any other public authority considered appropriate if the information relates to the safety, welfare or well being of a child or young person; or to any person in order to prevent or lessen the likelihood of harm being done to any person.

Summary Offences Amendment (Places of Detention) Act 2002

This Act commenced on 21 February 2003. It permits correctional officers to stop, detain and search people and/or vehicles in the immediate vicinity of a place of detention in specified circumstances, and to use dogs in any searches. It also creates a number of offences, including unreasonably failing or refusing to comply with a request or direction by a correctional officer exercising the new powers, and unreasonably resisting or impeding a search.

Under the *Crimes (Administration of Sentences) Amendment Act 2002*, referred to above, the Ombudsman is required to monitor the operation of the new provisions for two years. More details may be found in 'Legislative reviews'.

Legislation not yet in operation

Crimes Legislation Amendment Act 2002

This Act inserts into the *Search Warrants Act 1985* a new Part 3A - detention after arrest during execution of search warrant. The purpose of the new part is to enable a person who is arrested at premises that are being searched under the authority of a search warrant to be detained by police officers on the premises for a limited time.

The new provisions provide for Ombudsman scrutiny, for a period of two years, of the exercise of functions conferred on police officers under the new Part.

Law Enforcement (Powers and Responsibilities) Act 2002

The Act introduces three new or revised powers that are to be reviewed by the Ombudsman for a period of two years after they begin operation. These are:

- powers to search people arrested or in police custody
- powers to manage a crime scene
- powers to obtain financial documents from 'deposit taking institutions' such as banks and building societies, if the documents are connected with an offence.

Police Powers (Drug Detection in Border Areas Trial) Act 2003

The Act empowers police to stop vehicles and use dogs for drug detection in border areas. The Ombudsman is required to keep under scrutiny the powers conferred on police for a period of nine months from commencement.

Appendix I: Significant committees

Internal

Joint Consultative Committee
Steve Kinmond, Assistant Ombudsman (Police); Katharine Ovenden, Manager Child Protection Team; Anne Radford, Manager General Team; Debbie Pinches, Personnel Officer; Wayne Kosh, Staff Representative; Eileen Graham, Staff Representative; Christine Flynn, Staff Representative; Vince Blatch, Staff Representative; Dorothy Molyneaux, Public Service Association Industrial Officer.

Team Managers Committee
Anita Whittaker, Manager Corporate Support; Anne Radford, Manager General Team; Julianna Demetrius, Manager Police Team; Katharine Ovenden, Manager Child Protection Team; Jennifer Owen, Manager Community Services Division.

Information Management Steering Committee
Bruce Barbour, Ombudsman; Allison Lawrence, Information Manager; Greg Andrews, Assistant Ombudsman (General); Vincent Riordan, Intelligence and Information Manager Police Team; Michael Gleeson PCCM Business Manager; Katharine Ovenden, Manager Child Protection Team; Anita Whittaker, Manager Corporate Support; Geoff Pearce, Manager IT; Anne Barwick, Assistant Ombudsman (Children and Young People)

Security Management Committee
Chris Wheeler, Deputy Ombudsman; Anita Whittaker, Manager Corporate Support; Geoff Pearce, Manager, IT; David Begg, Network Administrator

Child Deaths Advisory Committee and Disability Deaths Advisory Committee
(office representatives only – please see 'Community Services' for more details)
Bruce Barbour Chair; Robert Fitzgerald

External (office representatives only)

Ombudsman - Bruce Barbour
Institute of Criminology Advisory Committee; Community Services Review Council (committee terminated as a consequence of the merger); Ombudsman Network (network of accountability agencies); Australasian Ombudsman; CEOs Group on Child Protection; Standing Committee with NSW Police; Regional Vice President International Ombudsman Institute

Deputy Ombudsman – Chris Wheeler
Protected Disclosures Implementation Steering Committee; Community Services Review Council (alternate member) (committee terminated as a consequence of the merger); Ombudsman Network (network of accountability agencies); Ombudsman/ICAC Liaison

Deputy Ombudsman (CSD) – Robert Fitzgerald
Premier's Advisory Committee on best practice service delivery for people with mental health and substance abuse disorders

Assistant Ombudsman (General) – Greg Andrews
Department of Corrective Services Liaison Meeting; Ombudsman/ICAC Liaison; Department of Juvenile Justice/Ombudsman liaison meeting; Department of Community Services/Ombudsman liaison meeting (June – December 2002); Public sector panel of the Churchill Fellowships

Assistant Ombudsman (Children and Young People) – Anne Barwick
Child Protection Forum; Child Protection Senior Officers Group (SOG); Department of Education and Training/Ombudsman Liaison Meeting; CCER/Ombudsman Liaison Meeting; Child Protection Squad Advisory Committee; Working with Children Check Working Party; Department of Juvenile Justice/Ombudsman Liaison Meeting.

Assistant Ombudsman (Police)- Stephen Kinmond
Police Complaints Case Management Program Review Group; Internal Witness Advisory Council; Standing Committee with NSW Police Service; Ombudsman/PIC Oversight Liaison Committee

Senior Investigation Officer – Jennifer Agius
Department of Corrective Services Liaison Meeting

Senior Investigation Officer - Lindy Annakin
Department of Juvenile Justice/Ombudsman Liaison meeting

Senior Investigation Officer (Inquiries and Resolution Team) – Margo Barton
Joint Initiative Group

Network Administrator – David Begg
PCCM WAN Management Forum

Project Officer (CSD) - Karen Bevan
Association of Children's Welfare Agencies/Centre for Community Welfare Training Foster Care Training Steering Committee; Association of Children's Welfare Agencies – Out of Home Care Forum (observer)

Investigation Officer - Vince Blatch
Department of Corrective Services Liaison Meeting; Steering committee for the Department of Corrective Service Support Line

Projects Officer - Selena Choo/Sarah Crawford
Protected Disclosures Implementation Steering Committee; NSW Public Sector Corruption Prevention Committee

Project Officer (CSD) – Melissa Clements
Disability Interagency Young People in Nursing Homes; Ethnic Communities Council Home and Community Care Subcommittee

Legal Officer (Police) – Simon Cohen
Ombudsman/PIC Oversight Liaison Committee; Standing Committee with NSW Police

Manager Police Team – Julianna Demetrius
Standing Committee with NSW Police Service

Project Officer (Forensic Procedures Review) – Juliet Dimond
Interdepartmental Committee on the Crimes (Forensic Procedures Act) 2000

Project Officer (CSD) – Christine Flynn
Association of Children's Welfare Agencies Kinship Care Steering Committee; Association of Children's Welfare Agencies Research Forum

Business Manager CAMS - Michael Gleeson
Tri Agency Steering Committee; PCCM Program Working Committee

Investigation Officer – Jacqueline Grima
NSW Health/Ombudsman Liaison Meeting

Senior Investigation Officer – Peter Jackson
Department of Local Government Liaison Committee

Senior Investigation Officer - Kate Jonas
Child Protection Learning and Development Forum

Manager Legislative Review Team – Emma Koorey
Law Enforcement (Power and Responsibilities) Steering Committee

Investigation Officer – Wayne Kosh
ADT FOI Users Group; ADT General Division Rule Sub-committee

Senior Investigation Officer - Elizabeth Le Brocq
Department of Education and Training/Ombudsman Liaison Meeting

Coordinator, Reviewable Child Death Project Team – Catherine Mullane
Attorney General's Department Working Party on Parents with a Disability; Council on Intellectual Disability Health Issues Working Party

Project Manager Research – Stephen Murray
Standing Committee for the Implementation of Crimes Penalties Notices Offence Act (observer only)

Manager, Service Improvement and Review (CSD) – Tony Ovadia
Centre for Developmental Disability Studies Support Needs project Advisory Committee; Department of Health Reference Group on needs of people with a disability during hospitalisation; Mental Health Coordinating Council Human Service Standards Advisory Committee; Department of Ageing, Disability and Home Care Nutritional Health Expert Advisory Committee (observer only)

Manager Child Protection Team - Katharine Ovenden
Child Protection Senior Officers Group; Department of Community Services/Ombudsman Liaison Meeting; CCER/Ombudsman Liaison Meeting; CCYP Guidelines Review Committee

Project Manager Research – Glen Payton
Standing Committee for the Implementation of Crimes Penalties Notices Offence Act (observer only)

Manager, IT – Geoff Pearce
PCCM WAN Management Forum; Tri-Agency Steering Committee

Senior Investigation Officer – Sue Phelan
Department of Juvenile Justice/Ombudsman Liaison Meeting; Department of Community Services/Ombudsman Liaison Meeting; NSW Health/Ombudsman Liaison Meeting

Investigation Officer – Michael Quirke
Ombudsman/PIC Oversight Liaison Committee

Manager General Team - Anne Radford
Joint Initiative Group

Intelligence and Information Manager – Vincent Riordan
PODS Business Team; PODS Steering Committee; Standing Committee with NSW Police; NSW/PIC/Ombudsman Joint Research Committee (Early Warning Systems)

Investigation Officer – Natasha Seipel
Department of Juvenile Justice/Ombudsman Liaison Meeting; Department of Corrective Services/Ombudsman Liaison Meeting

Principal Investigator – Kylie Symons
Child Protection Forum

Senior Review Officer (Disability Deaths) – Margaret von Konigsmark
ASSID Working Group on Palliative Care

Legal Officer (Child Protection) - Greg Williams
Commission for Children and Young People/Ombudsman/DoCS Legislation and Policy Working Party; NSW Law Society Children's Legal Issues Committee; NSW Law Society Government Lawyers Committee; Child Protection Forum; Industrial Relations Commission – Court Users Forum

Index

Publications list

The following is a list of our most recent publications. Our general information (such as brochures and fact sheets) is available free of charge, but we usually sell our guidelines and reports for a nominal fee to cover the cost of production. We are regularly reviewing and updating what we publish. A complete list of our publications as well as a price list and an order form is available on our web site www.ombo.nsw.gov.au.

Annual Report

Oct 2002
Annual Report 2001-2002

Reports to Parliament

Apr 2003
Speedometers and speeding fines: A review of police practice

Sep 2002
Improving the management of complaints: Police complaints and repeat offenders

Jun 2002

- Improving the management of complaints: Assessing police performance in complaint management
- Speedometers and speeding fines: A review of police practice

Apr 2002

- DOCS–Critical issues - Concerns arising from investigations into the Department of Community Services

Mar 2002

- Improving the management of complaints: Identifying and managing officers with complaint histories of significance

Fact sheets

Jul 2003

- Bad Faith, Bias and Breach of Duty
- Conflict of Interests

May 2003

- Apologies by Public Officials and Agencies

May 2003 (continued)

- Apologies by Councils
- Apologies and Child Protection
- Apologies by Community Services Providers

Dec 2002

- Community Services Division Fact Sheet 1: Expanded Role for the NSW Ombudsman in Community Services
- Community Services Division Fact Sheet 2: Handling Complaints
- Community Services Division Fact Sheet 3: Reviewable Deaths—Children and Young People, and People with a Disability
- Community Services Division Fact Sheet 4: Licensed Boarding Houses

Jun 2002

- Council fact sheet no. 1: Having trouble with unlawful development activity?
- Council fact sheet no. 2: Unhappy with a proposed development?
- Council fact sheet no. 3: Having trouble with your development application?
- Council fact sheet no. 4: Having trouble with your rates and charges?
- Women's Issues: The Ombudsman & You

Various dates
The Ombudsman & You (available in Chinese, Arabic, Macedonian, Hindi, Singhalese, Tamil and Indonesian)

Discussion papers

Sep 2003

- Discussion Paper: The Child Protection (Offenders Registration) Act 2000
- Discussion Paper: Put on the Spot – Criminal Infringement Notices Trial

Jun 2003

- Discussion Paper: The Police Powers (Drug Premises) Act 2002

Guidelines

Aug 2003
Good Conduct and Administrative Practice Guidelines for state and local government

Jun 2002
Enforcement Guidelines for Councils

Jan 2002

- Protected Disclosure Guidelines (4th ed)
- Model Internal Reporting Policy for Councils
- Model Internal Reporting Policy for Agencies Other than Councils

Brochures (free)

Aug 2003
That's not fair! (for Aboriginal people)

Jun 2003

- Got a problem with out-of home care services for children and young people?
- Got a problem with a disability service?
- Got a problem with a Home and Community Care (HACC) service?
- Got a problem with a Supported Accommodation and Assistance Program (SAPP) service?
- Got a problem with a child protection or support service provided by the Department of Community Services?

Dec 2002

- Trouble with council?
- Problems with police?
- Unhappy with an FOI decision?
- Guarantee of service
- Problems in detention?
- Child Protection

Jun 2002
General information

Jan 2002

- Thinking about blowing the whistle? Brochure for public sector agencies other than councils
- Thinking about blowing the whistle? Brochure for councils

Various dates
General information available in Vietnamese, Spanish, Greek, Turkish, Korean, Serbian, Italian and Croatian.

Staff list

Executive and Corporate Support

Ombudsman – Bruce Barbour
Deputy Ombudsman – Chris Wheeler
Manager Corporate Support – Anita Whittaker

Marianne Adzich
Bina Aswani
David Begg
Mary Anne Borg
Selena Choo
Chi Chung
Sarah Crawford
Katie Doherty
Lisa Du
Rebeca Garcia
Therese Griffith
Allison Lawrence
Jayson Leahy
Barbara McAuley
John McKenzie
Mani Maniruzzaman
Tania Martin
Lilia Meneguz
Bao Nguyen
Geoff Pearce
Anne Penny
Debbie Pinches
Michelle Stewart
Cuong Tran
Stan Waciega

Child protection team

Assistant Ombudsman – Anne Barwick
Team Manager – Katharine Ovenden

Jacinta Ballinger
Glynis Bartley
Tamaris Cameron
Jan Coughlan
Birgit Cullen
Jessica Farrell
Eileen Graham
Judith Grant
Jacqueline Grima
Sally Haydon
Adam Johnston
Kate Jonas
Joanne Jones
Elizabeth Le Brocq
Pauline O'Callaghan
Sue Phelan
Rebecca Piper
Julie Ross
Pamela Rowley
Natasha Seipel
Marie Smithson
Kylie Symons
Greg Williams
Sophie Woods

General team

Assistant Ombudsman – Greg Andrews
Team Manager – Anne Radford

Jennifer Agius
Lindy Annakin
Margo Barton
Vince Blatch
Geoff Briot
Julie Brown
Christine Brunt
Michael Conaty
Victor Darcy
John Davies
Tony Day
Helen Evans
Helen Ford
Kerrie Gazzard
Samantha Guillard
Elizabeth Humphrys
Peter Jackson
Charlene Joyce
Wayne Kosh
Galina Laurie
Ian McCallan-Jamieson
Aaron Magner
Kate Merryweather
Oliver Morse
Sheila O'Donovan
Wendy Parsons
Lin Phillips
Janette Ryan
Alison Shea
Sanya Silver
Margaret Smee
Sue Sullivan
Kim Swan
Stephanie Taplin
Merly Vasquez-Lord
David Watson
Ray Williams
Bev Willis
Jacqui Yanez

Police team

Assistant Ombudsman – Steve Kinmond
Team Manager – Julianna Demetrius

Lucia Abdipranoto
Ruth Barlow
Zaldy Bautista
Nicole Blundell
Violeta Brdaroska
Heather Brough
Jillian Burford
Peter Burford
Claire Carroll
Kim Castle
Terry Chenery
David Chie
Michelle Chung
Louise Clarke
Simon Cohen
Tasha Daldaris
Brendan Delahunty
Anika Dell
Juliet Dimond
Shelagh Doyle
Lily Enders
Jo Flanagan
Michael Gleeson
Faye Greville
Katie Hall
Alex Hicks
Phil Janson
Opal Kiang
Katy Knock
Emma Koorey
Rosemary Kusuma
Samantha Langran
Richard Lee
Gabrielle McNamara
Allan Matchett
Sue Meade
David Mewing
Stephen Murray
Daryn Nickols
Jane O'Toole
Kate Owens
Glenn Payton
Yvon Piga
Michael Quirke
Vincent Riordan
Laurel Russ
Katrina Sanders
Joanne Scott
David Snell
Nicole Tarrant
Robert Wingrove

Community Services Division

Deputy Ombudsman – Robert Fitzgerald
Division Support Manager – Jenny Owen

Phil Abbey
Kirsteen Banwell
Karen Bevan
Carolyn Campbell-McLean
Christine Carter
Melissa Clements
Betsy Coombes
Janet Coppin
Gary Dawson
Emily Dempster
Stella Donaldson
Chris Flynn
Josephine Formosa
Gaye Josephine
Kathy Karatasas
Tricia Kelly
Ivy Kwan
Mary McCleary
Helle McConnochie
Alison McKenzie
Kathryn McKenzie
Mark Mallia
Jeannette Mangan
Catherine Mullane
Tony Ovadia
Edwina Pickering
Michele Powell
Karen Price
Ian Robinson
Storm Stanford
Lois Stevenson
Mele Tapa
Margaret von Konigsmark
Julie Withers
Monica Wolf
David Wright-Smith

Complaining to the Ombudsman

Anyone can make a complaint to the Ombudsman. If you do not want to complain yourself, you can ask anyone — a relative, friend, lawyer, social worker, your local member of parliament — to complain for you.

How do I make a complaint?

Start by complaining to the agency you are dissatisfied with. If you need advice at any time, you can phone us. If you are unhappy with the way an agency has handled your complaint, you can complain to us. Complaints should be in writing. Your complaint can be in any language. If you have difficulty writing a letter — due to language or a disability — we can help. We can also arrange for translations, interpreters and other services.

What should I include with my complaint?

Briefly explain your concerns in your own words. Include enough information for us to assess your complaint to determine the most appropriate response. For example, describe what happened, who was involved, when and where the events took place. Remember to tell us what action you have already taken and what outcome you would be satisfied with. Include copies of all relevant correspondence between you and the agency concerned.

What happens to my complaint?

A senior investigator will assess your complaint. Where appropriate we will phone the agency concerned and make inquiries. Many complaints are resolved at this stage. If we are not satisfied with the agency's response, we may investigate.

We do not have the resources to investigate every complaint, so priority is given to serious matters, especially if it is an issue that is likely to affect other people. If there are reasons why we cannot take up your complaint we will tell you.

What happens in an investigation?

The first step in an investigation is to require the agency to comment on your complaint and explain its actions. Generally, we will tell you what the agency has said and what we think of its explanation. Some matters are resolved at this stage and the investigation is discontinued.

If the investigation continues, it can take several months until a formal report is issued. We will tell you what is likely to happen.

If we find your complaint is justified, the findings are reported to the agency concerned and the relevant minister. You will be told of the conclusions and findings. In a report, the Ombudsman may make recommendations. We cannot force an agency to comply with our recommendations, however, most usually do. If they do not, the Ombudsman can make a special report to Parliament.

What if I am unhappy with the Ombudsman's actions?

If you are unhappy with our decision you can ask for it to be reviewed. However, a decision will only be reviewed once. All reviews are conducted by a senior staff member and by someone other than the staff member originally assigned your complaint. To request a review, telephone or write to the complaints manager in the general, police or child protection team.

If you are unhappy with any of our *procedures* write to:

Clerk to the Committee
Committee on the Office of the Ombudsman
and the Police Integrity Commission
Parliament House,
Macquarie Street, SYDNEY NSW 2000

The committee monitors and reviews our functions. It cannot review our decisions about individual complaints.

Acknowledgements

Our annual report is a public record of our work and through it we are accountable to the people of New South Wales.

Our report is prepared against criteria set out by NSW Treasury and the Annual Report Awards.

Thank you to all members of staff who contributed to this year's annual report.

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