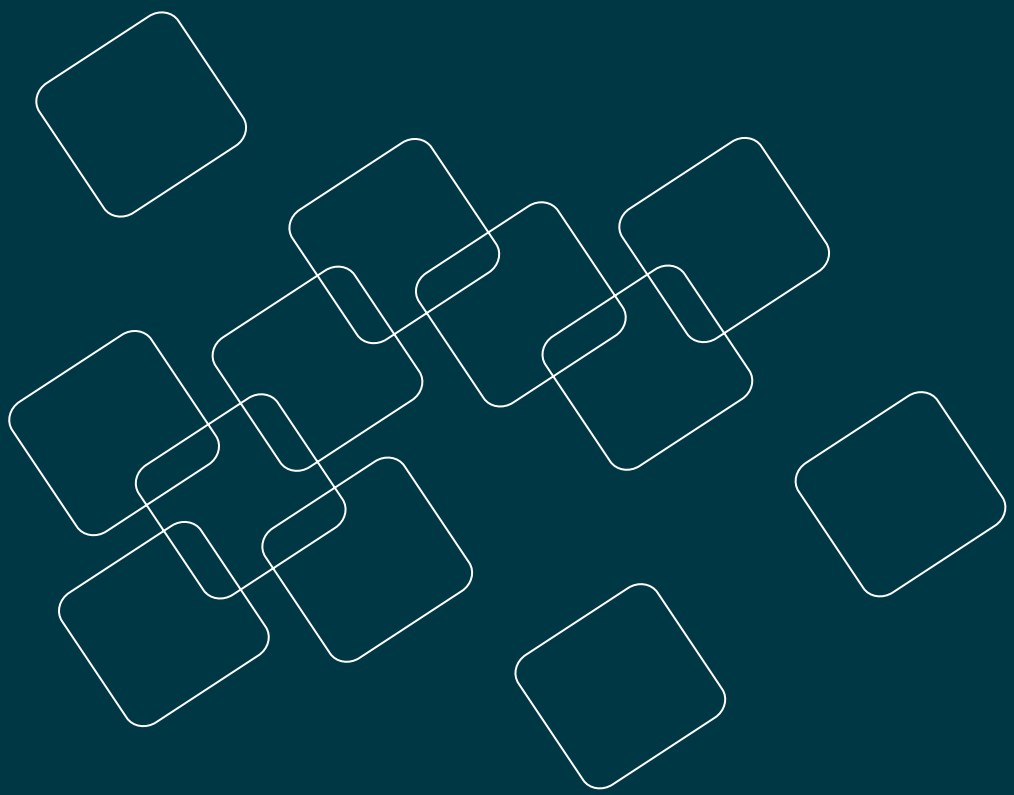
NSW Ombudsman

annual report 2003–2004



contents

October 2004

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 29th annual report to the NSW Parliament.

This report contains an account of our work for the twelve months ending 30 June 2004 and is made pursuant to ss.30 & 31 of the *Ombudsman Act 1974.*

The report also provides information about my office's functions under the *Police Service 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 2004).

Yours sincerely

Bruce Barbour
Ombudsman

ombudsman's message

I am pleased to present my fifth annual report on the work of this office. Over the past five years the office has grown significantly taking on new functions and responsibilities, dealing with an ever-increasing workload, and meeting the many challenges posed by changes in the society in which we live. One of our strengths has always been the capacity to look at how a broad range of agencies provides services to the general public – health, policing, education. With the expansion of our functions to include scrutinising agencies that provide community services, we have an even greater capacity to look at the quality of services people receive. This gives us the opportunity to achieve better outcomes when things go wrong, and try to prevent people from 'falling through the cracks' in services providing them with essential support.

This year we had serious concerns about the quality of certain services being provided to homeless people and to children and young people with a disability, two of the most vulnerable and marginalised groups of people in our society today. These failings were caused not by the actions of a few, but by systemic issues such as flawed policy decisions, poor coordination between different agencies providing services and inadequate staff training. As a result of our work, government and non-government service providers have committed to making significant improvements to the way these services are provided. These are just two examples of the positive outcomes we are pleased to document in our annual report.

Accountability is one of the cornerstones of an effective democracy. Services that are established for the specific purpose of providing people with support, that are authorised, licensed, funded or provided by the State, should operate for the benefit of those people. We continue to play a critical role in keeping them accountable and thereby delivering better results to the public.

As one of the lead Ombudsman offices in the region, it is important to provide practical assistance and support to smaller, less well-developed regional offices. This year AusAid has provided funding for the completion of a project identification study as the first stage of an institutional strengthening and capacity building program for seven Ombudsman offices in the South West Pacific. We will be working with the Commonwealth Ombudsman's office on this important project.

We also made several changes to our internal structures during the year to better fulfil our expanded functions. During the year we reviewed our corporate plan and developed a statement of corporate purpose to guide our work during 2004-2007 and improve our effectiveness in achieving positive outcomes for the people of NSW. We will report on our progress in next year's annual report. A significant event during the year was the departure of Robert Fitzgerald. I would like to take this opportunity to thank Robert for his significant contribution to the provision of community services in NSW, both in his position as Community Services Commissioner and, during his time here, as Deputy Ombudsman.

I would also like to thank the staff of this office, whose professionalism and enthusiasm never wanes, even in the face of continual changes to the type of work we do and the way that we do it, and the constant pressure not only to deliver the highest quality service to the public but to maintain constructive relationships with the agencies we keep accountable.

Bruce Barbour
Ombudsman

achievements

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

1 to assist agencies to remedy deficiencies and improve their service delivery

2 to be a cohesive and effective organisation

3 to be accessible and responsive

4 to be a leader in standards of service.

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.

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.

strategies

goal 1

- Assess service delivery and the conduct of agencies and assist agencies to address deficiencies.
- 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 issue.

goal 2

- Ongoing review of structures and operational practices of the office to maximise flexibility, cohesion and efficiency.
- Ensure that staff are supported as main resource of office. Improve sharing of knowledge and information across the office.

goal 3

- Identify needs for and implement effective access and awareness and information programs.
- Maintain a strong identity to ensure continuing relevance and better recognition.
- Consider the views of people with whom we deal.

goal 4

- Ensure appropriate internal standards and policies relating to administrative conduct are in place.
- Continue to improve the quality of our service. Provide effective and meaningful reporting and performance measurement strategies.
- Regularly review complaint-handling, investigative and other practices to ensure best practice.

highlights for this year

future

As a result of our work:

- DADHC will be addressing inadequacies in services provided to children and young people with a disability
- DoCS has agreed to improve the provision of SAAP services to homeless people
- in over 1,700 complaints agencies have taken action to address our concerns (eg changed their decision, apologised, corrected errors, trained staff and paid compensation)
- a new 'class and kind' agreement has been finalised with NSW Police that will make the handling and oversight of complaints more effective
- a training package has been developed for independent schools seeking accreditation to be exempted from reporting some child protection matters to us
- agencies with child protection obligations were well-equipped to handle changes to the child protection scheme.

We plan to:

- develop a regional focus for raising systemic issues with agencies providing community services
- focus on promoting improvements in particular community service program areas including disability support and accommodation services
- look into issues concerning people with an intellectual disability and the criminal justice system
- audit the systems agencies have for preventing conduct by employees that may be abusive to children and handling allegations of such conduct
- conduct free training for agencies on topics such as complaint-handling and protected disclosures.

- reviewed and updated our corporate plan, developing a new statement of corporate purpose.
- restructured the community services division to improve their capacity to handle matters and created a specialist corrections unit in the general team
- set up a working group to coordinate external training and joint projects.
- finalised our working at home policy, provided support for staff who are undertaking further study and gave staff the opportunity to attend relevant conferences.
- completed the implementation of our electronic document management system, including an extension project to build interfaces with existing databases.

We plan to:

- develop team business plans based on our new statement of corporate purpose
- restructure the personnel area to provide an improved service to management and staff
- employ a training officer to further improve our organisational capabilities
- continue to support staff attendance at relevant conferences and staff who undertake further study.

- reviewed and updated our access and equity plan
- developed and distributed a range of publications – including our general information brochure in 16 community languages, 6,000 copies of guidelines for agencies with child protection obligations, our newsletter for the community services sector called *Communicate*
- made 31 visits to 21 different correctional centres and 16 visits to nine different juvenile justice centres
- consulted widely with Aboriginal community and other representatives, and with people in Vietnamese and Greek-speaking communities who have a disability, their families and carers.
- conducted nine workshops for about 160 consumers of community services, provided training to hundreds of police, including student police, and participated in training for DoCS managers.
- conducted 'child protection forums' for people involved with child protection issues.

We plan to:

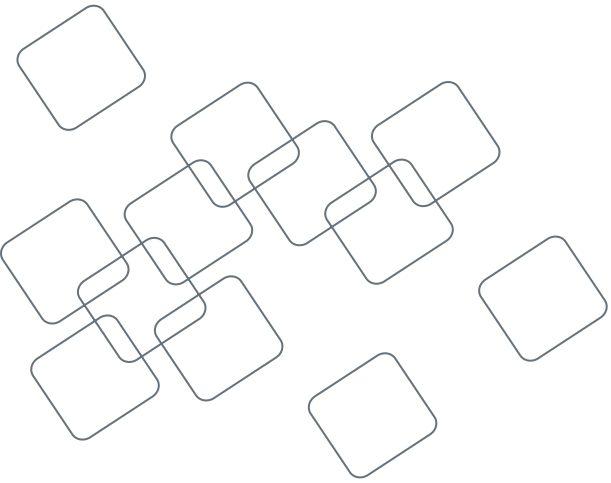
- implement the strategies in our new access and equity plan
- conduct a new education program targeted at residents of licensed boarding houses, intermediaries and proprietors
- continue providing workshops for consumers of community services and for agencies providing services to children, community services and public services
- continue to seek the views of agencies about the implementation of the child protection scheme through regular liaison meetings and industry forums.

- our general team maintained a reduced average time taken to finalise written complaints.
- new arrangements for handling complaints about community services matters, focussing on local resolution.
- updated the child protection team's systems and trained staff to accommodate changes to the legislative scheme.
- put in place arrangements for exchanging information with NSW Police about 'at risk' police officers.

We plan to:

- review and improve corporate and team performance measures, and our system for managing the individual performance of staff, as part of implementing our new statement of corporate purpose
- complete a review of our internal standards for handling notifications and complaints.

01: about us



who we are & what we do

The NSW Ombudsman is an independent and impartial watchdog. Our central goal is to keep government and some private agencies accountable. Ultimately this is for the benefit of the public.

We promote good conduct and fair decision-making by agencies. We use our experience and knowledge to 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 the State's Parliamentary Ombudsman. Our office was established by the *Ombudsman Act 1974*. One of our fundamental characteristics is that we are independent of the government of the day and accountable to the public through the Parliament itself. The current Ombudsman is Bruce Barbour. He has held this position since June 2000 and is the fifth Ombudsman since the office was established.

Like many other Ombudsman around the world, we were 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'. Many countries have now adopted the Ombudsman concept, with more than 150 Ombudsman-type agencies affiliated to the International Ombudsman Institute. Australia has a Commonwealth Ombudsman and a Parliamentary Ombudsman in every state and territory. There are also several specialised industry Ombudsman — for agencies providing electricity, water, gas, telecommunications and banking services.

Every member of the public has the right to complain to us, so much of our work is generated by complaints. We also handle complaints by people who work for the agencies we keep watch over. When we handle a complaint, we do not take sides. We listen to all parties involved and try to find an outcome that is in the public interest.

Over the years we have become more proactive in our approach. We seek to improve the overall satisfaction of the public with the services they are provided - to reduce the causes for complaint. For example, we review how agencies deliver their services and suggest improvements, we help agencies handle complaints more effectively, and we encourage them to see complaints as a source of feedback that can help them improve their performance.

We still investigate more serious complaints but, in many cases, we encourage agencies to handle complaints themselves. If necessary we can give them support or directly monitor how their investigations are progressing.

Our key focus is on helping agencies identify and fix any problems with their performance that our work brings to light.

In addition, we have specific functions relating to:

- the protection of children in NSW
- the delivery of community services
- the causes and patterns of deaths of certain children and people with a disability
- public sector agency decisions on freedom of information applications
- the use of powers to conduct controlled operations
- the administration of the witness protection program.

In recent years we have also been given the unique function of reviewing and reporting on the implementation of various new pieces of legislation conferring additional powers on people such as police and correctional officers. These include laws that give police powers to keep DNA samples of serious offenders, to use sniffer dogs to find drugs on members of the public, and to establish a register of child sex abuse offenders.

Please see Appendix I for a full list of the legislation that affects our work.

our statutory officers

Bruce Barbour LLB
Ombudsman

Bruce Barbour has been NSW Ombudsman since June 2000. Prior to that, he was a Senior Member of the Commonwealth Administrative Appeals Tribunal for nine years. He has been a Member of the Casino Control Authority and Director of Licensing at the Australian Broadcasting Authority. He has extensive experience in administrative law, investigations and management.

Chris Wheeler BTRP MTCP LLB (Hons)
Deputy Ombudsman

Chris Wheeler has been Deputy Ombudsman since 1994. He has extensive experience in management, investigations and public administration. He has a background as a town planner and solicitor and has worked in a variety of state and local government organisations in NSW and Victoria, and in private legal practice.

Robert Fitzgerald AM LLB, B.Comm
Deputy Ombudsman (Community Services Division) and
Community & Disability Services Commissioner (1 July 2003 – 31 January 2004)

Robert was appointed as Deputy Ombudsman (CSD) and Community and Disability Services Commissioner when the former Community Services Commission and our office amalgamated in December 2002. Robert was Commissioner for Community Services during the period 1999-2002. Prior to 1999, Robert practised as a commercial and corporate lawyer and management consultant for over 20 years.

Steve Kinmond BA LLB Dip Ed Dip Crim
Deputy Ombudsman (Community Services Division) and
Community & Disability Services Commissioner

Steve Kinmond was recently appointed to this position but has been acting in the role since February 2004 (following the resignation of Robert Fitzgerald). Before that he had been the Assistant Ombudsman (Police) for seven years and had close to 10 years involvement in the community services area specialising in working with young people. He has also worked as a solicitor and run his own consultancy practice.

Greg Andrews BA (Hons) M Env Loc Gov Law Graduate Cert Public Sector Management
Assistant Ombudsman (General)

Greg Andrews has 20 years experience as an investigator with our office, 16 of those as Assistant Ombudsman. He has extensive experience in management, investigations, education and training. Prior to joining the office, he worked in the fields of educational innovation, university teaching and legal publishing.

Anne Barwick BA Dip Soc Wk M Mgt (Community)
Assistant Ombudsman (Children & Young People)

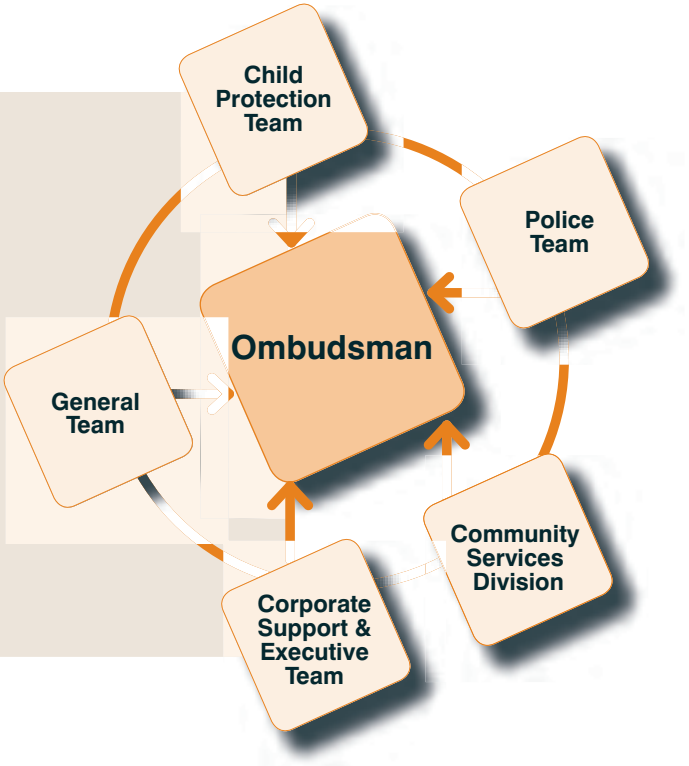
Anne Barwick was appointed to this position in March 1999. Her background includes experience as a social worker in the welfare, health, education and disability sectors. She has over 20 years experience in the management of community service organisations.

Simon Cohen LLB (Hons 1)
Acting Assistant Ombudsman (Police)

Simon Cohen has acted in this role since February 2004. He has been a solicitor with our office since 2001. His previous experience includes working in a number of legal and management roles for independent state and commonwealth statutory agencies.

our organisation

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 functional responsibilities of each team are outlined in chapters 3, 4, 5, 6 and 9



where we fit with the other watchdog agencies in NSW

In the three decades since our office was established, many other watchdog agencies have been created and we have taken on more and more functions. It is easy for people to become confused about who they should approach about their concerns.

Our main role is to keep the following categories of agencies under scrutiny:

- agencies delivering public services
- agencies delivering services to children
- agencies delivering community services
- agencies conducting covert operations.

Our focus with these agencies is on good administrative conduct — not corruption, financial mismanagement, industrial disputes, discrimination or negligence.

We want to expose and eliminate conduct that is illegal, unreasonable, unjust or oppressive, improperly discriminatory, based on improper or irrelevant grounds, based on a mistake of law or fact or otherwise wrong.

other watchdog agencies

Some of the other watchdog agencies in NSW are the:

- Independent Commission Against Corruption – public sector corruption
- Audit Office:
  serious and substantial waste of public money
- Commonwealth Ombudsman:
  complaints about Commonwealth agencies
- Health Care Complaints Commission:
  health care services
- Legal Services Commissioner:
  legal services
- Anti-Discrimination Board:
  discrimination issues
- Energy and Water Ombudsman NSW:
  electricity, water and gas suppliers
- Telecommunications Industry Ombudsman:
  telephones, internet service providers
- Banking and Financial Services Ombudsman:
  banks and other providers of financial services

how we keep agencies accountable

who we scrutinise — how we keep them accountable

→ agencies delivering public services

- several hundred NSW public sector agencies including departments, statutory authorities, boards, government schools, universities and area health services
- the police
- 155 local and county councils
- certain private sector organisations and individuals providing privatised public services, such as the operators of Junee Correctional Centre, private certifiers (performing certain local council functions) and accreditation bodies for those private certifiers.

- we handle complaints about the work of the agencies
- we handle complaints about the merits of their decisions about freedom of information requests
- we handle and investigate protected disclosures from employees and complaints about how these disclosures were handled
- we make sure that complaints about police officers are handled appropriately and investigations are carried out properly
- we assess decisions of the police not to investigate complaints against officers — we may decide a complaint should be investigated, and, if so, will require the police to investigate
- we monitor the progress of investigations into complaints about police officers
- we assess whether investigations into complaints about police officers were conducted properly and in a timely manner, and whether appropriate action was recommended and taken as a result
- we keep under scrutiny the systems the police have to handle complaints about officers
- we hear appeals against certain decisions and orders made by the Commissioner of Police about participation in or exclusion from the witness protection program.

→ agencies delivering services to children

- over 7,000 agencies providing children's services including non-government schools, child care centres and agencies providing substitute residential care.

- we receive notifications of allegations of conduct by employees that could be abusive to children
- we receive notifications of convictions made against employees that involve the abuse of children
- we handle and investigate these 'reportable' allegations or convictions and complaints about how the agency handled them
- we monitor the progress of agency investigations of reportable allegations or convictions
- we assess whether investigations into these allegations were conducted properly and in a timely manner, and whether appropriate action was recommended and taken as a result
- we keep under scrutiny the systems agencies have to prevent employees from behaving in ways that could be abusive to children, and their systems for handling and responding to allegations or convictions.

→ agencies delivering community services

- community services provided by the Department of Community Services or 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 or the Minister for Ageing and Disability Services, including licensed boarding houses and fee-for-service agencies.

- we handle and investigate complaints about the provision, failure to provide, withdrawal, variation or administration of a community service
- we review the systems agencies have to handle complaints about their services
- we review the situation of children, young people and people with a disability who are in out-of-home care
- we review the deaths of certain children, young people and people with a disability in care
- we monitor, review and set standards for the delivery of community services
- we inspect certain services where children, young people and people with a disability live.

→ agencies conducting covert operations

- law enforcement agencies such as the police, the Crime Commission, Independent Commission Against Corruption and Police Integrity Commission

- we review agency compliance with accountability requirements for undercover operations and the use of telephone intercepts.

02: management overview

a snapshot of our year

the year in numbers

This year a total of 35,688 matters were brought to our attention. Of these matters, 9,167 were formal matters and 26,521 were informal complaints and inquiries.

formal matters

Figure 1 shows the number of formal matters we received this year (compared to last year), broken down into the number of:

- complaints received about public sector agencies
- complaints received about agencies providing community services
- notifications received as part of our child protection functions
- complaints received as part of our role in scrutinising complaints about police officers, and
- complaints received about agencies outside our jurisdiction.

This year we finalised a total of 9,239 formal matters. 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 2003–2004 are still being dealt with and some matters we finalised during the year were brought to our attention before the reporting period. The actions that we take to finalise matters include:

- resolving a complaint by the agency concerned taking some action as a result of our involvement
- resolving complaints by undertaking a formal investigation and making findings of wrong conduct and recommendations
- resolving complaints by providing information, an explanation or advice
- resolving complaints by making preliminary inquiries and finding no wrong conduct
- referring a complainant to another agency or advising them to complain directly to the agency concerned
- scrutinising the way an agency has handled an allegation of conduct by an employee that could be abusive to children following their notification to our office
- scrutinising the way NSW Police has handled a complaint about a police officer.

Figure 2 shows a breakdown of the number of formal matters we finalised this year (compared to last year).

Figure 1: Formal complaints and notifications received

Subject	02/03	03/04
Public sector agencies*	2530	2836
Community services**	-	531
Child protection	2560	1698
Police	3099	3565
Agency is outside our jurisdiction	550	537
Total	**8739**	**9167**

Figure 2: Formal complaints and notifications finalised

Subject	02/03	03/04
Public sector agencies*	2566	2853
Community services**	-	536
Child protection	2724	1988
Police	3204	3316
Agency is outside our jurisdiction	558	546
Total	**9052**	**9239**

* This includes complaints about public sector agencies that we find to be outside our jurisdiction because of the nature of the complaint.

** Last year we were unable to provide figures for complaints about agencies providing community services.

Figure 3: Formal complaints and notifications finalised — five year comparison

	99/00	00/01	01/02	02/03	03/04
Received	9388	9820	8292	8739	9167
Finalised	7752	9734	9164	9052	9239

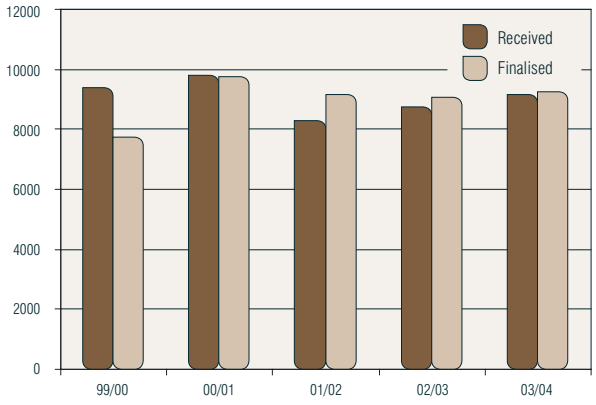
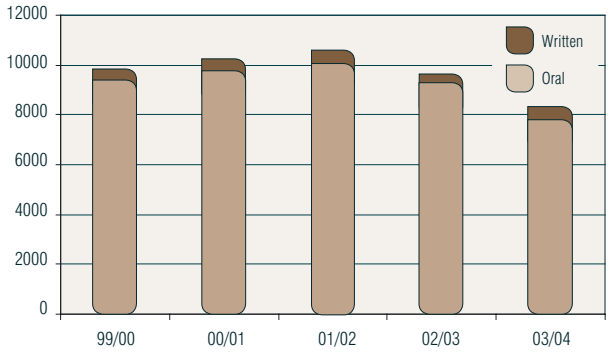


Figure 5: Complaints received about matters outside our jurisdiction — five year comparison

	99/00	00/01	01/02	02/03	03/04
Written	530	639	588	550	537
Oral	9388	9751	10111	9316	7825
Total	**9918**	**10390**	**10699**	**9866**	**8362**



informal matters

Figure 4 shows the number of informal matters we received, broken down into the number:

- received about public sector agencies
- received about agencies providing community services
- received about issues relating to our child protection functions
- received about issues relating to our role in scrutinising complaints about police officers
- received about agencies or issues outside our jurisdiction, and
- that were requests for information.

Informal matters consist of telephone calls and in-person complaints and inquiries made to our office where we were able to help the person by giving them information or explaining something to them, referring them elsewhere, or advising them to make a formal complaint to us. The vast majority of these matters are resolved on the same day we receive them.

Figure 4: Informal complaints and inquiries received

Subject	02/03	03/04
Public sector agencies	9445	10082
Community services*		1209
Child protection	795	668
Police	3114	3394
Outside our jurisdiction	9316	7825
Requests for information	3397	3343
Total	**26067**	**26521**

* Note: last year we were unable to provide figures for matters about agencies providing community services.

A variety of people contact us — members of the general public, families of people who are receiving community services, members of Parliament, people who work in the public sector. They bring to our attention a variety of concerns — wanting to reverse decisions that adversely affect them, asking for help, bringing mismanagement to light.

We try to help people as much as we can, given the number of matters that we need to handle each year and our limited resources. In many cases we do not have any formal powers to look into the concerns people have raised but we will still try to help. With these matters, which we call 'outside our jurisdiction', we often refer people to an organisation that can help them, or give them information that may enable them to find a solution themselves. This year we received 8,362 of these types of matters. See figure 5.

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 the rest of this report.

other work

This year we also reviewed the deaths of 247 people and formally scrutinised the systems of around 20 agencies, both government and non-government. This included auditing over 7,500 police records. We coordinated over 3,000 visits by official community visitors and met widely with Aboriginal communities and other representatives. We conducted over 70 workshops and briefings attended by over 2,000 people in regional areas and in Sydney. This year we also distributed over 14,000 information tool kits, guidelines and newsletters to various agencies, community groups and individuals.

balancing our books

This year we received a total of $18.83 million in funding (see figure 6). Most of our revenue is spent on employee-related expenses. These include salaries, superannuation entitlements, long service leave and payroll tax. In 2003–2004 we spent approximately $14.2 million on employee-related expenses. See figure 8.

our people

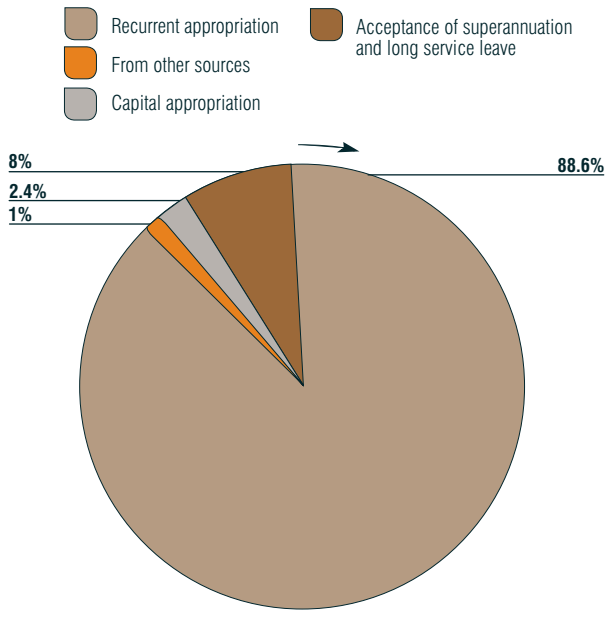
We have a committed team of 199 people working for our office on either a full or part-time basis. These people are an energetic and diverse mix of experience and skill, coming from a range of backgrounds, including investigative, law enforcement, community and social work, legal, child protection and teaching. Our collective experience gives us insight into the agencies we keep accountable and helps us to be a persuasive advocate for change.

Figure 7 (equivalent full-time staff levels) shows how we have grown over the past five years. We have had to recruit more people because of the work involved as a result of our expanding jurisdiction and increased workload.

Most of our staff are employed on a permanent full-time basis. We also have 41 part-time and 42 temporary staff.

Figure 6: Total revenue 2003–2004*

Government	
Recurrent appropriation	$16,695,000
Capital appropriation	$447,000
Acceptance of superannuation and long service leave	$1,514,000
Total government	**$18,656,000**
From other sources	$176,000
Total	**$18,832,000**



*including capital funding and acceptance of employee entitlements

Figure 7: Staff levels – five year comparison

	99/00	00/01	01/02	02/03	03/04
Statutory officer	5	5	5	6	6
Investigative staff	75	96.2	98.2	139.5	149.4
Admin. staff	13.6	16	19.3	22.5	25
Total	**93.6**	**117.2**	**122.5**	**168**	**180.4**
Trainees	1	1	0	0	0

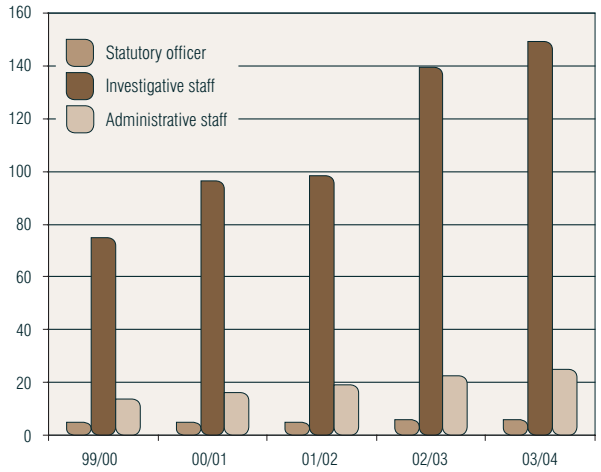
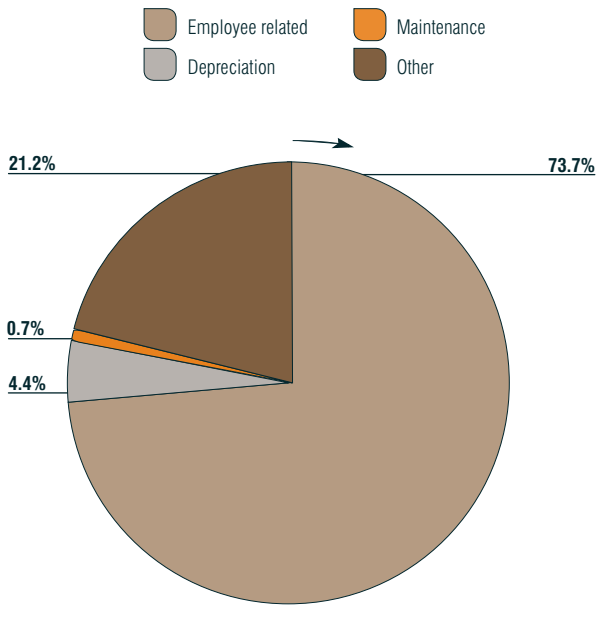


Figure 8: Total expenses 2003–2004

Employee related	$14,212,000
Depreciation	$847,000
Maintenance	$142,000
Other	$4,091,000
Total	**$19,292,000**



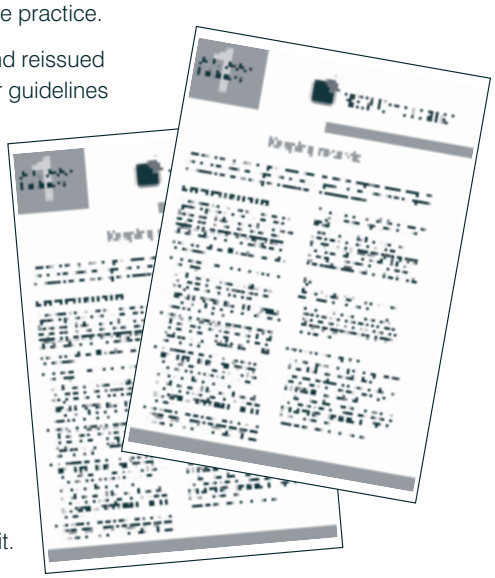
guidelines

Over the past 10 years we have published a series of guidelines and fact sheets for organisations within jurisdiction. These publications can be broadly divided into two categories:

- the handling of complaints, disclosures and notifications, and
- good conduct and administrative practice.

Most of our guidelines were updated and reissued during the course of the year. Our major guidelines included:

- Child Protection in the Workplace: Responding to Allegations Against Employees
- Enforcement Guidelines for Councils
- Good Conduct and Administrative Practice
- Investigating Complaints — A Manual for Investigators
- Protected Disclosures Guidelines, and
- The Complaint Handler's Tool Kit.



The guidelines have been well received across the public sector, the community services sector and by organisations that have child protection obligations. They have also been widely used by equivalent organisations in Australia and New Zealand as the basis for guidelines issued by those organisations. This includes investigation guidelines published by the Crime and Misconduct Commission (Qld), the Corruption and Crime Commission (WA) and the WA Ombudsman. Our Protected Disclosures Guidelines have been used by the Public Sector Standards Commission (WA), Victorian Ombudsman and Tasmanian Ombudsman. We have also agreed to the Northern Territory Ombudsman adapting many of our guidelines for their own use and have given permission for various fact sheets and guidelines to be used by a range of other organisations.

This year we have also issued a number of fact sheets in most major areas of jurisdiction. In relation to public sector agencies, fact sheets so far issued in an A-Z series include: Apologies by public officials, Bad faith, bias and breach of duty, Conflict of interests, Discretionary powers, Enforcement, Frankness and candour, Gifts and benefits, and Handling complaints. A number of these guidelines and all fact sheets can be downloaded from our website.

special reports to parliament

Sometimes we feel it is in the public interest to reveal to the public the concerns we have about a particular issue or a particular agency. We will make a special report to Parliament in these cases.

During 2003-2004 we tabled two special reports to Parliament. They were about:

- inadequacies in the provision of services to children and young people with a disability by the Department of Ageing, Disability and Home Care, and
- supported accommodation assistance program (SAAP) services for homeless people, in particular, the effect of agency exclusion policies on people with high and complex needs.

These reports are discussed in further detail in chapter 3: community services division.

corporate governance

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 need to be flexible and adapt readily to change. We continually monitor our performance to identify areas for improvement and then work towards making those improvements.

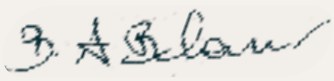
We have found that employing and developing specialist staff is the most effective way of fulfilling our various functions. We also make sure that corporate knowledge is shared and work and management practices are consistent across the individual teams.

This section discusses some of our strategies for meeting the challenges we face.

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, each 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 is crucial to maintaining our independence because it ensures that we are accountable to Parliament, not to the government of the day.

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 s.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 the report if we feel it is in the public interest.

Each year we enter our annual report in the Australasian Annual Report Awards. All NSW public sector agencies are encouraged to do this as a means of promoting better reporting practices. Our 2002-2003 annual report won a silver medal, as did the previous two annual reports.

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 code of conduct, the information security policy and the records management policy. We also have consistent performance indicators across the different teams.

We are finalising our review of our corporate plan to take into account the new functions we perform since the merger of the former Community Services Commission. This year we engaged an external consultant to conduct focus groups and obtain feedback from a variety of staff members to develop a new statement of corporate purpose. This will be introduced next year.

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. We have performance benchmarks to measure these factors at the corporate, team and individual staff level and use workflow statistics to inform procedural changes. Key performance indicators are reported on in this report. The general team reviewed its performance indicators during the year with the assistance of an evaluation consultant and is currently considering possible changes to the indicators they use.

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. In particular we look at timeliness and the quality of our decision-making.

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

At an organisational level, we have put in place vigorous checks and balances in areas of high risk such as where money, staff entitlements or our computer network could be compromised. Our accounts, personnel and payroll systems are also subject to external scrutiny, being audited annually by external auditors.

timeliness

We have set performance benchmarks for file turnaround times and have consistent monitoring to identify where there may be backlogs, delays or inefficiencies. We periodically review all files that have been open for more than six months and conduct internal audits of file handling.

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. If an agency's tardiness is causing an unreasonable delay, we will try to escalate the matter. If a matter takes too long to resolve, there is a risk that all affected parties could be unsatisfied and it may be too late for any of our recommendations to be implemented.

accuracy, integrity and good decision-making

To ensure the integrity of the information we keep, we regularly audit the recording of information on our case management system to check its accuracy.

We also use close supervision and systems for consultation and discussion to ensure that we make sound and consistent decisions when assessing complaints and notifications. However, there will be times when our reasoning could be improved. If a complainant challenges one of our decisions we make sure that a different, and usually more senior, member of staff reviews the decision so that the most appropriate action is taken.

We also have rigorous procedures for supervising, checking and authorising any correspondence and reports we send out to make sure they are factually accurate and properly reasoned.

internal structures and systems

We aim to provide a cohesive and open environment for staff and use our resources and corporate knowledge in the most effective way. Our internal structures and systems are designed to achieve this.

Changes to the structure of the community services division took effect this year. These changes were designed to improve the division's capacity to respond to individual, service-level and systemic issues and to bring them more into line with our other office structures. Major features of the new structure include:

- a new position of principal investigator and projects officer created to give the division more capacity to conduct major investigations, have quality assurance for reports and manage projects as they arise from time-to-time
- expanding the role of the team leader for official community visitors to supporting systemic improvements in the agencies visited
- the creation of the dual position of team leader, complaints/legal officer to provide the division with legal advice.

This year we also reviewed the structure of our personnel section. In 2004-2005 we will implement a new structure for our personnel section to better support the business areas of the office. We also held a records planning day to critically examine whether our structures and work processes were appropriate. As a result, we will be improving the training we provide for records staff and reviewing our records management policies.

We received an increment to our budget after the closure of the Office of the Inspector General of Corrective Services to increase our capacity to deal with correctional complaints. We now have a correctional unit within the general team that handles the majority of complaints from correctional centre inmates. This unit has a senior investigation officer, two investigation officers and two complaints officers.

policies and procedures

We continued to review and develop our policies and procedures during 2003-2004. A number of new policies were implemented, including our interviewing complainants policy and procedures and our style guide. A revised version of the general team procedures manual was also issued.

meetings

Our senior staff meet weekly to review the progress of work, exchange information and discuss issues of concern.

Team managers, office-wide committees, issues groups and teams meet regularly to discuss current developments, share information, and reinforce new policies or management directions. We also hold a meeting for all staff once a month.

Over the past year our child protection team and community services division have worked together on various projects and met regularly to consult about common issues and agencies.

intranet, newsletters, bulletins and operations reports

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

Our intranet gives staff easy access to complaint management information, legislation, precedents, the policy and procedure documents of agencies we keep accountable, some management and other reports.

This year each operational team presented a lunchtime session to inform the rest of the office about their functions and the kind of work they were doing.

training and development

Members of staff work most effectively when they have up-to-date information and are trained in the appropriate skills. This year our staff took advantage of training opportunities in topics as diverse as risk management processes, legal issues, supervisory skills, plain English writing, conciliation and mediation skills, mental illness awareness, network and operating systems, and project management. In-house training in operational topics relevant to each team is provided regularly. Staff were also trained in the use of our electronic document management system and in issues relating to occupational health and safety.

The NSW government has supported a number of executive development programs designed to provide encouragement for people with leadership potential by developing their skills and knowledge of issues concerning public administration. This year the government funded two members of our staff to undertake studies for a graduate diploma in public administration.

See 'Corporate support' for more details.

relationships with others

ombudsman offices here and overseas

Like other Australian Ombudsman, we are part of the International Ombudsman Institute and participate in the activities of the Australasian and Pacific Regional Group.

This year our Ombudsman, Bruce Barbour, attended the 21st APOR conference in Madang, Papua New Guinea as the recently-elected Regional Vice-President for that region and Director of the International Ombudsman Institute. At that meeting the members agreed to endorse the formation of the Pacific Islands Ombudsman Forum for the purposes of promoting and strengthening the institution of the Ombudsman in the Pacific region, thereby ensuring good governance and stable leadership in the region. Our office is providing ongoing support for this initiative. In particular, we are working with the Commonwealth Ombudsman on a project for the institutional strengthening and capacity building of each of the Pacific Islands Ombudsman. AusAID has agreed to provide financial assistance.

We continue to be a leader in the field of accountable public administration. We are pleased to promote the importance of the Ombudsman concept in other jurisdictions and to make our guidelines and experience available. Networking with other Ombudsman's offices also gives us the opportunity to learn from their experience and provide mutual support. This year we were visited by the New Zealand Ombudsman, and later staff of that office, as well as staff from the Queensland Crime and Misconduct Commission. We also provided briefings to delegations from the Chinese Ministry of Supervision, the Shanghai Municipal Government, the Legislative Bureau of the House of Councillors of the Japanese Parliament and to members of the Supreme Court and High Court of Indonesia.

Our Deputy Ombudsman, Chris Wheeler, has been in regular contact with Deputy Ombudsman from other States to discuss operational issues, including the preparation of a paper to be presented to the Standing Committee of Attorneys General in relation to accountability of cross-border law enforcement activity.

other watchdog agencies

We are part of the Joint Initiatives Group (JIG) which is a network of staff of watchdog agencies covering a range of jurisdictions. The group meets regularly to share information and resources and develop opportunities for joint activities such as training and community outreach. This year JIG continued its series of seminars to promote the discussion and understanding of issues and developments in complaint handling and alternative dispute resolution.

During 2003-2004 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 had similar meetings with the Children's Guardian.

We also liaise with watchdog bodies in other states. After our participation in the 9th Australasian Conference on Child Abuse and Neglect in November 2003, we met with Queensland's Commissioner for Children and Young People and a representative from the Victorian Ombudsman to share educational materials and discuss our jurisdiction and processes.

agencies within our jurisdiction

It is very important for us to maintain cooperative relationships with the agencies we scrutinise. 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 Department of Community Services, the Department of Ageing, Disability and Home Care and the different state departments providing services to children (including the Department of Education and Training (DET)), as well as with peak bodies representing non-government agencies that provide services to children (such as the Catholic Commission for Employment Relations (CCER)).

class or kind agreements and memorandums of understanding

In some areas of our work, we make formal arrangements with agencies to ensure a smooth working relationship and easily resolve issues as they arise. For example, we have a memorandum of understanding with the Department of Community Services to help us carry out our work with agencies providing community services and those providing services for children, and with the Department of Corrective Services in relation to their internal telephone inquiry system for dealing with inmate complaints. This year we also entered a memorandum of understanding with the Department of Local Government that included arrangements for referring complaints and sharing information.

In other areas of our work, we enter into agreements with selected agencies so that they do not need to report certain matters to us. This year we continued our 'class or kind' agreements with NSW Police, the DET and the CCER. Because of changes to the child protection scheme, we will be reviewing our agreements with the DET and the CCER next year.

We also have a 'class or kind' agreement with the PIC that defines the categories of police complaints that each of us is responsible for.

other stakeholders

Maintaining good relationships with community groups, unions, peak bodies, other interest groups and government departments involved with public administration is important to us. We regularly meet with, give presentations to and convene discussions with a range of organisations. For example, we hold a biannual round table discussion to share information on community services issues affecting children and young people with peak community bodies such as the Association on Children's Welfare Agencies, NCOSS, the Aboriginal Child, Family and Community Case Secretariat and the Country Children's Services Association.

We also hold biannual round table discussions to share information on issues affecting people with a disability with peak community bodies such as People with Disabilities Australia, NSW Council for Intellectual Disability, Multicultural Disability Advocacy Association, Carers NSW, ACROD NSW and the Disability Council of NSW.

This year we participated in the NSW Police child protection and sex crimes squad advisory committee which meets quarterly to discuss child protection issues and share information.

other international agencies

In July 2003 we received a request for information by email from a company in Wales that had been commissioned by the National Assembly for Wales and the National Health Service in Wales to undertake a review of existing guidelines in relation to allegations of child abuse against professionals and carers. A member of our staff was planning a holiday to Wales and arranged to meet with the agency. She gave them a briefing on the NSW child protection scheme, our responsibilities and our expectations of agencies when handling these kinds of matters. She also provided them with some of our guidelines.

Mr Geoff Briot (senior investigation officer) with a delegation from the Legislative Bureau, House of Councillors, Diet of Japan - (L to R) Ms Nanako Mataki, Mr Yoichi Ozaki and Mr Shigenori Musashi (Assistant Director).

relationships with our customers

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.

We record and analyse complaints, compliments and suggestions for improvement 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. During 2003-2004 we reviewed our procedures for dealing with delayed complaints, implemented more rigorous procedures and provided further training for staff.

This year we received a range of compliments about the quality of our advice and assistance to customers and the timeliness of our intervention.

Figure 9: Complaints about our office

Issues	Number
Bias/unfair treatment/tone	18
Confidentiality/privacy related	4
Delays	10
Denial of natural justice	3
Failure to deal appropriately with complaint	19
Lack of feedback/response	9
Faulty procedures	12
Inaccurate information/wrong decision	6
Poor customer service	28
Other	5
Total issues	**114**
Total complaints	**76**
% of all formal complaints finalised	**1%**

Figure 10: Complaints about our office – outcome

Outcome	Number
Unjustified	38
Justified or partly justified	7
Some substance and resolved by remedial action	31
Total complaints	**76**

requests for reviews of our decisions

We try to make sure that we provide complainants with a quality service by always giving reasons for our decisions and by handling any requests for reviews in a fair and professional manner.

A request for a particular decision to be reviewed gives us an opportunity to identify any weaknesses in our decision-making processes or in the way we communicate our decisions, and make improvements. It may also give us a chance to reconsider a matter in light of further information or a contrary interpretation of available information.

However, reviewing decisions often requires substantial resources and our long-standing policy is to only review a decision once. Although on some occasions the complainant concerned will be dissatisfied, our primary goal is to make an impartial decision in the public interest, not to satisfy every complainant who has dealings with us.

Due to the nature of their work, our general team traditionally receives the most requests for decisions to be reviewed. This year they assessed their review procedures after a noticeable increase in requests the previous year. They decided that, before reviewing a decision, they would try talking to a complainant first to discuss their concerns. We often find that a complainant asks for a decision to be reviewed primarily because they do not fully appreciate the reasons for our decision. Most of our decisions are communicated by letter. Telephoning gives us the opportunity to clarify issues and explain our decision more clearly. We will continue to monitor the effectiveness of this new approach over the coming year.

Figure 11: No. of requests to review our decision received this year (% of formal complaints finalised)

Subject	No. of requests	No. of formal complaints finalised	%	02/03
Child protection*	4	80	5.0%	2%
Community services	11	536	2.0%	N/A
Corrections	11	469	2.35%	2.98%
Freedom of information	7	129	5.43%	5.71%
Local councils	97	865	11.21%	13.31%
Other public sector agencies	107	1390	7.7%	8.38%
Police**	64	3316	1.93%	1.32%
Outside our jurisdiction	7	546	1.28%	1.82%
Total	**308**	**7331**	**4.2%**	**3.17%**

* Note: the majority of our work in the child protection area is overseeing how certain agencies handle allegations of conduct by employees that could be abusive to children. Only a small part of our work is handling complaints made directly to our office about how those allegations have been handled. We deal with those complaints in much the same way as with complaints about NSW public sector agencies - we may decide to decline the complaint, make preliminary inquiries or investigate. This table shows that, of the 80 complaints made directly to our office, 4 complainants asked us to review the decision we made on how to handle the complaint.

** Note: Although the system of handling complaints about police requires NSW Police to directly investigate each complaint, and our office plays an oversight role, the police team considers all requests to review the way a complaint about a police officer was handled as a request to review our decision in relation to the NSW Police outcome. This table shows that, of the 3,316 complaints about police officers that we oversighted this year, 64 complainants asked for the outcome to be reviewed.

Figure 11 shows the number of requests that we received this year, as a percentage of the formal complaints received in the different areas. As was expected, as many complaints about local councils involve neighbourhood grievances directly concerning the complainant, the number of reviews as a percentage of formal complaints in that area is the highest across the office. However, we were pleased to see a drop in the proportion of reviews this year across most areas of our work.

Figure 12 shows the number of reviews that we conducted, and the outcomes of those reviews. As each review may take days or weeks to complete, some requests we received this year will not have been finalised and the requests for some of the reviews we conducted this year would have been received in 2002-2003.

Performance indicator: Requests for review of our decision, as a percentage of complaints finalised in 2003-2004

Team	Target	02/03	03/04 Number of reviews
Child protection	<6.0%	2 (2%)	4 (3.5%)
Community services division	<6.0%	N/A	11 (2.2%)
General	< 6.0%	231 (9.1%)	229 (6.7%)
Police	< 1.8%	41 (1.3%)	64 (1.9%)

Interpretation

This year we reviewed this performance indicator in relation to the child protection team to better reflect what it aims to measure. In past years, the number of requests has been measured against the total number of notifications and complaints finalised. In practice, requests to review our decision only arise from the work we do handling complaints. Therefore, this year we have aimed for less than 6% of complaints finalised to return to our office as requests for our decision to be reviewed. This is now consistent with the general team. This year we have reported on the performance of the community services division for the first time.

Figure 12: No. of reviews of our decision conducted this year, with outcomes

	original outcome affirmed		Resolved	Reopened	Total
	after the review inquiry	after telephone			
Child protection	3	1	0	0	4
Community services	7	0	3	0	10
Corrections	8	3	0	0	11
Freedom of information	6	1	0	1	8
Local government	33	55	4	6	98
Other public sector agencies	60	30	6	8	104
Outside our jurisdiction	8	0	0	0	8
Police	60	0	0	4	64
Total	**185**	**90**	**13**	**19**	**307**

03: community services division

what we do

introduction

This year we have been consolidating our expanded role in community services, following the amalgamation of the former Community Services Commission in December 2002.

There is now a stronger and more streamlined framework for protecting consumer rights and scrutinising the delivery of community services, drawing on a combination of powers available under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and the *Ombudsman Act 1974*. Some of these powers, which were not previously available to the former Community Services Commission, enable complaints about community services to be assessed more readily and those services to be scrutinised more effectively than before. In particular, our ability to conduct investigations on our 'own motion' gives us the capacity to look into matters arising not only from complaints, but also from other areas of our work, including reviews of the death of vulnerable children and adults in care, concerns raised by official community visitors, or through our reviews of the circumstances of people in care.

For example, this year we started an investigation into the services provided to a particular child by the Department of Community Services and NSW Police before the child died, after concerns were raised during our review of the child's death. We anticipate that own-motion investigations will become an increasingly important area of our work.

People who rely on community services often also have concerns about the services they receive from other public sector agencies such as housing, health and the police. Our broad jurisdiction gives us the capacity to address issues for these people relating to all of the agencies providing them with services. For example this year we began looking at issues concerning people with an intellectual disability and the criminal justice system, and the access of people with a disability to services from the Department of Housing.

our functions

Our community services division is responsible for addressing issues of concern for consumers of community services and helping agencies to better respond to consumer needs and concerns. In particular, the division:

- handles, resolves and investigates complaints about community services
- monitors the implementation of recommendations we make for improving services
- provides advice or assistance to people making inquiries
- reviews complaint-handling systems
- coordinates the official community visitors scheme
- provides information and training to consumers of community services and agencies about complaint handling and consumer rights and needs
- promotes improvements to community service systems
- reviews the situation of people in care
- reviews the deaths of certain children and people with a disability
- promotes 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 those services.

community services we scrutinise

We can scrutinise and handle complaints about all community services provided by over 5,000 agencies including:

- the Department of Community Services (DoCS)
- the Department of Ageing, Disability and Home Care (DADHC), and
- non-government agencies who are funded, licensed or authorised by the Minister for Community Services, Ageing and Disability Services to provide certain community services. This includes licensed boarding houses and fee-for-service agencies.

These agencies provide a variety of services including:

- child protection and support services
- out of home care services (OOHC) for children and young people such as 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, Post-School Options/Adult Training Learning And Support (PSO/ATLAS) programs, day programs and attendant care
- supported accommodation and assistance program (SAAP) services including refuges for families and young people, women and men, proclaimed places, outreach and referral services.

reporting on our work

Much of the work of our office requires confidentiality and is also subject to legislative provisions that constrain our ability to make issues public. In our work we often deal with sensitive and personal information. However, special reports to Parliament are an opportunity for significant issues to be placed in the public domain - in the public interest - and we are committed to this form of reporting whenever the issues demand.

During 2003-04 we presented two special reports to Parliament about our inquiries into:

- SAAP services for homeless people, and exclusion policies which impact particularly on people with high and complex needs. Our inquiry revealed that most exclusions from services were linked in some way to limited capacity and resources in the SAAP program, and incapacity in other service systems, particularly health and disability, and
- Inadequacies in the provision of services to children and young people with a disability by DADHC. Our inquiry highlighted a lack of service options for supporting those children and young people at risk of entering out-of-home care, and too few respite care services.

We are continuing to work with the agencies and peak bodies involved about the issues raised in our special reports, and will monitor the extent to which our recommendations are implemented.

working with stakeholders

We have found that we are most effective when we are able to work cooperatively with agencies providing community services, and with peak and advocacy bodies. We meet regularly with DoCS and DADHC and conduct six-monthly 'round tables' with key stakeholders in the child and family sector and disability sector to share information on key issues. We also benefit from the valuable advice and expertise of our child death and disability death advisory committee members in regard to complex death matters, policy and health practice issues.

We discuss our work with different stakeholders later in this chapter.

→ future directions

In 2004-2005, we plan to focus particularly on the following areas:

child protection:

- the adequacy of responses by DoCS to risk-of-harm notifications
- the development and implementation by DoCS of prevention and early intervention services for children and families and of a protocol to guide their work with Aboriginal and Torres Strait Islander children and families
- systemic issues raised in relation to the deaths of children reviewable by our office
- monitoring the continuing roll-out of $1.2 billion in extra funding to DoCS for child protection, OOHC and early intervention, and the impact it has on improving outcomes for children, young people and families.

out of home care services:

- DoCS's use of agencies providing fee-for-service care and support to the most vulnerable children and young people in care, and the extent to which there is a strong assessment and monitoring framework to ensure that quality care is being delivered
- DoCS protocols and procedures for recruiting, assessing, training and supporting foster carers, the case management of children in OOHC, and the role of DoCS foster care support teams
- planning by DoCS and DADHC for people leaving care, in particular young people with disabilities leaving statutory care.

in disability support and accommodation services:

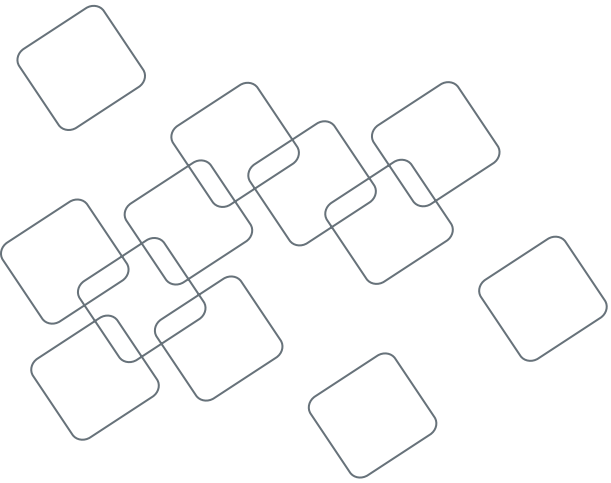
- services for people with an intellectual disability in the criminal justice system
- progress of the devolution of large residential services
- implementation of DADHC's systems for monitoring the quality of the services it funds
- service provision for children and young people with a disability and their families
- the adequacy of planning for the individual needs of people with a disability in care
- systemic issues surrounding the deaths of people with a disability in care reviewable by our office.

in SAAP services:

- more inclusive access to SAAP for people with high and complex needs and the effectiveness of complaint-handling systems in SAAP agencies.

in services that our official community visitors visit:

- working with official community visitors and key agencies to improve service delivery in residential services for children, young people and people with a disability.



investigations and complaints

We received 1,740 formal and informal complaints about community services during 2003-2004.

The majority of complaints are made to us orally - usually by telephone - and often by family members, guardians, advocates and others with a genuine interest in the situation of people receiving services.

Over half of these complaints were about services provided by DoCS, with another 15% about services provided by DADHC. Around 16% (or 280) of the complaints we received were about non-government funded, licensed and authorised services. Figure 14 shows a breakdown of the complaints we received by the agency concerned.

Figure 13: Program areas the subject of complaint 2003-2004

Program area	Number	%
Child protection services	622	36
Out of home care services	356	21
Disability accommodation services	234	13
Disability support services	159	9
Aged services	54	3
Childrens services	32	2
Supported accommodation and assistance program (SAAP) services	20	1
Adoption services	14	1
General community services	15	1
Family support services	9	0.5
Disaster welfare services	0	0
Other	8	0.5
Outside our jurisdiction	76	4
General inquiry	141	8
Total complaints received	**1740**	**100**

Most of the complaints were about:

- child protection services provided by DoCS
- out of home care services — provided by DoCS and non-government agencies
- disability accommodation and support services — provided by DADHC and non-government services.

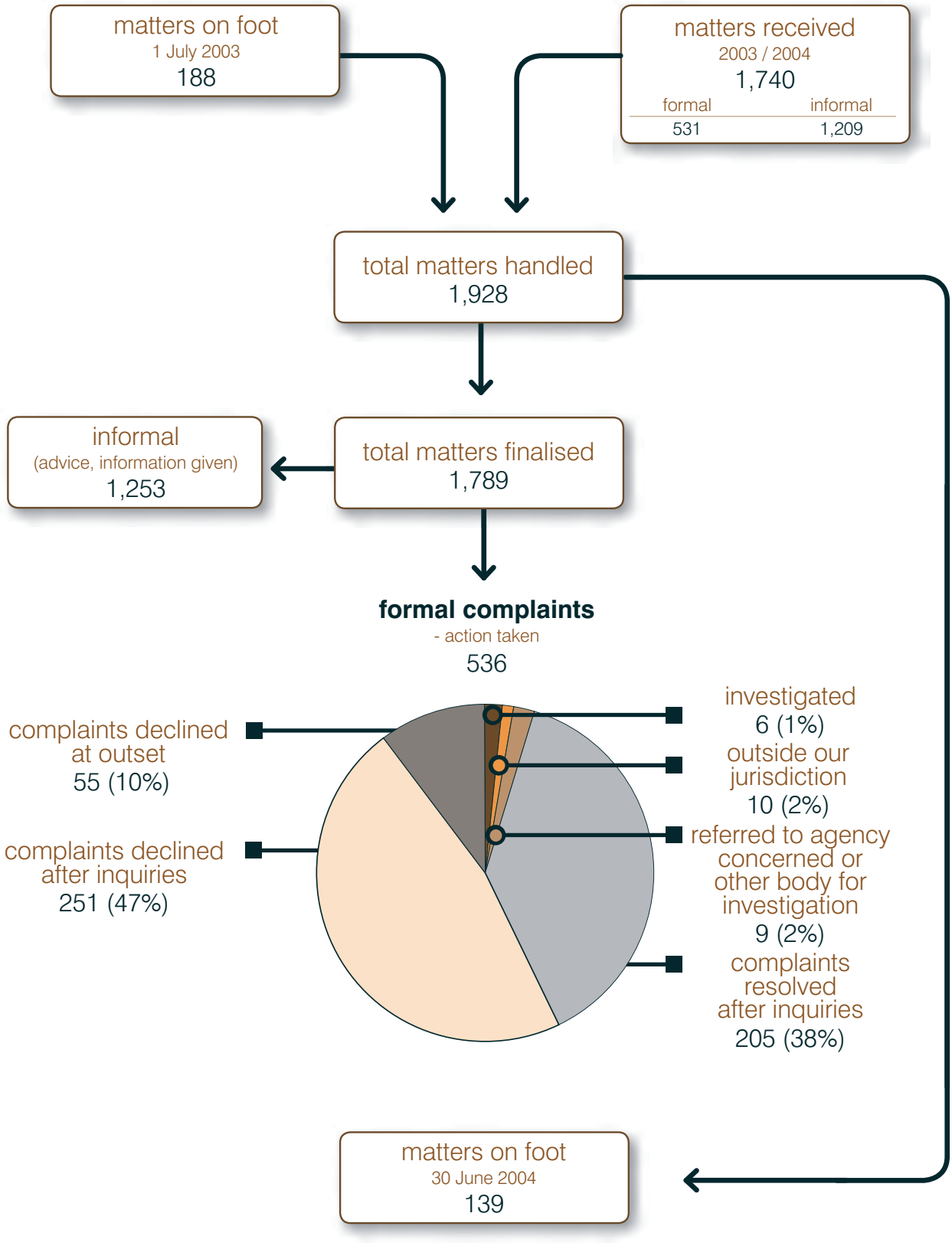
Figure 13 shows a breakdown of the complaints we received by the program area concerned.

Our work has identified inconsistencies in how DoCS and DADHC respond to complaints. We are aware that both departments are in the process of developing new complaints systems and we will monitor the implementation of these systems in 2004-2005.

Figure 14: Agencies the subject of complaint 2003-2004

Agency	Number	%
DoCS:		
Child protection services	603	35
Out of home care (OOHC) services	314	18
Other (incl. requests for assistance, licensing)	27	1.5
Adoption	13	0.5
Sub-total	**957**	**55**
DADHC:		
Disability accommodation and support services	178	10
Home care service	76	4.5
Policy and strategic services	12	0.5
Sub-total	**266**	**15**
Non-government funded or licensed services:		
Disability services	113	7
Out of home care (OOHC) services	46	3
Home and Community Care (HACC) services	39	2
Supported accommodation and assistance program (SAAP) services	17	1
Childrens services	19	1
Boarding houses	12	0.5
General community services	10	0.5
Family support services	4	0
Other	20	1
Sub-total	**280**	**16**
Not in jurisdiction	96	6
Other (general inquiries)	141	8
Total complaints received	**1740**	**100**

Figure 15: Matters received and handled this year by the community services division



licensed boarding houses

We have only had jurisdiction over licensed boarding houses for adults with disabilities since December 2002 and, in 2003-2004, received 12 complaints about these centres.

We have been actively providing information to the proprietors of boarding houses to help them better understand their obligations under CS-CRAMA and how our work may affect them.

Next year we will continue to work with proprietors and other key support services such as Home Care/HACC services, Active Linking Initiative (ALI) providers and health services to provide more information to residents of licensed boarding houses about their rights to complain.

issues

People can complain to us about all aspects of an agency's conduct. In particular, people have the right to complain about the way an agency provides, fails to provide, withdraws, varies or administers a community service.

This year, concerns about how DoCS responded to child protection risk of harm reports made up almost a quarter of the complaints we received. Other issues most frequently complained about included:

- failure to meet the individual needs of people, particularly children and young people and people with disabilities in care
- failure to adequately develop and implement case, individual and behaviour management plans for people in care
- failure to address the human rights of people in care including their education, health, hygiene, nutrition and safety and the maintenance of their family relationships
- inadequate responses by agencies to concerns and complaints about the provision of services
- access to services, particularly accommodation and support services and HACC services for elderly people and people with disabilities
- failure to involve people receiving services (or their families and advocates) in planning and decisions affecting them
- failure to make adequate arrangements for the placement of children and young people in out of home care
- inadequate arrangements for recruiting, training, assessing and supporting foster carers.

complaints finalised

We finalised 1,789 complaints this year - 1,253 informal and 536 formal complaints. See figure 15.

We call complaints 'informal' if we provide information and advice or suggest that the person try to resolve their complaint directly with the agency concerned. We generally tell people that they should contact us again if they are not able to achieve a satisfactory outcome by dealing directly with the agency. See figure 16 for the outcomes of the informal complaints we finalised. Please note that there may be more than one outcome per complaint because we may deal with various aspects of a complaint differently. For example we may refer one aspect of a complaint to another agency but provide information and advice on another aspect.

We call complaints 'formal' if we take direct action to resolve or investigate the complaint. We try to resolve formal complaints in several different ways. Firstly, we make inquiries and assess each complaint. If there are complex issues about the current care, treatment or safety of a person our assessment may involve asking the agency for a detailed response or the person's case file.

Often our inquiries will, in themselves, resolve the complaint. If further involvement is necessary, we may:

- refer the complaint for resolution by the agency concerned
- refer the complaint for investigation by the agency concerned
- refer the complaint for investigation by another agency — for example the funding body such as DoCS
- try to resolve the complaint through conciliation
- investigate the complaint ourselves
- take no further action — this could be, for example, if the complaint raises no serious or significant issues or if a court, tribunal or other legal body has or can make a decision about the issues raised.

Even if we decide that no further action is warranted, we may make comments or suggestions to help agencies improve their systems, policies and procedures. During 2003-2004 we provided this kind of feedback as part of our handling of 40 formal complaints.

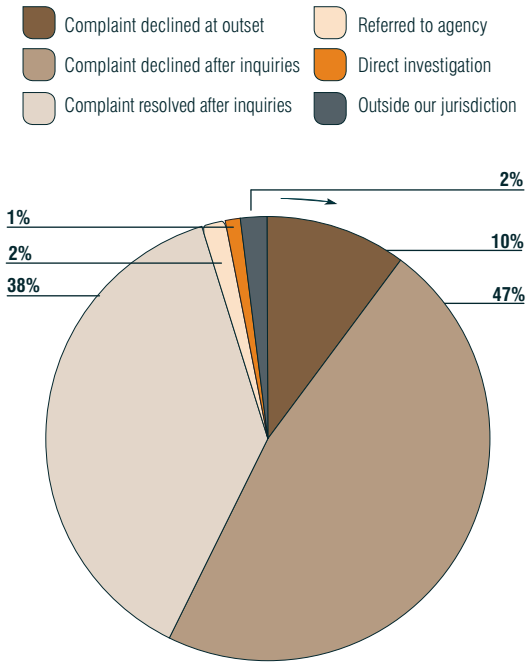
Figure 17 shows the action we took on the 508 formal complaints we finalised in 2003-2004. Please note that there may be more than one outcome per complaint because we may deal with different aspects of a complaint differently. For example we may decline one aspect after unsuccessfully trying to resolve it, but resolve another aspect successfully. Case studies 1,2,3,4 and 5 are examples of some of the complaints we handled this year.

Figure 16: Outcomes for informal complaints finalised 2003-2004

Outcome	Total	%
Informal complaint in jurisdiction		
Provide information and advice	368	28
Premature complaint – referred to DoCS	243	18
Complainant agrees to resolve complaint with service provider	174	13
Complainant decides not to pursue complaint after advice	70	5
Refer complainant to other agency	48	4
Advised to seek legal advice (civil/criminal matter)	44	3
Premature complaint – referred to DADHC	44	3
Premature complaint – referred to NGO	14	1
Refer complainant to advocacy support	9	1
Total	**1014**	**76**
Informal complaint - out of jurisdiction		
Provide information and advice	66	5
Refer to government agency	46	4
Advised to seek legal advice (civil/criminal matter)	21	1
Refer to other agency	7	1
Refer to other Ombudsman team	8	1
Refer to non-government agency	5	0
Refer advocacy, support service	5	0
Total	**158**	**12**
Informal complaint - general inquiry		
Provide information and advice	98	8
Refer to government agency	30	2
Refer to other agency	17	1
Advised to seek legal advice (civil/criminal matter)	7	1
Refer to non-government agency	4	0
Refer advocacy, support service	1	0
Total	**157**	**12**
Overall total	**1329**	**100**

Figure 17: Outcomes of formal complaints finalised 2003 - 2004

Complaint outcome	Total
Complaint declined at outset	55
Complaint declined after inquiries	251
Complaint resolved after inquiries, including local resolution by the agency concerned and complaints conciliated by our office	205
Referred to agency concerned or other body for investigation	9
Direct investigation	6
Outside our jurisdiction	10
Total	**536**



casestudy1

A mother complained to us that a child care centre had decided to exclude her daughter from the centre because of her newly diagnosed intellectual disability. Although she had made other arrangements for her daughter's child care, the mother remained very concerned about the centre's decision. Our preliminary inquiries found that DoCS, who license child care centres, were already aware of the complaint and were reviewing the centre's entry and exclusion practices.

We monitored the outcome of the DoCS review. They found that the child care centre staff had very limited understanding of intellectual disability or expertise to assess a child's needs. The review also resulted in DoCS and DADHC developing a training program for child care centre staff about assessing the needs of, and working with, children with disabilities.

casestudy2

DoCS has parental responsibility for a 17-year-old who would formerly have been known as a 'state ward'. He is about to turn 18, at which time DoCS will cease to have any responsibility for his care. The young man phoned us to say that three months previously DoCS had held a case conference to plan for his leaving care, agreed to help him set up his own flat, and linked him with an after-care service. He had been in care for three years, had got a job, saved and purchased most of his furniture. He attends TAFE and is studying for a welfare certificate. He said he had struggled and worked hard to overcome many problems.

The young man said DoCS had delayed paying, or was now refusing to pay, for some household items such as a fridge that they had previously agreed to fund. He also said that he had asked DoCS to make a contribution to his 18th birthday party. A temporary DoCS manager had told him that his leaving care plan did not specify exactly what was agreed to, he was asking for too much, and any decision to approve financial assistance would have to wait until the permanent manager returned. The young man was very worried that nothing would happen until after he turned 18 and he would then be left without assistance and with debts, because he had budgeted taking into account what he understood DoCS would fund.

We phoned the young man's DoCS case manager who explained that he was generally well supported, but that recent contact had been minimal as staff had been involved in training about the new DoCS computer system. The manager confirmed there had been delays in approving financial assistance because a temporary manager was in place, and that a final case conference was planned for the following week to sort out all outstanding issues in helping the young man to become independent. The manager agreed to contact him immediately to talk things over.

We later heard that DoCS had sorted out the young man's concerns and helped him with the costs of setting up his home.

casestudy3

A foster care couple complained to us that DoCS had breached their privacy by disclosing personal information about them during children's court proceedings. In response to our preliminary inquiries, DoCS acknowledged their breach of the privacy principles of the *Privacy and Personal Information Protection Act 1998* and formally apologised to the couple.

DoCS also undertook to produce new interim guidelines for their staff about this Act and the privacy principles. We have monitored the development and dissemination of these guidelines — they provide clear advice to staff about how to mange personal and private information.

casestudy4

A young man in his twenties has a severe intellectual disability that results in behavioural problems. An official community visitor informed us that the non-government disability accommodation service where the young man lived planned to exit him from the service because they believed they could no longer manage his challenging behaviour.

The visitor said that the service had not found alternative accommodation for him, nor had they consulted adequately with his parents who were also his guardians. Instead, the service planned to return him to his parents' care even though they were elderly and in poor health.

We met the young man's parents and they made a complaint about the service's decision regarding their son. We made preliminary inquiries with the service and the Department of Ageing, Disability and Home Care (DADHC) about the young man's situation, the level of support he was getting, how the service was addressing his challenging behaviours and the exiting process. The service agreed to hold off exiting him while we looked into the matter.

The service talked to DADHC about the young man's care needs and DADHC arranged alternative accommodation with another non-government disability service. His parents and the visitor were satisfied that the new arrangement met his long-term needs.

We made comments to the service and to DADHC about the exiting process and related service provision issues. In turn, DADHC started intensive work with the service to address these issues.

casestudy5

A young man with an intellectual disability was in gaol and eligible for parole. However parole was dependent on DADHC finding suitable accommodation for him in the community. His mother complained to us that DADHC were taking too long to arrange the accommodation.

Our preliminary inquiries indicated that DADHC were actively looking for accommodation options. They were also negotiating a service agreement and joint case management plan with the Department of Corrective Services, the Corrections Health Service and the Department of Health so that the young man had access to ongoing supports once he was paroled.

Because of his vulnerable situation, we monitored DADHC's progress on this matter.

After a number of months, DADHC located a suitable placement with a non-government disability service and the young man was released from gaol. DADHC and other involved agencies are cooperating in supporting his successful transition back to community living.

However we remain concerned about the adequacy of DADHC and interagency support arrangements for people with intellectual disabilities who are in the criminal justice system. Better protocols are needed to guide DADHC and other agencies in their work with people in this situation.

helping agencies to resolve complaints

One of the quickest and most effective ways of handling complaints is for the agency concerned to resolve the complaint themselves. This is especially appropriate in the community services sector where agencies and the people who receive their services (in particular children and young people, people with disabilities and elderly people) are often involved in a long-term relationship of support or care.

When we refer a complaint to an agency, we find out how they plan to handle the complaint and may also suggest ways of resolving it. If we feel the agency needs closer scrutiny, we may monitor their investigation closely.

Agencies must report back to us about the outcome. If the complaint has not been resolved, we assess whether further action may be necessary. Sometimes we also suggest improvements to the agency's complaint-handling systems.

In 2003-2004, we referred 95 of the 508 complaints finalised to agencies for local resolution and 87% were successfully resolved. The other 13% were considered to be 'declined after inquiries' because they could not be successfully resolved.

See case study 6 for an example of a complaint that was resolved locally by the agency concerned.

referring complaints for investigation by the agency concerned or to another body

Sometimes we refer a complaint back to the agency concerned, or to the funding body (that is, DoCS or DADHC), for them to investigate. This year we referred several complaints about disability accommodation services – six non-government, funded services and one DADHC disability service – to the agency concerned to investigate. These complaints contained allegations of abuse of residents, inadequate responses to critical incidents, problems with health and medical care, and concerns about policies and procedures such as complaints handling policies and procedures.

We also referred a matter to DoCS about the adequacy of support for, and supervision of, a foster care family and the decision-making process leading up to the removal of the children from the foster carers.

conciliating complaints

If there is a high level of conflict between a complainant and an agency, or other ways of resolving a complaint have been unsuccessful, we may try formal conciliation. Both parties must voluntarily agree to participate in this process.

In 2003-2004, we formally conciliated seven complaints. Five matters were about disability accommodation and support services, and one each about an out-of-home care service and a SAAP service. We assisted the parties to reach agreements about issues such as communication and future service provision. See case studies 7 and 8 for examples of complaints we have successfully conciliated.

casestudy6

A couple who were former foster carers of a boy in care complained to us about DoCS' arrangements for their contact with the boy after he moved to a long-term placement. We contacted DoCS and they agreed to organise a professional assessment of the boy's situation to help inform their decisions about future contact arrangements. We therefore referred the complaint to DoCS for resolution.

DoCS reported to us that, as a result of the professional assessment, contact between the boy and his former foster carers was being increased. The assessment had also raised issues about the long-term carer's compliance with contact arrangements so DoCS organised a mediation session between both sets of carers to resolve differences.

DoCS' local resolution of the complaint addressed the foster carers' concerns and gave the boy the opportunity to maintain contact with people who were important figures in his life.

casestudy7

The long-term DoCS foster carers of a 17 year old young man with an intellectual disability complained of inadequate support from DoCS for the young man and themselves, particularly when his behaviour became more challenging. They also complained that DoCS was not planning for his support after he turned 18, at which time responsibility for his long-term care would shift from DoCS to DADHC. The foster carers told us that they had been unsuccessful in resolving their concerns directly with DoCS over a long period.

As there was significant dispute between the family and DoCS, and a need to clarify arrangements for the young man's future care and support, we arranged a conciliation involving the foster carers, DoCS and DADHC. An agreement was reached which included a combined DoCS / DADHC action plan about meeting the young man's immediate and future needs.

During the conciliation, DoCS also formally acknowledged the high level of care and advocacy the foster carers had provided to the young man and apologised for the difficulties that had occurred in resolving their concerns.

casestudy8

A 16 year old complained about a young person's refuge (SAAP service) that had asked him to leave. He said that the service did not give him an opportunity to reply to allegations made about his behaviour, before asking him to leave, and did not help him to find alternative accommodation. The service told us that there had been a number of instances of difficult behaviour and that the young man had been asked to leave after a third and final warning, in accordance with their policies.

Although the young man had found alternative accommodation by the time he complained, it was important to resolve the matter as young people such as him can sometimes be excluded from a SAAP service if there is a history of difficult behaviour.

With the agreement of the young man and the service, we conciliated the complaint and helped him to find an advocate to support him.

During the conciliation, the young man voiced his concerns to the service manager but accepted responsibility for some of the incidents. The service manager acknowledged that the service did not handle the situation well and apologised to the young man about this. He also told the young man that he was welcome to return to the refuge if he ever needed to in the future.

investigating serious complaints

We will investigate a complaint ourselves if it raises serious questions about the current care, treatment or safety of vulnerable people, or significant questions of public interest. During 2003-2004, we started five investigations and finalised six others.

special report to Parliament

Our investigation into services being provided by DADHC for children and young people with a disability raised concerns that we felt should be made public. We made a special report to Parliament about this investigation in April 2004.

There are over 115,000 children and young people with disabilities living in NSW, and it is estimated around 35,000 of them need ongoing support from specialist disability services. DADHC's services are clearly of critical importance. We began our investigation because of concerns raised by individual complaints, in-care reviews, and official community visitor reports about DADHC's systems and practices.

We found that there were significant deficiencies in DADHC's implementation of their policy for children and young people, 'Living in the community — putting children first'. There are high levels of unmet demand for permanent supported accommodation and respite services for people with a disability and their families. The significant stress experienced by many families who care for children with a disability is unduly aggravated when they are not able to get the services they need to support them through difficult times.

In particular, we identified:

- a lack of clarity about how to get services and a fragmented and inconsistent system for those able to access them
- poor coordination of services
- no clearly defined avenue for review and appeal when services were denied or considered inadequate by families.

DADHC accepted our findings and recommendations and have begun to implement a detailed 'action plan' to address the problems we identified. We will continue to monitor the implementation of their action plan.

other investigations finalised

We finalised several investigations into DoCS this year. One matter concerned the adequacy of DoCS' assessment and supervision of kinship carers and their response to allegations of abuse of children in foster care placements. See case study 9.

We also investigated how DoCS assess and prioritise the child protection risk-of-harm reports they receive. Although our investigation confirmed that the DoCS community service centre had responded to the risk-of-harm reports in accordance with procedural requirements, we were concerned about delays by their Helpline in processing and referring the reports to the community service centre. These delays had the potential to hamper a prompt and effective response to the reports. We have asked DoCS for more information about the operation of the Helpline, and are monitoring what they do in response to our concerns.

This year we also investigated DADHC's enforcement of licensing conditions in licensed boarding houses. See case study 10.

Another of our investigations this year was into a decision by a non-government disability support service to remove an adult with disabilities from the service. We found that the service's decision was unreasonable. In response to our finding and recommendations the service apologised to the person and their family, and amended their exiting policies and procedures so that the problem does not happen again. DADHC made arrangements for the person to receive an appropriate alternative service.

casestudy9

We investigated the adequacy of DoCS' assessment and supervision of kinship carers and their response to allegations of abuse of children in a foster care placement. We were concerned that DoCS' assessment of the carers had not taken into account all relevant information, particularly past child protection allegations concerning the family. We are monitoring DoCS' implementation of our recommendations about the carer assessment process and how they check the probity of foster and kinship carers.

In 2001 DoCS approved a woman as a foster carer for Aboriginal children. She and her husband had three children of their own living in the family home.

In early 2002 a DoCS Community Services Centre (CSC) placed four siblings, aged three to 11 years, with the woman — 'the first children'. In mid-2002 allegations were made to DoCS that the foster carers had abused the children. DoCS did not inform the foster carers of the allegations, nor investigate them at that time. They had still not done so when they decided to remove the children from the placement in August 2002.

About two weeks later, a second DoCS CSC placed a family of five children — 'the second children' — aged four months to seven years with the woman when their mother, who was homeless, signed a temporary care agreement. DoCS had still not addressed the allegations of abuse in care concerning the first children. Subsequently, further extensive concerns were reported to DoCS about the safety and well-being of the second set of children. In October and November 2002, two siblings of 'the second children' self-placed with the foster carer, after their mother signed temporary care agreements for both of them.

While 'the second children' were in the woman's care, a third DoCS CSC placed another three-year-old child with her for two months. This third placement occurred despite the fact that the women had seven foster children and her own three children in her care and was already providing care in excess of the approved number of children.

It was not until November 2002 that DoCS finally acted in response to the allegations of abuse in care and removed 'the second children' from the placement. In December 2002, DoCS revoked the woman's approval to foster.

The woman complained to us about DoCS' actions in placing children with her when there were allegedly concerns about her capacity to undertake foster care, their decision to revoke her carer authority, and the lack of support she received from DoCS during the placements.

We subsequently added to these complaint allegations — the adequacy of the DoCS investigation of risk of harm reports and the adequacy of the process that authorised the woman as a carer in the first place.

During our investigation, DoCS conducted a comprehensive review of the case which showed that:

- cultural issues were affecting the way DoCS addressed the concerns about the foster carers
- because of cultural factors, DoCS staff applied 'double standards' when assessing the risks to the children and deciding to not proceed with an investigation and assessment when the first allegations of abuse in care were made
- caseworkers appeared to have tried to avoid acting in an insensitive manner
- staff vacancies in critical areas had affected the level of supervision and support for foster carers
- the process of assessing the woman as a foster carer was flawed, and the DoCS assessor had an unacknowledged conflict of interest.

Our investigation endorsed the findings of the DoCS review and noted their extensive failure to comply with their policies, procedures and legislative requirements.

We were deeply concerned that DoCS had, by failing to comply with their own procedural requirements and those laid down in the care and protection legislation, placed homeless children into an abusive household.

The direct result of DoCS' poor decision-making and management of this case, their failure to investigate properly the risk of harm reports about the children, and their failure to act on the information they had about the woman, had exposed children to further abuse. The risk of abuse may well have been lessened had DoCS provided appropriate support to the foster carer during both placements. At the very least, the issues would have been identified and the children removed much sooner.

We are monitoring DoCS' implementation of the recommendations from their internal review report and scrutinising how they address the serious and significant systemic issues identified.

casestudy10

This year we completed an investigation into how DADHC enforces boarding house licensing conditions, after a complaint about conditions in three particular boarding houses. We found that DADHC staff had made reasonable efforts to monitor the boarding houses, within the limited resources available.

The enforcement of licensing conditions had been severely curtailed following legal advice to DADHC in 1999 that they could not legally enforce conditions concerning the welfare and rights of residents, as opposed to those relating to the physical structure of boarding houses. Despite this advice DADHC had continued to monitor welfare and rights matters, even attempting to impose an extra condition that criminal record checks of staff working in the boarding house be conducted.

Conversely, we found that DADHC took no action to enforce licensing conditions where they had the power to do so, and stopped prosecuting breaches of enforceable license conditions. For example, DADHC staff have the power to enter boarding houses to inspect them and talk to residents. Our investigation identified that one boarding house proprietor obstructed the entry of DADHC staff over a long period of time, but no action was taken.

The consequence of DADHC's action was that boarding house residents, some of the more vulnerable people in our society, were often left in substandard conditions.

During our investigation, DADHC commissioned a review of the legislation governing the licensing of boarding houses - the *Youth and Community Services Act 1973*. The review was completed in September 2003 and DADHC has prepared an options paper for the Minister.

As a result of our investigation, we also recommended that DADHC:

- Amend and ratify their policy and procedures for monitoring boarding houses and train staff about the policy. Our investigation identified that their licensing, monitoring and closure policy had been in draft form for a number of years.
- Review all boarding house files to ensure all relevant documentation has been placed on the files. DADHC supported this recommendation and agreed to reinforce with staff the importance of keeping reliable and accurate records.

monitoring recommendations for service improvement

At the end of each investigation, we often recommend improvements to services for particular individuals or the agency's systems. We then monitor the extent to which service providers implement our recommendations.

During the year we completed our monitoring of the implementation of recommendations we had made at the end of five investigations, including into the following matters.

- The quality of services provided to an adult with disabilities by the Home Care Service.

Our investigation had found significant problems with aspects of Home Care's assessment of the person's needs, and the way that they managed complaints about their services to that person. In response to our findings, the Home Care Service reviewed their service arrangements to ensure the person's needs were met, and also reviewed and updated their complaint-handling system and training for staff about the system.

- A non-government, fee-for-service, out-of-home care service's management of the challenging behaviours of a young person in care, and their behaviour management policies and procedures.

Our investigation found that the agency had poor policies and procedures for managing and responding to behavioural issues for young people with intensive support needs. The agency has since reviewed and amended their policies to our satisfaction. We have also worked closely with the official community visitor to monitor the service's management of the young people in their care, and have noted substantial improvements in day-to-day services.

- DoCS' policies, procedures and practices for determining when to intervene in the Family Court where there have been child protection risk-of-harm reports about children.

We found that DoCS's failure to intervene in a Family Court matter, in response to safety and care concerns for a child, was unreasonable. We also found that DoCS provided inadequate guidance to their staff about deciding when to intervene in such matters. In response to our findings and recommendations, DoCS clarified their policies and procedures and provided relevant information and training to staff. However, DoCS is still to finalise a protocol with the Family Court, guiding both agencies' responses to such situations. We will continue to monitor this aspect of the matter.

reviewing complaints systems

One of our functions is to review complaint-handling systems in individual agencies and community services sector program areas. Our aim is to help agencies more effectively resolve complaints themselves.

We did not conduct any new reviews during 2003-2004. We had planned to review 30 SAAP services but decided to wait for our special report to Parliament to be considered by those agencies concerned — we will be conducting those reviews in 2004-2005.

During the year, we were satisfied with the implementation of recommendations we had made following our review last year of the complaint-handling systems of 19 agencies providing disability respite care services.

coordinating the official community visitors scheme

Official community visitors are people appointed by the Minister for Community Services to attend places providing accommodation services for children, young people and people with a disability. This includes licensed boarding houses. These accommodation services are provided directly by DoCS and DADHC, or by non-government agencies that receive funding from DoCS or DADHC.

The role of the official community visitors is to:

- inform the Minister and the Ombudsman on the quality of the services being provided
- encourage the promotion of legal and human rights of residents, including the right to privacy, adequate information and consultation and the right to complain
- act on issues raised by residents, staff or other people having a genuine concern for the welfare, interests and conditions of residents
- provide information to residents about the advocacy services available to help them with their concerns, and
- help resolve complaints.

Official community visitors act, in a way, as the 'eyes and ears' of the Minister and the Ombudsman. They have legislative authority to enter and inspect places at any reasonable time, talk in private with any person who is a resident or employed by a service, and inspect any document relating to the service's operations. However they do not have some of the more coercive powers that we have, such as the power to require an agency to answer questions.

If official community visitors see practices or conduct that concerns them, and they cannot effectively address those concerns themselves, they can report their concerns to us and we will decide if it is in the public interest for us to become involved. Sometimes official community visitor reports enable us to see systemic flaws that may affect several agencies providing similar services, so we might investigate those kinds of concerns, or review the circumstances of a person in care, and try to achieve improvements across a whole sector.

We are responsible for coordinating the scheme, supporting visitors in their work and ensuring that they focus on visiting those people in care who are most vulnerable. We are also required to prepare an annual report on the work and activities of the official community visitors. This report will be available when published from our office or on our web site at www.ombo.nsw.gov.au.

statistics

There were 26 official community visitors at the start of 2003-2004. Six of them left the scheme during the year and we are currently recruiting nine new visitors. They are appointed by the Minister on the recommendation of the Ombudsman for an initial term of three years, with the option of reappointment to a maximum of six years.

This year there were 3,121 visits conducted, 6% more than in 2002-2003. See figure 18. The number of hours that visitors spent fulfilling their functions also increased, from 8,879 to 10,822 (an increase of 22%). Visitors spend their time visiting places where services are provided, talking to families, writing reports, attending meetings and monitoring how each agency has responded to the concerns they raised during or following their visit.

Figure 18: Number of visits to services in 2003-2004

Target group of services	Number of services	Number of residents	Number of visits 02/03	Number of visits 03/04	Number of activity hours 03/04
Children and young people	111	266	259	282	1341
Children and young people with disabilities	62	209	189	184	632
Children, young people and adults with disabilities	37	258	166	144	437
Adults with disabilities (including residents of licensed boarding houses)	959	5895	2324	2511	8412
Total	**1169**	**6628**	**2938**	**3121**	**10822**

managing the scheme

We work closely with official community visitors on a range of service delivery issues arising from their work. We are responsible for:

- allocating resources to make sure that visits are focused on those people in care who are most vulnerable
- providing visitors with the support they need
- promoting stakeholders' understanding of the visitors' role
- providing visitors with support in raising their concerns with agencies and trying to have those concerns addressed
- analysing information collected by official community visitors about systemic issues and concerns about individual agencies, and helping visitors make sure those concerns are raised with the agencies and addressed
- improving the operation of the scheme.

casestudy11

A non-government disability service established in the 1960s and located on a rural property currently has 30 residents, all adult men. Accommodation is based on an institutional model, although residents do have single rooms and a semi-independent unit has been developed for three residents. There are plans to build two houses on the site to provide semi-independent living for another eight residents.

The current official community visitor to the service asked our liaison officer to visit the service with her to see the improvements that had been made over the past 12 months. The visitor said that the service had been very responsive to recommendations and suggestions she had made about ways to improve the daily lives of the residents.

Our joint visit showed that the service:

- provides a high level of meaningful community access activities for residents both in the local area and on visits to the Sydney CBD
- had reviewed resident programs and individual plans and was focusing on developing the skills of residents and building their independence
- had improved their communication with residents, including using photos to help residents make decisions about the community access activities they wanted to do.

The enthusiasm of staff developing the new programs was clearly evident and the manager of the service was appreciative of the visitor's input.

allocating resources

During 2003-2004 the number of services that official community visitors are able to visit, under the CS-CRAMA, increased by eight to 1,169. This includes 62 licensed boarding houses. This increase was modest compared to the 14.5% increase during 2002-2003.

The recurrent budget for the scheme in 2003-2004 was $724,000, similar to the previous year. These resources were allocated not only for visiting activities, but also to provide training, support and consultation opportunities for official community visitors.

In last year's annual report we foreshadowed that we would need to review the allocation of visiting resources due to budget constraints and the increasing number of services that official community visitors could visit.

This year we took a different approach. This was because of concerns that visitors were not able to spend enough time during each visit to do their work effectively and some services were being visited so infrequently that it was impossible for visitors to effectively monitor the quality of the service being provided.

We decided that every service provider would be visited, but if the service provider had accommodation services at more than five locations, 80% of those locations would be visited twice during the year. We also allocated visitors four hours (instead of three) for each visit to cover preparation, the actual visit and following up issues.

Further visits were allocated on the basis of:

- the age of the residents — more visits to services where children and young people live
- the number of residents living there — more visits to services with more residents.

In the coming year, we plan to visit service providers at locations that were not visited in 2003-2004 (there were over 250). We will continue to review this approach to allocating resources.

Official community visitors John Archer (right) and Scott Goodwin (2nd from right) meeting with service providers.

Source: John Archer

supporting visitors

Visitors work alone and the nature of the work can be stressful and demanding. We support them in a variety of ways and try particularly to help them deal with complex service issues.

Our 'support' activities during the year included:

- visitor conferences in November 2003 and May 2004 for training and networking
- coordinating representations of visitors to discuss systemic service issues with the Minister for Community Services in September 2003 and May 2004
- briefings in February 2004 for visitors to boarding houses, and in June 2004 for visitors to disability services
- consultation with visitors through four regional groups
- three newsletters to visitors to promote the exchange of good practice ideas and provide updates about the sector
- expanding our team by appointing a liaison officer to provide a range of support, including joining visitors on their visits and attending meetings with agencies if issues were not being resolved or responded to
- improving coordination and the sharing of information between official community visitors and Ombudsman staff so that we can better address visitors' concerns about service issues
- developing specific information to assist visitors to licensed boarding houses.

promoting stakeholder understanding of the visitors' role

It is important that people who live in residential services, their families and support people, and the services themselves all understand the role of official community visitors and how the scheme can benefit them. To promote this understanding this year we:

- updated and re-published the booklet 'A Voice for People in Care: Answering your Questions about the Official Community Visitor Scheme'
- gave presentations to service staff and families about the role of visitors
- answered queries from service staff and families.

casestudy12

A non-government service provides group home accommodation to adults with a disability in an isolated part of NSW. The official community visitor to this service has raised a number of concerns about poor service delivery to residents and, in particular, their lack of access to meaningful activities and programs. Apart from day program or post school options activities, residents spend a considerable period of time within the group home. Community access is very limited and they do not have the opportunity for individual outings.

During the year, the visitor and our liaison officer made a joint visit to the service to review these issues first-hand. A follow-up visit to the service by the Deputy Ombudsman (CSD) and staff of the Department of Ageing, Disability and Home Care is planned in the next few months.

issues identified by official community visitors

Visitors reported 3,099 service provision issues during 2003-2004, an increase of 8.8% compared to 2002-2003. Figure 19 shows that, although some agencies address concerns raised by official community visitors as soon as they are brought to their attention, in many cases the agencies are unable or unwilling to make the necessary improvements, or the issue is complex and takes longer to resolve. Visitors continue to follow-up unresolved issues with the agency concerned when they visit their services again. We will continue to work with visitors to help them improve the rate of issues resolved by agencies themselves.

improving the operation of the scheme

Some of our initiatives to improve the effectiveness of the scheme during the year included:

- revising the policy and procedures manual for visitors and our staff
- meeting with visitors to discuss issues affecting their work and to consult them about developing the scheme
- reviewing the business requirements of the visitors' database and identifying specific areas for enhancement.

Our priorities for 2004-2005 include developing a regional focus for raising systemic issues with service providers, and continuing to manage the imbalance between the demand for visiting and the available resources.

Figure 19: Issues reported by visitors in 2003-2004

Target group of services	Total no. of visitable service	No. of issues identified	No. of issues resolved as a percentage of the no. of issues identified.	Key issues identified
Children and young people	111	449	215 (48%)	• Inadequate response to meeting residents' needs • Poor management responsibility • Inadequate attention to residents' privacy
Children and young people with disabilities	62	221	97 (44%)	• Inadequate response to meeting residents' needs • Poor management responsibility • Poor condition of premises and facilities
Children, young people and adults with disabilities	37	88	36 (41%)	• Inadequate response to meeting residents' needs • Poor management responsibility • Inadequate attention to health, nutrition and hygiene
Adults with disabilities in residential care	897	2133	791 (37%)	• Inadequate response to meeting residents' needs • Inadequate attention to health, nutrition and hygiene • Poor condition of premises and facilities
Adults with disabilities in licensed boarding houses	62	208	65 (31%)	• Inadequate nutrition, hygiene and health care • Poor facilities and premises • Poor management of residents' funds
Total	1169	3099	1204 (39%)	

educating and informing the sector and the community

It is important for people to understand their right to complain about the services they receive and have those complaints resolved effectively. It is equally important for agencies to understand the positive role that complaints can play in helping them to meet the particular needs of individuals and the needs of their clients overall.

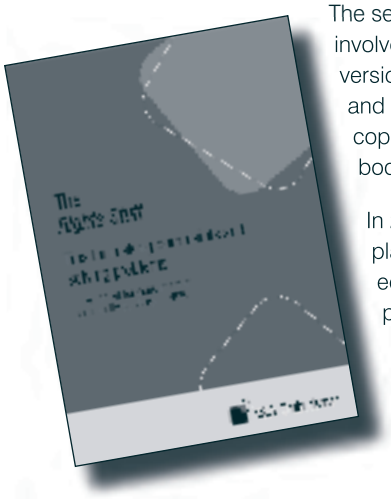
Our work includes:

- educating agencies and the community about standards for the delivery of community services
- providing information, education and training about the resolution of complaints and the delivery of community services
- giving practical advice, information and education about problem-solving and making complaints to people who receive community services
- promoting the role of our office in community services and informing stakeholders about what we do.

informing people who receive community services

This year we broadened our consumer education program, The Rights Stuff, to include consumers of community services, their families and support people from a variety of backgrounds. These groups included older people, people with an intellectual or physical disability, carers groups and people living with HIV/AIDS.

The program is made up of two key elements. The first part involves consumer workshops to inform participants of their rights as consumers of community services, to give them tools to solve problems with their service provider and, if necessary, to make complaints. The workshops also offer the participants a valuable opportunity to talk to each other about concerns and avenues of support. We conducted nine workshops attended by 160 people — two in regional areas and seven in the Sydney metropolitan area.



The second part of the program involved publishing a revised version of *The Rights Stuff Toolkit* and distributing over 2,000 copies to individuals, advocacy bodies and services.

In 2004-2005, we are also planning a community education and information program targeting residents of licensed boarding houses, boarding house proprietors and intermediaries.

(L to R) Margaret Kaye, Carolyn Campbell-McLean and Betsy Coombes, community education officers in our community services division.

providing training for agencies

This year we participated in a 'roadshow' organised by DoCS and presented sessions to DoCS managers across NSW on the role of the Ombudsman, particularly in relation to community services and workplace child protection issues.

We also delivered two different workshops for front-line staff in community services, and for managers of community services, to provide them with the skills and strategies for dealing with client complaints effectively and confidently. We conducted six workshops in regional areas (Wagga Wagga, Ballina, Bateman's Bay, Maitland, Armidale and Gosford) and six in Sydney. The workshops were attended by around 300 people and we received very positive feedback.

Our reviewable deaths team ran two seminars in Sydney for disability service providers and other interested people on issues concerning the deaths of people with a disability in care and epilepsy management issues. These seminars were attended by 55 people.

educating the sector and the general public

Since the merger of the former Community Services Commission into our office, we have been conducting an information program for key stakeholders to talk about our office's expanded role in community services. In 2003-2004 we ran six information seminars in regional areas (Newcastle, Wollongong, Albury, Wagga Wagga, Bateman's Bay and Ballina) and spoke to 28 community and consumer groups about the work of our office.

This year we launched our new newsletter for the community services sector called *Communicate*. We published two editions and distributed around 6,000 copies of each. We aim to use the newsletter to regularly inform the community services sector of our work in this area and key issues of concern.

promoting improvements to community service systems

We promote the development of standards for the delivery of community services by inquiring into significant issues of concern, reviewing the causes and patterns of complaints, and making recommendations for improvement.

We have a key role in promoting changes in the community services sector that will benefit the lives of consumers and improve the service delivery system. A large part of our work involves consulting with community service stakeholders, gathering information and analysing developments across the sector, and responding to systemic issues within specific program areas and the sector as a whole.

the supported accommodation and assistance program (SAAP)

Under s.11(1)(e) of CS-CRAMA we can inquire into matters affecting service providers and consumers. These inquiries can be about a specific community service program area, a consumer group or groups, or matters affecting a number of program areas.

In May 2004, we tabled a special report to Parliament detailing the findings of an extensive inquiry we conducted into exclusion from SAAP services, and the implications such exclusions have particulary for people with high and complex needs. Homeless people are one of the most vulnerable and marginalised groups in our community, and SAAP is the Commonwealth/State-funded safety net that is often the last resort for these people. It may also be their starting point for re-engagement with the community.

Our inquiry showed that significant groups of homeless people are being affected by agency exclusion policies and practices. These groups include:

- people who use, are affected by, or are dependent on drugs or alcohol
- people who exhibit, or who have previously exhibited, violent or other challenging behaviour
- people with mental illness
- people with disabilities including people with physical disabilities, intellectual disabilities and acquired brain injury
- people not willing to enter into formal 'case management' arrangements
- people unable to pay for their accommodation
- pregnant women
- people who have been 'banned' by agencies.

We found that a significant proportion of exclusions are based on 'global' policies of turning away all individuals belonging to these groups (16.5% of the agencies surveyed). Even where there was flexibility in applying eligibility criteria, grounds for exclusion were often based on assumptions about the impact of a person's condition or characteristics.

Most of the exclusions were linked in some way to limited capacity and resources in SAAP, as well as the incapacity of other service systems, particularly health and disability, to deal with the needs of homeless people with substance abuse issues, mental illness or a disability.

We made recommendations primarily to the Department of Community Services (DoCS), which administers SAAP in NSW, but also to agencies delivering SAAP services. Our recommendations focused on promoting more inclusive access to SAAP and basing exclusions on fair and transparent assessment and exiting procedures. We also called for more funding to enable agencies to address our concerns.

There has been support for our recommendations although some stakeholders, particularly those representing agencies delivering SAAP services, have been critical. Their concerns included that:

- we assessed SAAP practice in isolation from other systems failures
- the issue of inadequate program funding has not been fully addressed
- exclusions occur in complex workplace situations that have not been adequately captured by our report.

The Deputy Ombudsman (CSD) has met with a number of agencies, including the Youth Action Association and NCOSS, to discuss these issues and to promote the report as a tool for service improvement. We will continue to monitor the outcomes of our recommendations in 2004-2005.

casestudy13

A young man with a mental illness was referred to a SAAP service on a Saturday, but when he arrived at the agency he was refused a place. He was told that this was because of his mental illness, even though he says he was not ill and was taking medication at the time.

As he couldn't find other accommodation, he rode the trains that night — to keep warm and get some sleep — before being referred to a single men's emergency shelter the next day where he stayed for the next two nights. Following advocacy by a youth worker, the young man was accepted into the SAAP service on the Tuesday.

casestudy14

During our inquiry into SAAP services, a homeless man told us what had happened to him when he applied to a SAAP agency in metropolitan Sydney. He called the agency from a phone box in a different part of town and was told he wasn't eligible because he was out of area. He couldn't understand this because as a homeless person he didn't live in any area.

individual planning audits

Individual plans help disability services providers to ensure that their services meet the current and future needs of each of their residents. Inadequacies in individual planning for people with a disability living in accommodation services is an issue brought regularly to our attention by official community visitors.

In March 2004, we began an audit of individual planning in 10 non-government disability accommodation services across NSW. The aims of the audit were to:

- examine individual planning for adults with disabilities living in the care of non-government organisations, and determine current levels of compliance with Disability Services Standards 2.0 and 2.1
- identify good practice in individual planning in non-government organisations
- identify systemic problems in individual planning in non-government organisations

By June 2004 we had completed file audits of 60 service receivers and provided written reports to the 10 services involved. The audits showed that although individual planning is widely used, there are inadequacies in the process.

These inadequacies include:

- poor documentation of individual planning procedures
- inconsistencies in how individual plans and comprehensive assessments of service user needs and goals are linked
- the extent to which plans are 'outcomes-focused' with achievements that can be measured
- the lack of reviews of individual plans.

In 2004-2005 we will report to DADHC about the systemic issues identified by the audits, in particular their role in helping agencies prepare and monitor individual plans.

(L to R) Kirsteen Banwell, an investigation officer, and Paula Novotna, an assistant investigation officer in our community services division.

monitoring and reviewing the delivery of community services

Our monitoring and reviewing role includes liaison and information gathering, analysing policy and legislative issues affecting community services, and providing advice to government policy makers, service providers and other stakeholders.

research and scoping

We research current issues in the delivery of community services to identify any concerns that we may need to address. This year we have focused on identifying issues for:

- people with disabilities who are ageing
- people with intellectual disabilities who have contact with the criminal justice system
- children in day care and out-of-school hours care
- family support services.

We analyse current developments in a particular program area or around a particular issue, and find out stakeholder views about how developments may affect service delivery and outcomes for consumers. This research helps us to decide on future priorities.

For example in 2004-2005, we will be examining progress by the relevant NSW government agencies in meeting the needs of people with intellectual disabilities who are in contact with, or at risk of being in contact with, the criminal justice system. Despite the significant commitments made in the last few years to provide this group of people with support to avert or better manage their contact with the criminal justice system, there do not appear to have been many practical outcomes.

developments in key program areas

We monitor specific program areas in community services to keep up to date with developments. This year we continued monitoring several DADHC programs including:

- the closure of large residential centres — and concerns in the sector that the devolution process is not on schedule
- implementation of the service access system for meeting the needs of people with a disability at risk of becoming homeless
- the systems DADHC has in place to monitor the quality of the services they provide or fund.

We also monitored significant areas of DoCS work including the implementation of their major projects and 'Blueprint for Change' in child protection, out of home care, and prevention and early intervention in child protection.

policy development and advice

We provide advice to government and other stakeholders on promoting improvements in the delivery of community services. This year we provided submissions to:

- DADHC on their proposed reform of advocacy services and arrangements
- the Children's Guardian on their draft guidelines on the exercise of parental responsibility and developing a behaviour management policy.

monitoring our recommendations

To ensure our work has a positive effect on service delivery, we monitor the acceptance and implementation of the recommendations we make. This year we continued to monitor the implementation of the recommendations from our 2003 inquiry into individual funding arrangements in out of home care.

Individual funding arrangements are financial arrangements used by DoCS to purchase out of home care services for individual children or young people on a fee-for-service basis from a non-government agency. Our inquiry found that the framework for administering these arrangements was flawed in a number of key areas including selection and monitoring processes, case management and planning.

We recommended a range of strategies for improvement including:

- the development of systems to allow for regular centralised collation and reporting of accurate data
- the development of a policy and funding framework to guide the planning and provision of residential care
- the clarification of casework responsibilities and monitoring of children and young people in placements funded by individual funding arrangements
- a review of the contracts between DoCS and service providers to ensure clear guidelines and processes.

In general, DoCS has responded positively to our recommendations and addressed some of our concerns. They have put in place clear review arrangements for intensive support/high needs clients and have started to improve compliance with contractual obligations.

There were however some recommendations that DoCS did not accept. For example, we recommended that all children and young people placed under these arrangements should be allocated a caseworker. DoCS acknowledged that their own business rules require this, but advised that they cannot do so with their present resources. We also recommended DoCS regularly audit their compliance with contractual obligations with the agencies providing these services. They advised that this was not one of their priorities at the moment.

We will continue to monitor progress in this area, focusing on the outcome of the DoCS initiatives which include:

- 50 more caseworkers to provide services to children and young people with high support needs in out of home care
- enhancement of funded out of home care to provide these services
- service mapping to clarify what services funded agencies are providing
- development of different models for caring for people and analysing how much these models cost
- enhancing the capacity of DoCS and non-government services to meet the needs of children and young people with complex needs.

Our community services division meets regularly to discuss issues and exchange information.

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. In 2003-2004 we were involved in the following initiatives.

culturally and linguistically diverse communities consultation project

We continued our joint project with the Disability Council of NSW to consult with people who have disabilities, their families and carers from Arabic, Greek, Vietnamese, Spanish, Italian and Chinese speaking backgrounds.

We held consultations with people from Vietnamese and Greek-speaking backgrounds in September 2003, and with people from Spanish-speaking backgrounds in November 2003.

These consultations help us understand the service needs of people with disabilities and their carers from these communities, the barriers to accessing services, and how people solve problems with the services they are getting. This information will also assist our planning to improve awareness of and access to our services.

round table discussions with disability and child and family peak agencies

This year, we held round table discussions with child and family sector peak bodies in September 2003 and May 2004, and with disability peak bodies in November 2003 and May 2004.

These discussions provide a regular forum for agencies to inform our office of current issues in the disability and child and family sectors, and for us to provide updates on the work we do that is of interest to the sectors.

reviewing people in care

We review the care and circumstances of vulnerable children, young people and people with a disability who live in licensed boarding houses or are in the full-time care of a service provided:

- DoCS or DADHC
- a non-government agency that is funded, licensed or authorised by the Minister for Community Services, the Minister for Aged Services or the Minister for Disability Services
- a non-government agency under an individual funding arrangement with DoCS or DADHC.

We can review the situation of individuals or groups of people. We look into the relevant aspects of the person's life and care, including how well their day-to-day needs are being met.

As part of an individual review we meet with the person, look at their file, and talk to significant people in their life to find out their views about the person's current circumstances.

We conduct a group review if a group of people in care share similar characteristics or are being cared for by the same agency - we call these 'service-level' group reviews. We will also do a group review if reviews of individuals identify service-wide or systemic issues.

Group reviews include an individual review and report on the circumstances of each person in the group, and a separate report identifying systemic service provision issues.

We report the results of our reviews to the relevant Minister and the agency concerned and, if necessary, make recommendations for changes to promote the welfare and interests of people in care. We then monitor the implementation of these recommendations.

statistics

During 2003-2004, we handled nine 'service-level' group reviews of people in care and 67 individual reviews — 62 of these were done as part of a service-level group review.

We finalised our work for 20 individual reviews and four group reviews.

service-level group reviews

A key focus of our service-level group reviews continued to be children and young people placed in the care of non-government agencies on a fee-for-service basis. This includes private 'for profit' agencies and non-profit agencies that may or may not get other sources of funding from government.

Inadequacies in arrangements with fee-for-service agencies, entered into by both DoCS and DADHC, were highlighted in our June 2003 inquiry report on DoCS' individual funding arrangements in out of home care, and our April 2004 special report to Parliament on DADHC's provision of services to children and young people with a disability.

During the year we completed reviews of 10 children and young people placed with two non-program, funded fee-for-service agencies. Our reviews identified a range of practices that adversely impact on the people in the care of the agencies, such as a lack of staff training and the inconsistent management and inappropriate restraint of children. We made recommendations to address these issues, both at the individual and service level, and monitored their implementation. In particular, we recommended that DoCS review the agencies involved to make sure they were providing the quality of service they had agreed to.

In June 2004 we also initiated a review of eight young people with a disability, aged between 14 and 18 years. They had been placed by DoCS and DADHC with The Centre, a disability accommodation service funded by DADHC. All of the young people have high support needs and complex behaviours. The reviews raise questions about the adequacy of care and service support arrangements for people with disabilities who have contact with, or are likely to have contact with, the criminal justice system. We started the reviews after receiving a number of complaints, concerns being raised by official community visitors, and concerns raised in Parliament about service delivery at The Centre. We will report on the outcomes of these reviews in 2004-2005.

During the year we also monitored the implementation of recommendations from the service reviews we did last year. One of the services, a non-program funded agency, ceased operating during the year.

Figure 20: Characteristics and placement of the people we reviewed in 2003-2004

	DoCS mgmt and care	DoCS mgmt/ non-govt agency care	DADHC mgmt and care	DADHC mgmt/ non-govt agency care	Non-govt agency mgmt and care	Total
Child or young person	7	6	0	0	1	14
Child or young person with a disability	1	37	0	7	0	45
Adult with a disability in care	0	0	0	0	0	0
Licensed boarding house resident	0	0	0	0	8	8
TOTAL	**8**	**43**	**0**	**7**	**9**	**67**

casestudy15

We reviewed the care arrangements for children and young people placed by DoCS with a non-program funded agency operating in the Newcastle area. The reviews were initiated after complaints by the official community visitor about the quality of care provided by the agency.

We found that agency staff were young, untrained, inexperienced and poorly supervised. Direct care staff worked on a rotating shift basis providing individual support to each resident, who lived in a house on his own. The houses were cheaply and minimally furnished and one, in our view, provided substandard accommodation. Residents were not encouraged to attend school and complained about being bored, isolated and lonely. They said it was difficult to talk to staff about things that mattered to them, such as missing their brothers and sisters. Daily activities were in the main determined by the young people. With the exception of one young person whose departmental caseworker took particular interest in his day-to-day life, young people — one as young as 12 — spent most of their days at home playing video games or watching TV.

In the absence of appropriate skills and support, staff managed the residents' behaviour inappropriately. One child was able to demonstrate how agency staff physically restrain him when he exhibits extreme behaviours. He told us that his arm is bent behind his back, a worker then hooks one leg around the boy's leg to unbalance him and he is pushed to the ground. His legs are then bent up to his back to stop him from kicking and, if he tries to spit, the worker pushes his face into the ground.

Although the service had comprehensive policies and procedures, they had been developed by a disability consultant and failed to take into account the NSW out-of-home care standards. Regardless of their adequacy, neither staff nor management were familiar with the agency's written policies and procedures.

Our reviews also identified that all the residents, except one young person, were placed with the agency on an emergency basis. However they stayed with the agency for periods in excess of 12 months, despite concerns about the ability of the service to adequately meet their needs. Their departmental caseworkers reported that this was because of lack of alternative placements.

In response to our individual and group review reports, DoCS suspended referrals to the service and made arrangements to exit the remaining children and young people placed with the service. They advised that they would review this decision if the service was successful in obtaining accreditation from the Children's Guardian to provide out-of-home care services in NSW.

young people with a disability leaving statutory care

In February 2004, we began reviews of the circumstances of 27 young people under the parental responsibility of the Minister for Community Services who will turn 18 in 2004. They have been identified by DoCS as having a developmental or intellectual disability or autism.

The focus of our reviews was the planning in place to assist these young people:

- with transition to independent living
- to return to live with their family
- to move from their out of home care placement to an appropriate alternative placement either funded or provided by DADHC.

By doing this review we were able to focus on a very vulnerable group about whose circumstances little is known and assess:

- the effectiveness of the care and protection provisions of Part 6 of the *Children and Young People (Care and Protection) Act 1998* as they relate to planning for leaving care
- the effectiveness of the DoCS/DADHC memorandum of understanding in relation to young people with a disability leaving statutory care
- the arrangements for leaving care, including the capacity of leaving care services to meet the needs of this group.

Our review has identified a number of systemic issues including:

- inconsistencies in the way leaving-care planning is prioritised by DoCS offices
- variations in the level of financial assistance provided to young people with disabilities leaving care
- insufficient placements to meet the demand for supported accommodation for young people with disabilities
- inadequate resourcing of after-care agencies to provide for long-term case management.

We will report in more detail about the systemic issues emerging from these reviews in the coming year.

casestudy16

We conducted a review of the care of a six-year-old child placed with a non-program funded agency. At the time of review, the child had been at the placement for a little over half a year and the issue of her future care was before the Children's Court. The child had experienced inadequate and inconsistent parental supervision and sexual abuse, and her mother had told DoCS that she could not manage her daughter's behaviour.

The review found that although the child was making certain progress in the placement, aspects of her care and management were wanting. She was living in a residential group home with 10 rostered workers. This was of particular concern because during our review she displayed inconsolable grief over parental separation. While the child's need for speech therapy and therapeutic support had been identified, services had not been put in place. On a positive note, the review confirmed that the structured environment provided by the agency was benefiting the child.

In response to our recommendations, the agency reduced the staff dealing with the child from 10 to six and she is now accessing appropriate therapy services.

casestudy17

Here are the stories of some of the young people with a disability who were turning 18 and due to leave statutory care, whose 'leaving' plans we reviewed.

- One of the young people turned 18 in February 2004. DoCS had developed and was implementing a comprehensive plan to ensure he was supported to complete school in 2004 and stay with his foster carers during this time. He will be moving to an accommodation service in 2005 where he will be assisted to develop the skills needed to live independently. Comprehensive liaison with all relevant agencies has ensured that key issues including income support, health care, accommodation, training and future employment have all been attended to.
- However leaving care planning for another young man had not occurred because, due to a communication problem, the DoCS office supervising him did not know he was under the parental responsibility of the Minister. DoCS has now moved to financially assist the young man to move into rented accommodation.
- The lack of appropriate accommodation resulted in another young person, now 18, remaining under the day-to-day supervision of DoCS until DADHC find a suitable group home placement. In the interim, the young person is being accommodated in a local motel under the supervision of a worker funded by DoCS.
- Our review of a young woman who has a mild to moderate intellectual disability revealed that her DoCS file was allocated to a worker six weeks before she turned 18. Leaving care planning for this young woman consisted only of a case conference being called at which she was asked by DoCS to identify what assistance she may need with independent living skills.

monitoring agency responses to our recommendations

This year we continued to monitor the implementation of recommendations from the group reviews we conducted in previous years.

Aboriginal children and young people in care

Our 2001 group review of 15 Aboriginal children and young people highlighted serious concerns about the adequacy of services provided by one of the largest funded Aboriginal out of home care service providers in NSW, Aboriginal Children's Services Limited (ACS).

This year DoCS advised that they had referred ACS to the Aboriginal and Torres Strait Islander Commission (ATSIC) for review. This was because of ACS's failure to ensure that their planned strategic directions were in line with DoCS funding expectations, and because ATSIC also funds the service. Most recently DoCS has advised that the federal government's decision to abolish ATSIC has 'necessitated the need to re-assess administrative arrangements for conduct of the review…' We will continue to monitor this matter.

Children under five years of age in out of home care

We made several recommendations following our 2003 review of 23 children aged under five in out of home care, including that case plans should address each child's needs for paediatric, dental and developmental assessment. DoCS has advised that most of our recommendations will be addressed by policies and procedures published throughout 2004. They have advised us that they are still compiling performance indicators for evaluating the delivery of out-of-home care services in NSW.

Residents of licensed boarding houses transferred to community group home accommodation

In last year's annual report, we detailed the results of our group review of the circumstances of 10 adults with a disability and high complex needs. They had been relocated from licensed boarding houses to community accommodation under the boarding house reform strategy, funded through DADHC.

We have been monitoring DADHC's implementation of the recommendations from our review and are awaiting their advice in relation to:

- the number of people with high needs still awaiting relocation from boarding houses to community group homes, and the timetable for their relocation
- progress on their review of the support needs assessment profile assessment tool
- their progress in establishing funding benchmarks for supported accommodation.

reviewing deaths

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 deaths and identify ways in which they could be prevented or reduced.

We are required to prepare a separate annual report on our work in this area. This report will be available when published from our office or on our website at www.ombo.nsw.gov.au. It includes a detailed analysis of information relating to the deaths that occurred in NSW between 1 December 2002 and 31 December 2003. This year we reported on the deaths that occurred during this 13 month period (instead of the usual 12 month calendar year) because our work started when the former Community Services Commission merged with our office on 1 December 2002. In this section we provide a brief summary of some of the work we have done in 2003-2004.

whose deaths do we review?

Under Part 6 of CS-CRAMA we are required to review the deaths of:

- any person with a disability who was living in, or temporarily absent from, a residential care service authorised or funded under the *Disability Services Act 1993*
- any person who was living in a licensed boarding house
- a child in care
- a child in respect of whom a report of risk of harm was made to the Department of Community Services (DoCS) in the three years before the child's death, or a child whose siblings have been so reported
- a child who may have died from abuse or neglect, or whose death occurs in suspicious circumstances
- a child in detention at the time of their death.

Sometimes a person who dies fits into more than one of these categories. For example, we may be required to review the death of a particular child because the child was known to DoCS and he or she died in suspicious circumstances.

our focus

We focus on examining systemic issues around deaths, reviewing trends and patterns in deaths, and making recommendations about policies and practices that may prevent or reduce untimely deaths and improve the safety of children and people with a disability.

We also have a responsibility to respond to matters raised by individual deaths. We can undertake detailed case reviews of individual deaths or, if necessary, investigate individual matters using our 'own-motion' powers.

In contrast, the State Coroner's main focus is on identifying the deceased person, determining the time and location of the person's death, and the manner and cause of their death. The Coroner can hold an inquest and look into more systemic issues surrounding a person's death, but this is usually only done in a very small percentage of matters.

During 2003-2004 and in relation to individual matters we:

- started two investigations and one preliminary inquiry
- made 'risk-of-harm' reports to DoCS in relation to 11 children
- notified DoCS of the death of a child in very similar circumstances to the previous death of a sibling
- referred four matters to the State Coroner for further consideration.

We also implemented systems to assist the timely receipt of information from external bodies such as the NSW Coroner and the Registry of Births, Deaths and Marriages, and enhanced our database systems to house the reviewable deaths register and capture relevant additional data about deaths.

deaths of children and young people

We receive data from the Registry of Births, Deaths and Marriages for all the registered deaths of children in NSW. We then refer to the client information databases maintained by DoCS to see if the child was known to DoCS, or was a sibling of a child known to DoCS, or was in care. We obtain police reports and autopsy reports from the NSW Coroner to help identify deaths that may be related to abuse or neglect, or that have occurred in suspicious circumstances or in detention.

From 1 December 2002 to 31 December 2003, we were notified of 605 child deaths in NSW by the Registry of Births, Deaths and Marriages. Fifty of these children died during December 2002. The other 555 died between 1 January 2003 and 31 December 2003.

Of the 605 child deaths identified, 161 (or 26.6%) were reviewable. Of those 161, 36 children (or 22.4%) were not known, nor were their siblings known, to DoCS in the three-year timeframe. The other 125 children (or 77.6%) had been reported to DoCS, and/or were a sibling of a child reported to DoCS, within three years of their death.

Of those 125 children:

- in 38 cases (30%) only the child was known to DoCS
- in 25 cases (20%) only a sibling of the child was known to DoCS
- in 62 cases, (50%) both the child and their sibling(s) were known to DoCS.

We are required to review all of the 'reviewable deaths' that occurred during each calendar year (and report on the results of our review). However, we were not able to complete all of the required reviews this year because full information to determine all of the reasons a death is reviewable was not available for 24 of the 161 deaths (15%) that occurred between 1 December 2002 and 31 December 2003. This is most often due to Coronial processes not being completed in the reporting period.

Of the 137 deaths where all information was available, 48 deaths were reviewable only because the child and/or the sibling of a child, was known to DoCS in the three years preceding his of her death, that is, not because they died in circumstances suggesting that they had been abused or neglected. In the other 89 cases, the death was also reviewable for other reasons, including their death being, or possibly being, related to abuse or neglect or occurring in suspicious circumstances, or the child being in care at the time of their death.

deaths of people with a disability in care

Under the NSW Disability Standards in Action, disability services are required to inform us of any person with a disability who dies in care.

Between 1 December 2002 and 31 December 2003 we received notifications of 114 deaths, 110 of which were determined to be in jurisdiction and recorded on our register of reviewable deaths. Three of these people were children who were known to DoCS and their deaths are also included in the data for reviewable child deaths. Twenty-two of these people died while living in licensed boarding houses.

Of the 110 deaths, 33 were included in our group review of people whose deaths related to respiratory illness (five of whom had been residents of licensed boarding houses).

In March 2004, we completed an issues paper on a review of the deaths of 37 people with a disability who died in care between 1 July and 31 December 2002. The majority (31) of the 37 individuals were identified as having an intellectual disability, with 15 reported as having a severe or profound disability. Our analysis identified a number of issues:

- respiratory illness was a common cause of death
- gastro-oesophageal reflux disease (GORD) and indications of poor oral health were present
- there were low immunisation rates across the review group, and
- complications had arisen from enteral nutrition regimes (providing food through a tube).

As part of the review process, we convened a round-table of representatives from DADHC, the Department of Health and the Health Care Complaints Commission to discuss the draft paper and to canvass some ways to improve the services provided to people with a disability in care. Following input from these agencies, we finalised the issues paper and identified a number of matters for consideration and action. These included proposals that DADHC:

- ensure better integration of health care services to every resident in DADHC accommodation services
- review immunisation requirements, and
- make available the Managing Client Health Policy to the non-government sector.

We also proposed that the Department of Health:

- review policies, clinical procedures and practice relating to gastrostomy procedures for people with a disability
- monitor the nutritional status of people with disabilities who are inpatients and maintained solely on intravenous fluids for longer than five days
- raise awareness of general practitioners about GORD and vaccination requirements for people with disabilities, and
- review the Priority Oral Health Program to ensure adequate priority is accorded to people with a disability in care.

We further suggested that both departments clarify their respective responsibilities for the health and dental care of residents in disability accommodation services, and extend oral health training programs to direct-care staff working in disability residential services. We will be monitoring their responses to our proposals.

We are keen to share information with service providers, peak and advocacy organisations, and families on strategies that can reduce or remove risk factors associated with deaths of people with a disability that are preventable.

During the year, we:

- addressed the Interchange respite care state conference on issues concerning deaths of people with a disability in respite accommodation services
- briefed dieticians at Rydalmere Centre on nutritional issues arising from a review of deaths of people with a disability
- briefed social workers at Westmead Hospital on our death review functions
- delivered two seminars for Sydney audiences on deaths of people with a disability and epilepsy management issues.

the mannix children's centre

In June and July 2003, we conducted an audit of the health care needs of residents of the Mannix Children's Centre at Liverpool as a follow-up to the former Community Services Commission's report, *Young Deaths*, published in February 2002. This report examined the deaths of eight children and young people with a disability who died at Mannix between July 1998 and February 2001. All of those who died had had high support needs and complex medical conditions associated with their disabilities and the service had failed to adequately address their medical, health, developmental and physical needs.

Our audit included a review of the centre's policies and procedures and eight client files at random. We found that increased access to, and better coordination of, allied health services and clinical oversight appeared to have contributed to the better management of residents' health, and work had been done to improve their nutritional status. We identified other areas requiring more attention and reported these to DADHC, the funding body who have taken over management responsibility for the service.

expert advisory committees

We have set up two expert advisory committees to help us perform our functions in this area. Since December 2002, the reviewable child death advisory committee has met on nine occasions and the reviewable disability death advisory committee has met on seven occasions. These committees provide us with valuable advice on complex child or disability death matters, policy and health practice issues. Some members of each committee also undertake International Classification of Disease (ICD-10) coding of mortality data.

reviewable disability death advisory committee – membership

Mr Bruce Barbour:	Ombudsman (chair)
Mr Steve Kinmond:	Deputy Ombudsman (CSD)
Dr Helen Beange:	Clinical Lecturer, Faculty of Medicine, University of Sydney
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
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 (resigned June 2004)
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

reviewable child death advisory committee — membership

Mr Bruce Barbour:	Ombudsman (chair)
Mr Steve Kinmond:	Deputy Ombudsman (CSD)
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:	CEO, 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 Prof 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 (resigned March 2004)
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

04: child protection team

introduction

The Ombudsman was given a child protection function in 1998 with the introduction of Part 3A in the *Ombudsman Act 1974.* Our child protection team was set up exclusively to fulfil our responsibilities for ensuring that employers in our jurisdiction deal properly with allegations that their employees have behaved in ways that could be abusive to children. This means we monitor the way agencies handle allegations against employees involving sexual offences, sexual misconduct, assault, ill-treatment, neglect and behaviour that causes psychological harm to children.

There are over 7,000 government and non-government agencies that have child protection responsibilities under the Act. These agencies vary in size and provide services such as schools, child care centres, substitute residential care, health programs and juvenile justice centres. Our work extends both to paid employees, contractors and the thousands of volunteers who give their valuable time to support the work of these agencies.

The heads of these agencies are required to:

- notify us within 30 days of becoming aware of any allegations of this kind of behaviour involving their employees
- investigate those allegations
- take appropriate action as a result of that investigation.

We assess these notifications and may decide to monitor the investigation closely or directly investigate the matter ourselves. After agencies have completed their investigation, we review their documentation and findings and advise them if we are satisfied with the way they have handled the matter. If we are not satisfied, we may ask them to take further action.

We also look at the systems agencies have for protecting children from employees who behave in ways that could be abusive to children and ensuring fairness for employees against whom allegations are made.

We have worked closely with many of these agencies and have seen significant improvements in the ways they deal with allegations against their employees. This has been particularly noticeable in some smaller agencies such as child care centres, independent schools and agencies providing substitute residential care. Increasingly employers have become more aware of the indicators of abuse in the workplace and are more competent at undertaking investigations and managing risks.

We plan to continue providing particular assistance to small regional agencies, ensure their good investigative practices are retained when key staff move on, and help new services with their responsibilities under the Act.

legislative changes

One important change this year has been the amendments to Part 3A of the Ombudsman Act which came into effect on 23 April 2004.

In 2003, some concerns were raised about the impact of employment related child protection legislation on employees. Teachers were especially concerned about the use of the term 'child abuse' when referring to low risk matters that had to be reported to the Ombudsman and the Commission for Children and Young People (CCYP). The government reviewed the impact of the legislation on employees and recommended some changes to the Ombudsman Act and the *Commission for Children and Young People Act 1998*.

The *Child Protection Employment Legislation Amendment Act 2003* amends those two Acts to clarify the type of conduct that does not have to be reported to our office and the CCYP. In this chapter we will discuss the changes only as they affect the work of our office, not the work of the CCYP. Please refer to the *Working with children check guidelines* for information about the role of the CCYP, available from www.kids.nsw.gov.au.

Employees who work with children in a nurturing role need to have some physical contact with those children. For example, they may need to comfort a distressed child or guide a child to gain their attention. The legislation now makes it clear that these matters are not reportable. It also exempts certain matters from notification and replaces the terms 'child abuse' and 'child abuse allegation' with 'reportable conduct' and 'reportable allegation'.

However, the scheme still retains the following principles:

- it is based on allegations
- the decision as to whether a matter is reportable is to be made, without delay, on the face of the allegation
- allegations must be dealt with in a timely way
- the results of inquiries and investigations must be appropriately recorded
- the Ombudsman is responsible for scrutinising how agencies handle these allegations.

In practice these changes mean that agencies will have to make more decisions about what is reportable, they will need to have current codes of conduct, and our scrutinising activities will increase.

To help agencies prepare for the legislative changes, we held focus groups for the child care, education, substitute residential care and government sectors. Some of these groups will continue to meet quarterly to discuss any issues arising from the legislation, share information and to network. We also reviewed our guidelines, *Child protection in the workplace: responding to allegations against employees,* with the assistance of senior counsel and key stakeholders, and distributed over 6000 copies to agencies. These guidelines contain clear and accurate information about the legislative scheme and how it is to be implemented, and are available from our office.

statistics

In the five years since we started our child protection work, we have received increasing numbers of notifications. See figure 21. We received 1,620 written notifications from agencies this year. This is 11% fewer than last year mainly because, under administrative arrangements called 'class or kind determinations', the Department of Education and Training (DET) and Catholic systemic schools do not have to notify us of certain classes of matters, and this year those classes were extended. Our class or kind determinations are discussed later in this chapter.

This year we also received 78 complaints about the way agencies handled allegations. We discuss our work with complaints later in this chapter.

In 2003-2004, we finalised 1,908 written notifications. Of these, we oversaw the agency's final investigation report in 71% of cases and monitored 21% of them more closely. See figure 22.

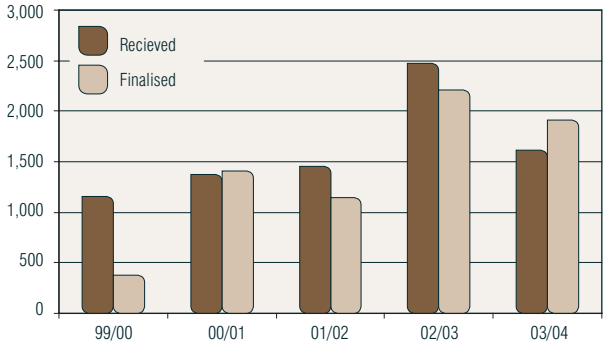
Each year some of the notifications we receive are about matters that did not need to be notified to us. This is because they involved allegations:

- about an agency that is not within our jurisdiction
- against someone who is not a current employee of the agency
- about someone who was not a child (that is, under 18 years old) at the time they were allegedly the victim of the inappropriate behaviour
- about conduct that need not be notified to us.

This year we dealt with 149 notifications that met one of these criteria. We therefore advised the agency concerned that we had received their notification but would not have any further involvement in how they handled the matter.

Figure 21: Written notifications received and finalised — five year comparison

	99/00	00/01	01/02	02/03	03/04
Received	1153	1379	1458	2473	1620
Finalised	377	1407	1141	2211	1908



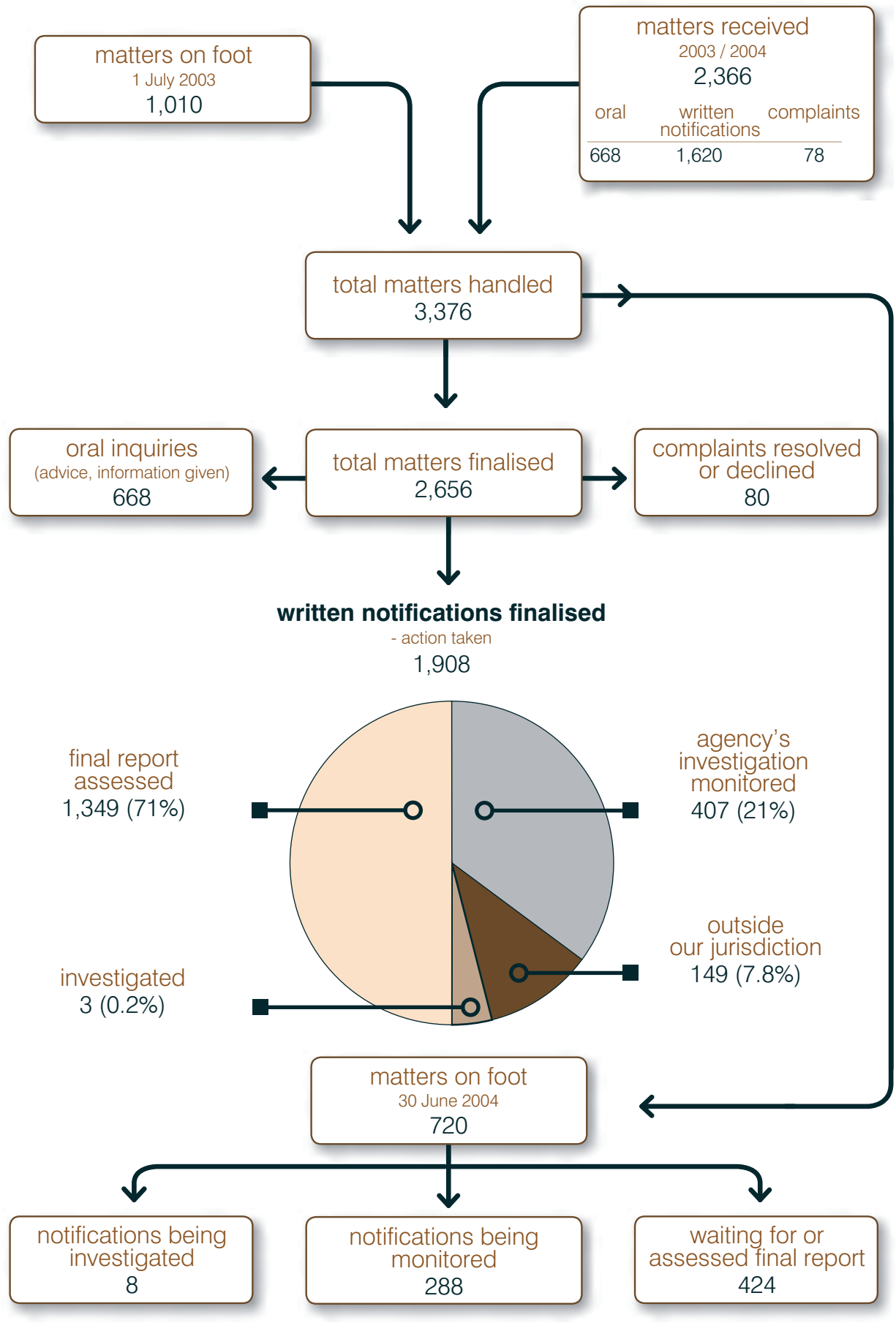
what should be notified

As a result of the legislative amendments, a range of matters that previously had to be notified to our office no longer need to be. Only 'reportable allegations' and 'reportable convictions' now need to be notified. This means that agencies generally need to notify us of all allegations or convictions of the following kinds of behaviour:

- any sexual offence or sexual misconduct committed against, with or in the presence of a child — including a child pornography offence
- any assault, ill-treatment or neglect of a child
- any behaviour that causes psychological harm to a child.

These allegations need to be notified whether or not the child has consented to the behaviour. The exact nature of the alleged behaviour may need to be clarified with the person making the allegation before agencies notify us. For example, see case study 18. However, agencies should not make in-depth inquiries (for example, to determine if the allegations are true) to decide whether or not allegations need to be notified to us – they must decide, without delay, on the face of the allegations themselves.

Figure 22: Matters received and handled this year by the child protection team



Allegations of certain conduct, such as the use of physical force towards a child that on the face of it is trivial or negligible and is not part of a pattern of behaviour, no longer need to be notified to us. However the legislation still requires that such allegations must be investigated by the employer and the results of the investigation recorded.

Conduct that is reasonable for the care or discipline of a child, as set out in an agency's code of conduct, also does not need to be notified. This could include comforting a hurt child or raising your voice to attract a child's attention.

Our guidelines *Child protection in the workplace: responding to allegations against employees* provides full details for agencies about how the Act works. These guidelines are available on our website.

case**study**18

We received a notification from a community based child care centre that a child care worker had 'touched' a three-year-old girl. The child made the allegation to her mother, in response to her questions about why she did not want to go back to the centre.

It was not clear from the notification in what way the child care worker had touched the child. We needed to know this to decide whether the matter needed to be reported to us at all, so we asked the centre to find out from the mother exactly what had happened. They told us that when they spoke to the child's mother she said that the allegations were about a specific incident where the girl had been upset by some other children and was spoken to by the child care worker concerned. We decided that, based on this information, the matter was not within our jurisdiction and declined the notification.

We advised the centre that in future they should clarify the nature of the alleged behaviour with the complainant before deciding to notify us.

any sexual offence or sexual misconduct

Changes to the Act have broadened the range of sexually inappropriate conduct that must be notified to us. This change was made to capture those inappropriate behaviours that often lead up to a sexual offence.

Sexual offences include sexual intercourse, acts of indecency and indecent assault. Sexual misconduct is a term used to describe a range of behaviours or a pattern of behaviours aimed at involving children in sexual acts. This could include inappropriate conversations of a sexual nature, inappropriate touching, possessing child pornography and 'grooming behaviour'.

The 'grooming' process is often used to build a child's trust and test boundaries before involving a child in sexual activity. It can include persuading a child that a 'special' relationship exists, undressing in front of a child, or allowing a child to sit on the person's lap. The rapid growth in personal electronic communication has increased the opportunities for offenders to communicate with children.

The internet in particular can provide easy access to children and increased opportunities to develop relationships with them. See case study 19.

We have provided significant training and advice to help agencies recognise these kinds of behaviour and intervene early enough to reduce the risk of serious offences taking place. See case study 20.

case**study**19

We received a notification from a school about allegations that an employee had sexually assaulted a girl on several occasions. The girl was now an adult, but the incidents were alleged to have occurred when she was a child. The school informed us that the allegations also extended to the employee having a collection of child pornography and developing a sexual relationship with another girl at the school.

The school sought our advice about how to proceed. We helped them develop a plan of action including clarifying whether the alleged victim had or was intending to report these allegations to the police and how to liaise with the police.

The school informed us that the alleged victim had notified the police and the school had suspended the employee from duty as an interim risk management strategy pending investigation. The person who made the allegations provided a detailed statement to the police outlining numerous incidents of sexual assault.

The school engaged an independent investigator who found documentation relating to the employee's involvement in an internet chat room relationship with a second school girl. This involved detailed sexual discussion and suggestions that he engaged in sexual activity with her. The investigation also uncovered clear evidence of an inappropriate relationship that had developed between the employee and a third school aged girl. This relationship eventually proceeded to a sexual relationship. A significant amount of child pornography allegedly belonging to the employee was also provided to the police.

The employee, on legal advice, refused to be interviewed by the investigator despite a direction to do so by his employer.

The allegations relating to sexual assault, 'grooming' on the internet and establishing an inappropriate relationship with the school girl were sustained. The allegation relating to child pornography could not be sustained because there was insufficient evidence to indicate it belonged to the employee. We agreed with the agency's findings in this matter.

The employee was reported to the Commission for Children and Young People (CCYP) and subsequently dismissed.

casestudy20

A school notified us of an allegation that an employee had invited a student to his home, offered him alcohol and cigarettes and given him a hug. The school engaged an independent investigator who found that the employee had breached professional boundaries by having the student at his home. The employee was given a formal warning.

A few months later, a new principal reviewed the matter and spoke to two senior members of the school who knew of other historic 'grooming' allegations about the same employee.

We met with the principal and requested that the school notify us of the previous allegations, undertake a risk assessment of the employee, and investigate the allegations. It seems that some form of investigation had previously occurred and the employee had been removed from his position of close contact with students. However the school could not locate the documentation about this earlier investigation. In addition, the employee's personnel records did not show any reason for his removal from his position at the time or that any disciplinary action had been taken.

The school's new investigation found an allegation of sexual misconduct against the employee to be sustained. The employee resigned and the matter was notified to the CCYP.

designated and non-designated agencies

Under the amended scheme, all agencies specifically designated in the Ombudsman Act must still report all reportable allegations or reportable convictions relating to their employees, even if the alleged behaviour did not take place in the workplace. All government agencies must still notify us of these kinds of allegations or convictions if the alleged behaviour occurs in the course of employment.

the way we work

Over the past five years, many agencies have established effective systems for reporting and handling child protection matters. We have been impressed with the increasing competence of agencies and the significant outcomes that have been achieved in providing safe environments for children.

This year we have focused on those agencies that do not yet effectively comply with their reporting obligations. We audited agency systems and increased our investigations into systemic issues.

We were particularly interested in working more closely with agencies that provide residential or custodial care for Aboriginal children. We have sometimes found it difficult to obtain information from them so that matters could be finalised. During the year we visited a number of these services with staff from our Aboriginal complaints unit and, as a result, have been able to establish better working relationships.

We deal with notifications in three ways – oversight, monitor or investigate. We also audit agencies to make sure that matters that are not notified to us because of a 'class or kind' determination are still handled appropriately.

class or kind determinations

Section 25CA of the Ombudsman Act permits the Ombudsman to exempt certain classes or kinds of allegations or convictions involving employees from notification. We have had 'class or kind' determinations with DET and the Catholic Commission for Employment Relations (CCER) for systemic schools since 2001.

In April 2003 we made new determinations with DET and the CCER and recently made other determinations with the Association of Independent Schools and with Barnardos. The determinations expanded the categories of behaviours that were exempted from notification to us. They now include:

- most first time allegations of physical assault, except where undue force was used by the employee or where 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, and where the risk of harm was reasonably perceived at the time to be low.

The determinations differentiated between allegations involving children from pre-school to grade 4 and older children. This is because younger children are much more vulnerable. The determination with the CCER was also extended so that Catholic independent schools were able to notify us of some allegations of physical assault or neglect by monthly schedule.

We conduct regular audits to make sure these allegations are still being handled properly. This year we audited DET and the CCER twice each and Barnardos once.

We found that DET's practices continue to be of a high standard. Barnardos demonstrated a high level of competence in handling investigations of allegation. In both cases we made recommendations about improving their documentation.

During our first audit of the CCER, we found that more than half of the matters reported had not been finalised at the time of our site visit. In some cases the reasons for the delays had not been documented. We recommended that the CCER set up a tracking system so that final reports could be completed in a timely manner. During our second audit, we noted some improvement in this area.

Despite our previous recommendations that the CCER should audit the 11 diocesan Catholic Education Offices, this had not happened so we started our own program of audits. We will complete audits of all these offices by the end of 2004.

oversight

We oversaw 71% of the 1,908 written notifications finalised this year. This means that while we did not get directly involved in the way the agency handled the allegations concerned, we scrutinised their investigation and decision-making by assessing their final investigation report. We also provided feedback if necessary. See case studies 21 and 22.

The matters we oversight mainly involve allegations of physical assault, neglect or behaviour causing psychological harm where there is no claim of serious injury or harm to a child.

Agencies are required to notify us as soon as practicable, or within 30 days at the latest, after they become aware of an allegation or conviction. Sometimes it is possible for the agency to investigate the allegations during that time, so they send us their notification and final investigation report together. This year we received 584 cases like this.

In 765 cases, agencies sent us their notification before their final report. This gave us an opportunity to assess, at that early stage, whether the agency had satisfactorily addressed any risks involved and were able to manage the matter themselves. If that was the case, we usually decide that no active involvement was needed until we received their final investigation report. Sometimes agencies will contact us for advice during their investigation — for example see case study 23.

This year there were many examples where we were satisfied that the agency had handled a matter well. For example, see case study 24.

Performance indicator 1: Average time taken to assess notifications

Target	01/02	02/03	03/04
5 working days	5	3	5

Interpretation: We aim to assess notifications within an average of five days of receiving them. This year we met our target.

Performance indicator 2: Average time taken to assess final investigation reports

Target	01/02	02/03	03/04
30 working days	30	49	38

Interpretation: We aim to assess all final investigation reports to determine whether or not allegations have been handled satisfactorily within 30 working days. This year we improved the amount of time taken compared with last year however we did not meet our target, due to the large number of final reports reveived this year relating to notifications received last year.

case**study**21

A child care student on placement at a large company-owned child care centre made an allegation to DoCS that a one year old child had been inappropriately restrained. The alleged incident involved three child care workers and DoCS assessed the student's account of the events as clear and credible.

We had a number of concerns about the investigation by the area manager of the company. The investigator showed a noticeable bias against the student by openly questioning her credibility and suitability to work with children, without any evidence to support this claim. This was inappropriate and raised the possibility of collusion by the centre.

The investigator failed to reach a finding and also had difficulty obtaining timely information from DoCS about the matter. This is an ongoing issue for many child care centres when they are investigating allegations against employees.

We provided the agency with extensive feedback on their investigative processes and the need to ensure an impartial and fair investigation. We also requested that they make a clear finding in the matter.

case**study**22

An early childhood teacher locked a three year old child in the centre's kitchen for misbehaving. Two child care employees witnessed the incident and reported it to the director who immediately suspended the teacher. The director interviewed the three employees and found that the child was locked in the kitchen for a period of 15-20 seconds. During this time the teacher kept talking to the child. The director found that the teacher's behaviour constituted misconduct and neglect and terminated the teacher's employment.

We considered that this action was harsh and that procedural fairness had not been given to the teacher. Although the behaviour of the teacher was inappropriate and breached the centre's standard of care, we do not believe it was so severe that termination was justified. We advised the centre of our view but, for practical reasons, were not able to recommend that the employee be re-instated.

case**study**23

An allegation was made in August 2003 that a child care worker had exposed her breasts to children at a child care centre and had held a three year old boy over a toilet upside down. DoCS had informed the centre of the allegations and advised the centre director, because of the nature of the allegation, to stand the employee down until the investigation was finalised.

The centre asked us about appropriate risk management action. We gave them detailed advice about how to conduct a risk assessment and encouraged them to document the assessment thoroughly. Relevant factors in this case included the employee's performance history and the risk posed to the children at the centre if the allegations were true.

The centre found that the employee had an impeccable employment history and it was highly unlikely that she could have behaved in this manner without being detected. They decided not to stand her down during the investigation. They thought that any risk posed by the employee was negligible but decided to increase supervision until the investigation was completed. As the centre's decision went against DoCS' advice, we offered to liaise with DoCS on the issue of risk management if required.

The investigation concluded that the allegation against the worker was false and, based on the evidence, we considered this to be a reasonable finding.

case**study**24

An independent school notified us of an allegation that a boarding house mistress used excessive force on a boarder causing bruising on both upper arms. A number of fellow students corroborated the allegation.

The school employed an external investigator. Towards the end of the investigation, a number of students came forward and disclosed information that indicated the allegations might have been vexatious. The investigator considered the new information and conducted another round of interviews, eventually finding the allegations to be vexatious.

This situation was potentially damaging for all parties concerned, but the school managed the outcome well. The boarding house mistress was offered counselling and strategies to minimise future risks, but she subsequently left the school for other reasons. The students showed remorse and acknowledged the consequences of their actions, particularly in respect to the boarding mistress's career. The school organised for the students to undertake a period of community service. This was seen as an opportunity to re-build some of the trust that had been lost as a result of the allegations.

We were satisfied with the school's investigation and commented in our feedback that their investigation showed a sound knowledge of child protection issues and procedural fairness. We commended them for attending to the welfare of the employee and the students.

monitoring

Most of the 407 matters that we monitored this year involved allegations of behaviour that could be seriously abusive to children and therefore required close scrutiny by our staff. We also monitored matters that had not been finalised within six months and where the agency had failed to finalise matters in a timely way despite our requests. This was most notably the case with the Department of Community Services (DoCS).

Monitoring gives us the opportunity to provide agencies with guidance, particularly if they are not experienced in handling such matters or are not aware of the options available to them. For example, in one case we were able to persuade an agency to change their decision to keep a person with past convictions of serious sexual assault in his position which involved some contact with children (see case study 25). In another two cases we advised the agencies that they should take their own risk management action rather than wait for the outcome of court proceedings. These proceedings involved criminal charges for aggravated indecent assault and aggravated sexual assault on young women with intellectual disabilities.

When we monitor an agency's investigation, we first do a risk assessment. This is to ensure that all steps have been taken to safeguard children and to check that the employee's rights to fair processes have been upheld. We also check whether the appropriate referrals have been made to the police and DoCS and if there are any risks to the agency's investigation or breaches of confidentiality. We ask the agency for regular updates on the progress of the investigation so that we can intervene promptly if necessary. We also ask the police or DoCS for information to help us decide what action we need to take. Our monitoring powers allow us to sit in on interviews or, in rare cases, take over the investigation if we have concerns about the agency's capacity to conduct it properly.

For examples of investigations we have monitored, see case studies 26, 27 and 28.

Performance indicator 3:
Reports recommending changes to law, policy or procedures

Target	01/02	02/03	03/04
90%	**100%**	**100%**	**100%**

Interpretation: As in the past two years, this year we exceeded our target of recommending changes in 90% of our reports.

Performance indicator 4: Recommendations implemented

Target	01/02	02/03	03/04
80%	**93%**	**86%**	**100%**

Interpretation: We monitor the degree to which the recommendations we make in our reports are implemented by the agencies concerned. This year we exceeded our target of 80%.

case**study**25

The Department of Disability, Ageing and Home Care (DADHC) notified us in July 2003 of allegations of past convictions of serious sexual assault against an employee. The allegations had surfaced after rumours about the employee's past were circulating in an isolated rural indigenous community. The employee's position involved limited contact with children.

DADHC had interviewed the employee about the convictions in May 2003, but failed to keep adequate records of the interview. The employee admitted having the convictions but stayed in his position throughout the period of the investigation. DADHC decided against taking further action because they were past convictions and the employee had cooperated fully.

We asked DADHC for more information about the matter, including the results of a criminal records check. The check came back clear and again the department informed us that they would take no further action.

Given the serious nature of the allegations and the fact that the employee had admitted the convictions, we again asked DADHC to obtain information about the employee's background from relevant investigatory bodies. A second criminal records check revealed serious convictions of child sexual assault and a current criminal prosecution involving sexual assault against children. We were informed that the discrepancies in the criminal records checks were caused by a change in police procedures.

In May 2004, DADHC conducted a risk assessment in light of this new information and decided to transfer the employee to alternative duties that did not involve any contact with children. The employee resigned from DADHC soon after.

case**study**26

In early 2002, a school's head of agency notified us of allegations against a gardener who was a member of a group of adults with intellectual disabilities who were contracted by the school to mow the lawns. It was alleged that, in February 2002, the gardener entered the school toilets and indecently assaulted a six-year-old female student.

The matter was reported to NSW Police. The gardener was interviewed and an apprehended violence order issued with regard to his proximity to the student and the school grounds. The victim's parents elected not to proceed criminally with the matter as they were concerned that the court proceedings might further traumatise their daughter.

The school wrote to NSW Police and the agency that funded the gardening group asking for further details about this matter, including the gardener's name. Both agencies declined to provide any information or to disclose his name. This affected the school's ability to conduct their own investigation of the allegations. It also made it difficult for the school to notify the matter to the CCYP as they are unable to accept a notification without the name of the subject of the allegations.

At the request of the school, the CCYP also tried to obtain details about the gardener from the gardening group's funding body - but they had no success either.

We held the view that this matter should be notified to the CCYP for future employment screening because of the serious nature of the allegation, and the high level of risk that the alleged offender may pose to children in the area. We wrote to NSW Police and obtained the name and particulars of the gardener. We were able to provide this information to the CCYP under s.34(1)(b1) of the Ombudsman Act. The CCYP has advised us that they are using this information to pursue the gardening group's funding body for a notification of this matter.

case**study**27

We monitored an investigation of allegations against a teacher of an inappropriate relationship with a female student. The relationship allegedly started in 2000 when the girl was 15 years old and the teacher was her mentor. It was alleged that the teacher had socialised with the girl outside school, communicated with her by telephone and email, and two years later allowed her to move into his house. It was also alleged that he had breached a direction not to have contact with the girl during the period of the investigation. The allegations against the teacher were sustained and the agency dismissed him.

The investigation was lengthy and complicated and took over two years to complete. Although we found the agency's investigation satisfactory and their findings reasonable, we were concerned about the potential for evidence to be contaminated because some people had acted as a 'support person' for a witness when they were being interviewed and were then subsequently interviewed as witnesses themselves. The agency agreed with the substance of our concerns but stated that in this instance it had been necessary.

Our other concern was that some staff had been aware of concerns about the student and the teacher but had failed to raise these with the principal. If these concerns had been reported to the principal earlier, setting limitations on the teacher might have protected the student. The agency initially disagreed with our advice as they considered that none of the staff had sufficient reason to report their concerns to the principal. However, they reviewed their position after they had investigated complaints from the student's parents and considered our advice.

This case highlights the importance of employees telling senior management about any concerns raised with them about another employee's relationship with a child, regardless of their own beliefs about the validity of those concerns. This ensures that the agency is fully informed and in a position to take any action necessary to protect both the child and the employee concerned.

case**study**28

During June 2003, South Eastern Sydney Area Health Service (SESAHS) notified us of an allegation relating to an incident alleged to have occurred some time ago. One employee recognised another employee (a trainee nurse) from her childhood. She alleged that the trainee nurse had sexually assaulted her when he was a teenager and she was a much younger child.

SESAHS met with us to discuss their planned approach and regularly informed us of the progress of their investigation by email, telephone and regular written reports. We monitored their investigation and found it to be grounded in a risk management framework. It was well planned and organised, thorough in its analysis of information obtained and meticulously documented.

SESAHS found the allegation sustained. Although the subject of the allegation was under 18 years of age at the time of the alleged incident and considered a child, he was nevertheless considered to be criminally culpable because he was older than 10 at that time. He was dismissed at the end of the investigation.

case**study**29

We received a notification of allegations about a foster carer for DoCS. The foster carer had worked for another agency and had been deregistered by that agency because of concerns about her child care practices. That agency had also contacted DoCS to warn them not to place any children with the carer without first discussing the matter with them. DoCS failed to consult with the agency when they originally assessed the foster carer and placed children with her.

After the allegations were made, DoCS engaged a series of independent professionals over a significant period of time to assess the placement. None of the independent assessments supported the foster carer's capacity to provide satisfactory care to the children. We became concerned about the inaction of DoCS and decided to conduct a direct investigation into their handling of the matter.

Our view was that DoCS needed to make some decisions, based on the professional advice they had already received, about the children's care. They also needed to review the foster carer's capacity to care for children.

DoCS subsequently removed the children from the placement. We have made a number of recommendations relating to systemic and case specific issues and have asked DoCS about the status of the foster carer. We will monitor their compliance with our recommendations.

investigations

We may decide to investigate a matter as a result of a complaint from an interested party who has concerns about the way an agency investigation has been conducted. We also have our 'own motion' powers to start an investigation if we become aware of information that suggests inaction or wrong conduct by an agency. We generally investigate matters where there are systemic issues that can only be resolved by using our formal powers.

In 2003-2004, we finalised three investigations carried over from last year and started eight new investigations. In three matters where we investigated the agency's handling of a particular allegation, we also found systemic issues.

At the end of all the investigations we made recommendations to address the problems we identified and achieved 100% compliance. This has meant we have been able to achieve positive outcomes for children as well as systems improvements. See case study 29.

scrutinising systems

One of our key roles is to ensure that agencies have good systems in place to protect children from abusive behaviour and to deal appropriately with allegations against employees. We gain a clear picture of these systems when we monitor an agency's investigations. We also take a proactive role and audit agencies that provide services to particularly vulnerable children if we have some concerns.

This year our auditing activities enabled us to give feedback to agencies about how their procedures were being implemented, identify good practice and provide advice about how systems could be improved. When we audit an agency, we look at their child protection policies and procedures and visit the agency to talk to staff, and those who use the service, to see if practice matches policy. We try to make the audit process as positive as possible and ask agencies to evaluate our own performance as auditors.

During 2003 –2004, in addition to our audits of agencies with class or kind determinations, we conducted audits of nine other agencies including seven independent schools with boarding facilities. We expect to increase our audit activity next year to make sure that those matters that no longer need to be notified to us continue to be dealt with properly by agencies. We also plan to focus on agencies such as child care centres because of the vulnerability of the children they look after.

audits of independent schools with boarding facilities

We were impressed with the results of the audits we did this year of seven independent schools with boarding facilities. We identified a number of good child protection practices including:

- effective supervision, comprehensive induction and development programs for all staff, including casual employees
- high levels of consultation and communication with staff, parents and students
- risk management strategies that identified students at risk and took into account interactions between students, ancillary employees and external contractors
- good support systems for students, including mechanisms for raising concerns.

Some recommendations we made to these schools included:

- providing regular child protection training for all staff and having clear codes of conduct for staff that defined appropriate and inappropriate behaviours, particularly with out of school hours contact
- providing clear information to parents about their rights and the processes for reporting allegations
- developing a complaints register to identify trends and patterns and assist with risk management.

handling complaints

When a parent, employee or other party complains to us it is usually about the way an agency has handled an investigation of a reportable allegation. Sometimes parents complain that their matter was not taken seriously or they were not satisfied with the outcome of the agency's complaint-handling process. Employees mostly complain about unfair processes or harsh treatment by an agency in dealing with allegations made against them.

Last year we received 78 written complaints. We believe it is important for agencies to have the opportunity to resolve issues with complainants before we get involved, so we usually refer complainants to the agency concerned in the first instance. We declined 44 complaints because the complainant had not raised the issue with the agency or it was not in the public interest for us to investigate the complaint. The complaints we did deal with involved systemic issues or matters that affected an employee's rights or a child's safety.

education and training

We have a significant role in educating agencies about how to meet their responsibilities under Part 3A of the Ombudsman Act. We provide workshops and briefings to agencies and make presentations to sector-wide conferences. In 2003-2004 we provided 26 workshops on risk management and investigation practice, and briefing sessions about the legislation to 21 groups that included several government departments, foster carers, family day care services, substitute residential care agencies, TAFE, independent schools and child care centres. We participated in a 'roadshow' that DoCS organised for their regional managers around NSW. See the access and equity chapter for more details.

Our workshops and briefings are generally targeted at managers or staff responsible for handling investigations of reportable allegations against employees. Feedback from participants has been very positive and we will continue to offer these workshops to interested groups next year.

People from a variety of agencies attend our child protection forum, chaired by Anne Barwick, Assistant Ombudsman (Left)

This year we piloted a train the trainer project with Home Care and helped them develop their own training packages for managers. We have found this to be an effective way to reach employees of large organisations. We have also been working with the Department of Health to develop a similar training package for their staff.

training with the AIS

In early 2004 we made a class or kind determination with the Association of Independent Schools (AIS) so that independent schools that they identified as being suitable could be exempted from notifying some matters to us. This is the same as the determination we made for public and Catholic schools.

As part of implementing the determination, the AIS set up an accreditation process for independent school staff who successfully completed a two day investigation training course. The accreditation process was open to all independent schools regardless of their AIS membership status.

We helped AIS develop the training package and co-presented at all the courses. To date, AIS has accredited 91 principals and school staff who successfully completed one of the nine investigation courses. Participants were assessed on their interviewing skills and knowledge base and had to complete a work-based project. We will continue to help AIS to deliver this course.

child protection forum

The child protection forum began in 1999 and meets bi-monthly to discuss current issues, investigative practice and legislative or policy changes in child protection. It brings together a range of agencies and staff who are responsible for investigating reportable allegations in the workplace.

We have conducted four forums this year that incorporated presentations from other agency staff. Some of the topics covered included:

- handling difficult complainants
- the child protection register and our legislative review of the *Child Protection (Offenders Registration) Act 2000*
- exchanging information between agencies and the police
- the legislative amendments to Part 3A of the Ombudsman Act and the Commission for Children and Young People Act.

The police have always been prepared to present information to the forum about various aspects of their work in child protection and we have observed an increased understanding by agencies of the police's role and expertise in this area. This was particularly noticeable during concurrent investigations where the police and an agency were investigating the same matter - the effective liaison and exchange of information between them meant better outcomes were achieved for the children concerned.

how agencies are performing

notifications

In 2003-2004 there was an increase in notifications from agencies providing substitute residential care, child care centres and the Departments of Juvenile Justice and Health. Figure 23 shows that DET remained the largest reporter of notifications this year.

Figure 23: No. of notifications received from agencies — two year comparison

Agency	02/03	03/04
Department of Education and Training	1460	685
Catholic systemic and independent schools	268	155
Department of Community Services	238	207
Substitute residential care	158	177
Department of Juvenile Justice	96	119
Child care centres	79	87
NSW Police*	87	77
Non-government independent schools	68	71
Councils**	43	48
Department of Health	32	40
Other NSW public sector agencies	17	13
Department of Corrective Services	6	4
Department of Ageing Disability and Home Care	4	7
Department of Sport and Recreation	2	2
Agency outside our jurisdiction	3	4
Other prescribed bodies	0	1
Total	**2561**	**1620**

* Note 1: Notifications that are made by NSW Police are dealt with by our police team in the same way as other allegations of police misconduct.

** Note 2: In last year's annual report we mistakenly omitted from figure 44 the 43 notifications we received from councils.

the department of education and training

The quality of investigations conducted by DET continue to be of a high standard and we were pleased with the way they prepared principals for the changes to the legislation. DET consulted us about the development of their training packages and we observed the delivery of that training where possible. The use of principals as co-presenters was a particularly effective strategy as they could share their experiences and anecdotes with their peers.

We continued our regular liaison meetings with the DET employment performance and conduct unit and resolved most of our concerns about findings, reporting matters to the CCYP, definitions of psychological abuse, inappropriate professional behaviour and other case-related matters. We conducted two audits of the unit and made preliminary inquiries about their changed notification patterns (a drop from 1,460 to 685).

catholic commission for employment relations

The Catholic Commission for Employment Relations (CCER) is currently the head of agency for most Catholic schools and Catholic agencies providing substitute residential care, child care and health services in NSW. The CCER has been delegated responsibility by the NSW Bishops for compliance with the Act. This means they are responsible for notifying and investigating reportable allegations against employees. They also have a broader compliance, systems monitoring, policy development and training responsibility.

We have been concerned for some time about the CCER's capacity to meet their obligations as head of agency. We sought a meeting in April 2003 with the NSW Bishops, through the CCER, to raise our concerns.

These concerns included:

- their failure to notify and properly deal with allegations involving clergy
- delays in notifying and completing investigations
- their failure to respond to our requests for information
- the inadequacy of their training and provision of information to Catholic employers about their responsibilities
- their non-compliance with the reporting obligations to the CCYP.

In 2003-2004 we initiated three investigations and five audits where we identified other systemic issues. These included the failure of CCER to:

- properly assist agencies that provide substitute residential care
- adequately monitor employers' training and assist with policy development
- provide accurate information about the class or kind determination to the bishops, employers and employees.

Two of the audits this year were of matters exempted from notification under our class or kind determination with the CCER. Two others were of metropolitan Catholic schools or education offices and we did one regional audit.

During these audits we found that:

- There were considerable differences between the investigation systems of different dioceses and the amount of support given by the CCER.
- In some instances the CCER had not passed on our assessment of their investigations to the Catholic school or education office concerned.
- Incorrect information about our class or kind determination had been given to employees — some were incorrectly told their matter had been reported to us when it had been exempted from notification. The CCER had not taken steps to rectify this problem.
- The CCER did not appear to have adequate systems in place for seeking regular updates on open investigations and for following up delayed investigations.
- There was no documented complaint-handling process in place.

We have issued audit reports to the dioceses and the CCER containing recommendations to address each of these issues. All agencies have agreed to implement our recommendations.

The failings uncovered in our audits and investigations and changes in legislation brought some urgency to the need to review the CCER's role as 'head of agency' for child protection matters. Our firm view is that, while we have worked constructively with the CCER, it is not a viable head of agency for Catholic agencies in the future. We have explained our concerns to CCER and NSW Bishops including meeting with Cardinal Pell, the Archbishop of the Sydney diocese and Chair of the NSW Bishops' Meeting. We have agreed to consult with representatives of the Catholic Church before finalising our view as to suitable new head of agency arrangements.

See case study 30.

case**study**30

The police contacted us about a sexual assault investigation they were conducting involving a priest who provided services to a local Catholic primary and infants school. The priest was regularly involved in the activities of the school, provided support for staff and took groups of students for reading classes. The police had concerns about the risk he posed to children and had conveyed their concerns to his employer. Despite the police concerns, the employer allowed the priest to remain in his role in the schools.

We made inquiries with the CCER who had not been notified of the child abuse allegations by the Catholic employer. We also received information that the school principal had not reported the matter to the CCER. After our inquiries with the CCER, the priest was immediately suspended from his duties.

We were concerned about the systems that the CCER has in place to ensure that Catholic employers are aware of their responsibilities to report and respond to these kinds of allegations and conduct appropriate risk assessments.

We conducted a direct investigation of their systems for reporting and responding to child abuse allegations and found wrong conduct by the CCER. They had failed to ensure that Catholic employers were aware of their reporting obligations, and failed to provide adequate training and information about risk management. We also made adverse comments about the employer who had jeopardised the police investigation by alerting the priest to the pending charges against him. We made a number of recommendations which the CCER agreed to implement.

This investigation raised a range of performance and practice issues concerning the CCER's role as head of agency for not only Catholic schools but other Catholic agencies. We decided to investigate the way CCER was fulfilling its obligations as head of agency for Catholic agencies providing substitute residential care.

department of disability, ageing and home care

The Department of Disability, Ageing and Home Care (DADHC) became a designated government agency in December 2002 after they took over DoCS' former responsibility for substitute residential care services for children with disabilities. This means that allegations of reportable conduct against all employees of DADHC are notifiable to the Ombudsman, even if they relate to conduct outside of employment.

We have raised our concerns with DADHC about their delays in progressing investigations and their failure to provide us with the appropriate documentation. DADHC finalised their child protection policy in early 2004 and this should strengthen their child protection responses, particularly in relation to their responsibilities under the Ombudsman Act.

department of community services

There has been a 14% decrease in the number of notifications made by DoCS this year. The majority of reportable allegations against employees continue to involve foster carers.

We are still concerned about DoCS' delays in making notifications to us. Despite the development of policies and undertakings to improve their internal systems, they have not adequately addressed this problem. We pursued this issue further with preliminary inquiries about several matters that were only sent to the head of agency some seven to 22 months after DoCS first received the matters. We were advised that departmental staff, including regional staff, were not following the internal policies.

DoCS has now established a centralised complaint assessment and review branch that is responsible for overseeing the handling of reportable allegations involving employees and we expect DoCS' compliance with their responsibilities to improve.

child care centres

We received 87 notifications from child care centres this year — and about a quarter of the oral inquiries we handled were also from child care centres.

There is an increased awareness among child care centres of their reporting obligations and the need to have appropriate policies and procedures in place for responding to reportable allegations. We believe that the children's services advisers from DoCS have contributed to this improvement by routinely informing centres of their reporting obligations.

Centres generally need intensive assistance with their investigations and we continue to provide support and advice by telephone and in meetings.

Centres that are small, have low notification numbers and high staff turnover have difficulties retaining knowledge and building on their expertise in conducting investigations. Conflicts of interests are also an issue for centres where allegations are made against the licensee or owner of a centre and it is difficult to find an independent investigator. For example, see case study 31.

case**study**31

A number of allegations of physical assault were made against the licensees and authorised supervisor of a privately run child care centre. An employee made the allegations to DoCS and subsequently resigned from the centre.

The allegations were about incidents that were alleged to have happened some time ago — there was little detail about the times and dates when the alleged incidents had occurred.

One of the licensees investigated the matter and asked for our advice about the notification process. He found that none of the allegations were sustained — we agreed that this finding was reasonable in the circumstances. This was a difficult investigation given the allegations were historic, the alleged victims no longer attended the centre and the allegations lacked detail.

However we were concerned about the conflict of interests involved. The investigator and his wife were subjects of the allegations and both of them were witnesses for each other in refuting the allegations. We commented on the conflict of interests and discussed ways the centre could handle such allegations in the future by, for example, appointing an external investigator.

substitute residential care

This year we received 177 notifications from agencies providing substitute residential care, up from 158 last year. These agencies provide care for highly vulnerable children and young people who can display significant behavioural problems. Many of the agencies are small and have difficulties securing adequate funding for their services.

The majority of notifications came from only a small percentage of those agencies. We believe there are still a number of agencies in this sector that are not complying with the Ombudsman Act and notifying matters to us.

Some agencies need a high level of support and advice from us during their investigations, especially when the allegations are serious. We have noticed positive results from our involvement, including a growing confidence among staff about their ability to conduct workplace investigations.

This year we visited a number of agencies in Sydney and in rural areas. We addressed issues raised by particular notifications and increased our knowledge and understanding of the services that the agencies provide.

Some agencies are still unclear about their responsibilities when DoCS or the police are involved in an investigation. They often rely solely on those investigations to make a finding about an allegation. Other agencies argue it is not their role to undertake investigations as they lack the skills or resources to do so satisfactorily, particularly when they need to interview children. See case study 32 for an example.

Figure 24 outlines the responsibilities of the employer, DoCS and the police.

We have tried to address agency concerns in our written publications, by personal contact with agencies, by conducting audits and through training and forums. This year we held a forum to discuss the changes to the legislation. Agencies were able to network and discuss issues relevant to the sector.

We also conducted investigations training for managers responsible for investigating allegations, and are planning an audit program for agencies that provide youth refuges and services for children with disabilities.

department of health

The Department of Health has notified 40 matters this year, an increase from last year. The majority of notifications involved allegations of sexual offences.

Since April 2003, area health services have sent their notifications to the department's employment screening and review branch (ESRB) for review before sending them to us. This process aims to improve communication between the area health services, ESRB and our office about notifiable child protection matters.

We hold regular bi-monthly meetings with the ESRB where we discuss specific cases and their coordination role and responsibilities. At these meetings we have discussed our concerns about the delays in providing final investigation reports to the Ombudsman and notifications to the CCYP. These issues are the subject of a current investigation into the department.

We also held workshops for the New England and the Mid Western area health services and completed an audit of the Hunter area health service.

case**study**32

We were notified by a substitute residential care agency that a child made an allegation to DoCS that his former foster carer had sexually abused him. The joint response team, comprising DoCS staff and police officers, interviewed the child. During the interview the child withdrew his allegations stating that he may have blown it out of proportion. DoCS did not provide the agency with any further information and the agency did not interview the child.

The agency made a 'vexatious' finding due to the retraction. We told them that retractions of these kinds of allegations were not uncommon among children who had been abused. Disclosing and discussing sexual assault can be very difficult and embarrassing for children, especially when they are asked to give a statement or details to the police. Retraction does not necessarily mean that the incident did not occur or was fabricated.

We asked the agency to review their finding and, in response, they changed their finding to 'not sustained — insufficient evidence'.

Figure 24: The obligations of agencies when a child abuse allegation involves an employee

Agency	Employer	DoCS	Police
Role	Risk assessment and management action	Child protection	Criminality
Responsibilities and decisions made	• Decides the risk posed by the employee in his or her current role. • Takes any management action needed to ensure the safety of children. • Provides procedural fairness to the employee. • Liaises closely with DoCS and police to ensure a coordinated approach and obtain information to help make a proper risk assessment and decide on appropriate management action.	• Decides whether it will investigate an allegation of child abuse after assessing the perceived risk of harm the alleged offender poses to children. • May take a more active role in managing the case if the matter is more serious. • May not interview the employee.	• Decides whether the case has a criminal element that warrants investigation or further action. • In more serious cases, may take a more active role in managing the case (employer may be asked not to investigate). • The police investigation may lead to charges and prosecution. • The police are not responsible for workplace risk assessments.

department of juvenile justice

The Department of Juvenile Justice sent us 119 notifications this year.

Since July 2003, the department's professional conduct unit has been responsible for managing all reportable allegations, rather than the individual centres. We consider this change in procedure to be a positive one.

After relying heavily on the use of external investigators with varied success, the department is now assigning more of their investigations to professional conduct unit investigators. It is anticipated that this will result in more consistent and satisfactory outcomes.

During the year there was a discernible shift in the department's decision-making process in relation to findings arising out of investigations. In particular, we have disagreed with them about what constitutes sufficient evidence to determine that an allegation is false. We have also been concerned about the lack of documentation they provide about their decision-making. We have been unable to reach consensus on these issues and are still trying to resolve them.

family day care

The coming year will see some significant changes in family day care services in NSW.

Council run family day care schemes make up the majority of schemes in our jurisdiction as councils are public authorities under s.25I of the Ombudsman Act. Other family day care schemes, conducted by designated agencies, are also in our jurisdiction.

However, community based family day care schemes that have not previously been within our jurisdiction have now come into jurisdiction. We expect the *Children and Young Person Care and Protection Act 1998*, item 23 of schedule 2 to the *Children and Young Persons Legislation (Repeal and Amendment) Act 1998* and the *Children's Services Regulation 2004* to come into effect on 30 September 2004.

This means that all family day care schemes, home based children's services and mobile children's services will have to notify us of reportable allegations and reportable convictions.

We expect that this change will:

- clarify the status of all family day care services in NSW
- provide an equitable arrangement for all services
- enable relevant training and briefings to be provided consistently across the sector
- allow us to oversee all allegations of reportable conduct against employees in family day care schemes, regardless of who administers the scheme.

systemic issues

We often come across issues that affect a number of agencies that need to be brought to the public's attention.

exchanging information, making findings and identifying notifiers

In last year's annual report we wrote about a number of systemic issues that we had raised with DoCS, including their reluctance to provide information to agencies investigating reportable allegations against their employees. Appropriate information sharing between agencies is one way of ensuring the protection of children. We argued that DoCS had the power under s. 248 of the Children and Young Persons (Care and Protection) Act to exchange information with agencies.

This year a working party involving DoCS, CCYP and our office considered this issue. They also considered other issues such as whether DoCS could make findings at the end of their investigations involving matters that were notifiable to our office and whether DoCS should provide us with the name of someone who had made an 'at risk of harm' report to DoCS.

The working party decided that a joint brief would be prepared seeking advice from senior counsel.

The advice about providing information under s. 248 was generally consistent with our position. On the issue of providing names of people, the advice was that such information can be supplied to us if we request it under Part 3A of the Ombudsman Act. We were further advised that making a finding was required when any disciplinary or other action in relation to the employee could be taken. Counsel thought that this would be limited to permanent employees of DoCS, but DoCS accepted that it would also extend to temporary employees and to carers authorised by DoCS.

In practical terms this meant that these three issues were resolved in a way that was generally consistent with our position. DoCS has agreed to produce administrative practice directions to guide their staff.

Senior staff in our child protection team meet regularly to exchange views and discuss the work of the team.

making a finding

It is important that agencies make clear and accurate findings at the end of their investigations so that:

- employees know the outcome of investigations
- we can assess the appropriateness of the action taken
- appropriate notifications are made to the CCYP.

Some agencies fail to reach conclusions at the end of their investigations after we have asked them to provide us with a finding. Other agencies have made incorrect findings after we have requested a review. For example, see case studies 33 and 34.

Findings in agency investigations should be based on the civil standard of proof, the balance of probabilities. This means the agency needs to decide whether it is more likely than not that the alleged incident occurred.

We have advised agencies that when they make a finding they need to consider factors such as the reliability, relevance, consistency and corroboration of the evidence. Once an agency makes a preliminary finding, they should put this to their employee for a response. Any response the employee makes should then be weighed up along with other evidence gathered so an accurate finding can be made.

We discuss this issue in more detail in the latest edition of our guidelines *Child protection in the workplace: responding to allegations against employees*.

case**study**33

We received a notification that a teacher was having an inappropriate relationship with a female student. It was alleged that at the end of 2001 the teacher had communicated with the girl by telephone on several occasions, socialised with her outside school during 2002, and allowed her to move into his house at the end of 2002 when she was 17 years old.

The agency had difficulties obtaining evidence during the investigation because the person who raised the concerns declined to provide further information or the contact details of the student. They found insufficient evidence to sustain the allegations.

We wanted to know whether the agency intended to refer the matter to the CCYP. Their initial position was that they would not. While the finding was inconclusive, they felt there was insufficient information to indicate that the conduct of the employee should be considered in future risk assessments.

After our request for the agency to make further attempts to find the student and obtain a statement from her, they found that she was living with the teacher. The student confirmed that she was engaged in a sexual relationship with the teacher but maintained that the relationship started in early 2003 — about three months after she had completed her final year at the school.

The agency changed their investigation findings to state that there was some evidence that the conduct had occurred and that it should be considered in future risk assessments. The teacher's details were therefore notified to the CCYP.

case**study**34

A substitute residential care agency notified us of allegations that a female youth worker had inappropriately touched a 13 year-old girl and had kissed and cuddled and bought gifts for another girl.

As this was an allegation of abuse in care, DoCS investigated the allegations. They determined that they could not confirm the alleged conduct occurred and there was evidence suggesting that one of the allegations may have been vexatious. The substitute residential care agency did not finalise their own investigation until 15 months after the allegations were made. They relied on DoCS' findings without making their own inquiries. During that time further allegations of a similar nature were made against the same employee – and were found to be sustained.

On the basis of this more recent investigation, the agency sustained all the allegations that had been investigated by DoCS. We advised the agency that although the information gained from the recent investigation was important when considering ongoing risk to children, it should not have been the basis for deciding if the previous alleged incidents had occurred.

We asked the agency to review the results of their first investigation and make any necessary changes to the findings they had made. The agency reassessed the outcome as 'not sustained as there was insufficient evidence'.

case**study**35

We investigated the way an independent school handled allegations of sexual assault against a teacher employed by the school. The teacher was charged with 30 child sexual offences including aggravated sexual assault, aggravated sexual intercourse with a child under 14 years and aggravated acts of indecency. The school did not believe they had the right to suspend the employee or move him to non- child related duties during the investigation and subsequent criminal court proceedings because they believed that this would be contrary to the concept of treating a person as innocent until proved guilty.

Initially, the school did not accept that the teacher posed an unacceptable risk to students. They did not have access to the students' statements of the assaults and had formed a belief that none of the incidents had happened at the school. Because the police were still collecting evidence, they were unwilling to share the details of the students' statements with the school for fear of contaminating the evidence.

The school had put some strategies in place to separate the alleged victims and the teacher and to monitor the teacher's movements. We were concerned about the effectiveness of these strategies and, during our investigation, inspected the school and found that the strategies did not satisfactorily address all the identified risks.

We emphasised to the school that they did not need to wait for a court decision before standing the employee down with pay or placing him on alternate duties. The fact that the teacher had been charged with a large number of serious child sexual assault offences was adequate grounds to stand him down. The school accepted our recommendation that he be stood down until the court matter was determined.

managing risks

In 2003-2004 we commented on two matters where employees were allowed to stay in their positions after allegations of serious child sexual assault were made against them. The employers' reasons for inaction were based on the presumption of innocence. They argued that to suspend their employees or move them to alternate duties might be seen as an indication that the outcome of the investigation had already been determined. For example see case study 35.

Agencies must take appropriate action to ensure the safety of children, particularly when serious allegations are made.

Risk management means assessing the risks inherent in a particular situation and taking steps to address those risks. In an employment related context, this includes predicting the likelihood and consequence of an employee behaving in a way that may be abusive to a child. It also involves assessing the risks to the employee, the agency and to the integrity of the investigation if the employee stays in their usual position. A decision to take action on the basis of a risk assessment has no relevance to the ultimate outcome of the investigation or the guilt of the employee concerned.

When doing a risk assessment, agencies need to consider:

- any evidence supporting or refuting the allegations
- the harm that may have been caused to the child or children involved if the alleged conduct did in fact occur - for example their feelings of powerlessness, guilt, shame and isolation, their loss of trust and safety, and other possible psychological harm
- the potential for there to be further victims
- the potential for the child or children involved to be harmed again
- the potential that other students and employees may feel intimidated about making allegations in the future.

The management of risk is considered in further detail in our child protection fact sheet no. 9 *Risk management following an allegation of child abuse against an employee.*

casual employees

Ten per cent of the matters notified this year involved casual employees. Of these, 69% were employees of DET and 10% were employees of Catholic schools. The majority of allegations were of physical assault or other kinds of misconduct.

There are a number of child protection issues that are unique to the employment of casuals. These issues include:

- managing risk in and outside the agency when an allegation is made
- completing the investigation process so that matters can be reported to the CCYP
- providing the employee with an opportunity to respond to an allegation
- managing the investigation if the employee resigns before the investigation is completed
- training for casual workers in child protection issues.

We found that some agencies were unaware that their casual employees were also employed by other agencies, and therefore did not consider this as part of their risk assessment when allegations were made. We have advised agencies to address this in their child protection policies. For example, they need to make sure that casual employees declare other work arrangements, they report risk of harm to DoCS so that other workplaces of the employee can be informed, and they regularly screen casual employees. Agencies should also arrange to train casual workers so they are kept informed of their child protection responsibilities in the workplace. For example see case study 36.

changes to the law affecting child protection issues

Some of the more significant legal changes affecting our work in child protection issues this year are:

- The *Crimes Amendment (Child Neglect) Act 2004* was passed in June 2004.This Act strengthens the protection of children by applying the offence of neglect to people with parental responsibility for children under the age of 16. The criminal law used to only provide for an offence of exposing or abandoning a child under seven years.
- The *Education Teaching Service Amendment Regulation 2003* was gazetted in November 2003. It enables the Department of Education and Training to appoint people with appropriate experience to conduct disciplinary hearings. A number of people have already been appointed under the regulation - this should ensure that disciplinary hearings will be conducted more promptly and effectively.
- Various provisions of the Children and Young Persons (Care and Protection) Act relating to the functions and responsibilities of the Office of the Children's Guardian commenced. This means that almost all provisions for this office are now in effect.

case**study**36

We received a notification about a casual teacher in a non government high school who was alleged to have had an inappropriate relationship with a 15-year-old female student. It was alleged that he had sent her inappropriate SMS messages, some of which had sexual implications, and had taken her to his house without her parents' permission and had kissed her. Some of the allegations were sustained. It was also found that the teacher had interfered in the investigation process by asking the alleged victim to lie for him and putting pressure on her to retract her evidence.

The school issued the teacher with a formal warning and suspended his employment for 12 months. A condition of the teacher's employment after this period was his attendance at child protection training and his agreement to a period of monitoring. A notification was also made to the CCYP.

We became aware that this teacher had existing approval to teach in another agency and was therefore unlikely to be re-screened for a considerable period of time. The second agency would not be aware of any risk issues associated with the teacher or the need to evaluate and address these risks. We made sure that the second agency was informed about the employee's risk to children.

trends and patterns

We collect and analyse information from a number of sources so that we can understand more about the workplace context of behaviour that could be abusive to children. We use this information in our risk management workshops and in our feedback to agencies to help them improve their child protection practices.

agency reporting patterns

Of the 1,620 notifications we received this year, 62% involved allegations of physical assault compared with 68% last year. See figure 25. These figures are consistent with the reporting patterns for the past 5 years.

Of the physical assault matters notified, 41% were allegations about an employee hitting or kicking a child, 8% were allegations of inappropriate use of restraint and 1% were allegations that a child had been shaken or thrown.

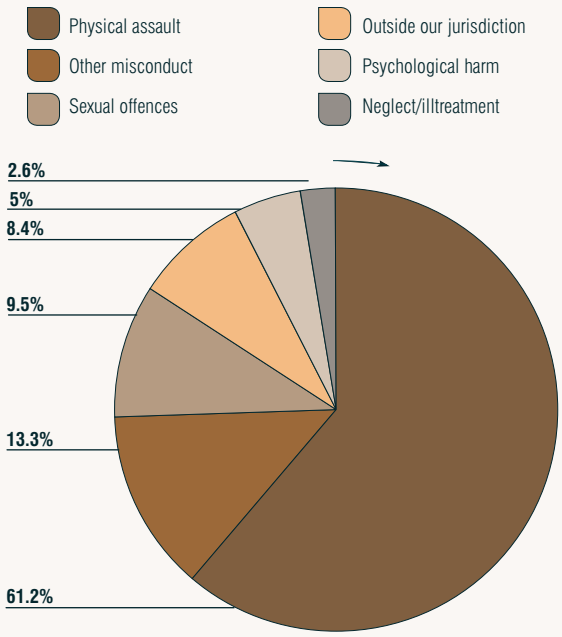
Other kinds of misconduct that were reported included allegations of inappropriate comments, inappropriate relationships or touching. We were also notified of allegations that employees had accessed or had child pornography in their possession or had exposed children to pornography.

Allegations of sexual offences were the third most common type of behaviour reported to us this year, making up almost 10% of notifications. Most of these related to sexual assault but some related to sexual harassment and non-physical exploitation.

The types of behaviour causing psychological harm included allegations of employees humiliating and belittling children and exposing children to violence.

Of the cases of neglect reported to us, most were allegations of a failure to provide adequate supervision. There were also allegations of a failure to provide adequate medical treatment.

Figure 25: Breakdown of notifications by allegation



agency findings

We ask agencies to make a finding at the end of their investigations so that we can assess whether the subsequent action they take is reasonable. This includes looking at whether or not the agency's decision to notify or not notify the CCYP is reasonable.

The following findings were made in the investigations agencies finalised in 2003-2004.

- 24% of cases were sustained
- 36% were not sustained due to insufficient evidence
- 15% of matters were found not to involve reportable conduct
- 6% were false
- 8% were misconceived
- 1% were vexatious.

We were satisfied in the majority of matters assessed that the findings made by agencies were reasonable.

alleged offender

Male employees were the subject of 55% of notifications reported to us this year. In 37% of notifications allegations were made against a female employee and in 8% of cases the sex of the employee was not known or not provided. Figure 26 shows that in 86% of notifications relating to sexual matters, the employee identified as the subject of the allegation was male. In 61% of notifications about allegations of neglect, the employee identified was female.

The majority of allegations of sexual assault were made against teachers (23%), foster carers (12%), youth or residential care workers (10%) and clergy (6%).

Figure 26: The sex of the employee identified as the subject of an allegation

Issue	Female	Male	Multiple	Unknown	Total
Physical assault	428 (43%)	507 (51%)	1	56 (6%)	992
Other misconduct	45 (21%)	153 (71%)	0	18 (8%)	216
Sexual offences	14 (9%)	132 (86%)	0	8 (5%)	154
Outside our jurisdiction	46 (34%)	52 (38%)	1	37 (27%)	136
Psychological harm	47 (58%)	31 (38%)	0	3 (4%)	81
Neglect/ill-treatment	25 (61%)	15 (37%)	0	1 (2%)	41
Total notifications received	**605 (37%)**	**890 (55%)**	**2**	**123 (8%)**	**1620**

alleged victims

Boys were identified as the alleged victim in 41% of notifications, compared to 23% for girls. There were multiple victims identified in 14% of notifications and in 21% of matters the sex of the alleged victim was not specified.

In the majority of matters, the alleged victims were between 13 and 15 years of age.

other issues

We are concerned about the over representation of Aboriginal children and children with disabilities who were alleged victims.

Children who identify as an Aboriginal or Torres Strait Islander make up 1% of the total population of children in NSW, but they were identified as the alleged victim in 127 or 8% of notifications we received this year. Of those notifications, 32% of the children were in government schools, 34% were in juvenile justice centres, 20% in departmental foster care and 9% in the care of other agencies providing substitute residential care.

We also received 266 notifications, or 16%, that identified children who have a disability as the alleged victim. Of these 45% were children in government schools, 24% were in the care of agencies providing substitute residential care, and 16% were in care provided or administered by the DoCS.

We will continue to audit schools and agencies providing substitute residential care and foster care to monitor these issues.

05: general team

introduction

The general team is responsible for a range of functions concerning public sector agencies. They also handle the bulk of our telephone inquiries work.

Specifically, the general team:

- handles complaints about public sector agencies, including complaints about NSW government departments and authorities, councils, correctional centres and juvenile justice centres
- handles complaints about the decisions public sector agencies make about freedom of information applications from members of the public
- handles complaints from people who work within the public sector - protected disclosures
- provides advice or assistance to people making inquiries of our office
- provides advice and guidance to agencies about good administrative conduct and practice, including complaint-handling
- visits juvenile justice centres and correctional centres and observes their operations
- keeps under scrutiny the implementation of new legislation in the corrections area
- audits records of investigative agencies undertaking covert operations and using telephone intercepts
- hears appeals and handles complaints about the witness protection scheme
- conducts 'mystery shopper' programs that test the agency's customer service performance
- provides training in investigations and complaint management.

We have specialised staff who exclusively handle local government complaints, complaints about correctional and juvenile justice centres, freedom of information complaints and matters relating to our covert operations and witness protection work. We report on those matters later in this chapter.

investigations and complaints

In 2003-2004 the general team received 3,373 written complaints and 21,250 oral inquiries about 135 NSW public sector agencies and 139 councils. Of our written complaints, 50 were from members of Parliament, some made on behalf of constituents. This year we did not deal with any written complaints that were formally referred to us from other agencies under Part 6 of the *Ombudsman Act 1974*.

A quarter of the written complaints received concerned councils and 14% were about correctional and juvenile justice centres. See figure 30. As with past years, a large proportion of the oral inquiries (37%) we received were about agencies outside our jurisdiction. In these cases we refer the caller to another agency who may be able to help them. See figure 29.

Even though this year the general team did not handle complaints about the Department of Community Services and the Department of Disability, Ageing and Health Care (see chapter 3: community services division), they still received over 9% more written complaints than last year. See figure 27.

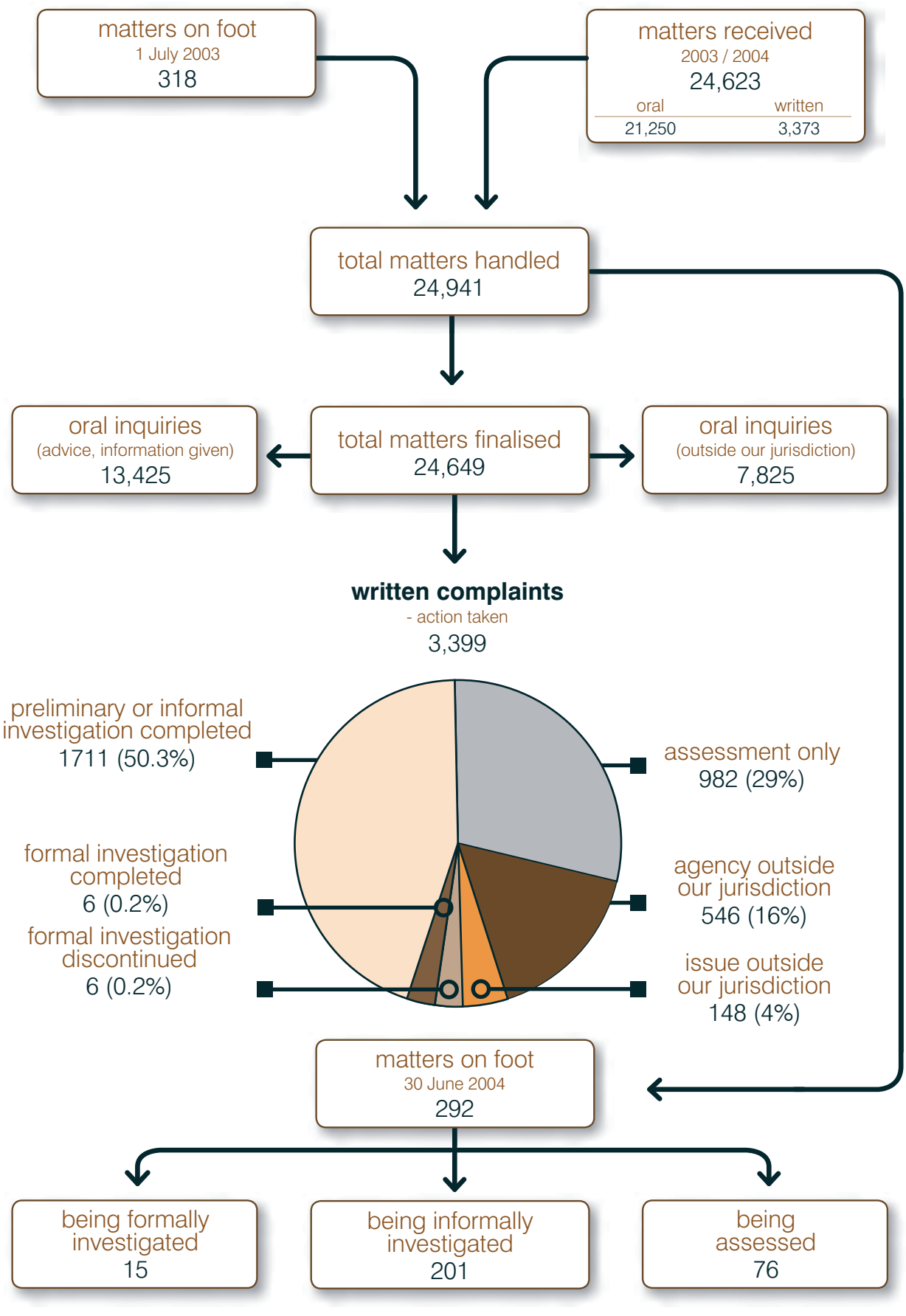
Figure 27: Written complaints received and finalised by general team — five year comparison

	99/00	00/01	01/02	02/03	03/04
Received	3025	3363	2960	3080	3373
Finalised	2914	2713	3164	3142	3399

** Note: This includes complaints about councils and state public sector agencies other than the police, DoCS, DADHC and any complaints of a child protection nature. The numbers for the previous four years include complaints about DoCS and DADHC.

We finalised 3,399 written complaints in 2003-2004. The number of complaints against the Infringement Processing Bureau (which deals with fines), the Department of Education and Training, and the Roads and Traffic Authority were higher than last year. We still handle a large number of complaints about the Department of Housing.

Figure 28: Matters received and handled this year by the general team



We undertook preliminary or formal investigations into 1,723 of these complaints and achieved a range of constructive outcomes. These outcomes included agencies:

- admitting and correcting errors
- mitigating consequences of decisions already taken
- providing reasons for decisions
- reviewing matters and changing decisions
- providing information
- taking disciplinary action against staff
- reviewing internal processes
- negotiating settlements
- giving apologies
- undertaking case reviews
- changing policies or procedures
- giving monetary compensation
- initiating relevant staff training
- proposing legislative changes.

Appendix C lists all the NSW public sector agencies that were the subject of complaints that we finalised this year and the actions we took on each complaint. Appendix D lists all the councils, Appendix E shows the outcomes for complaints about corrections, and Appendix F shows the outcomes for complaints relating to freedom of information.

public sector agencies

This year we received 1,390 written and 4,161 oral complaints about a range of public sector agencies (other than local government, corrections and complaints about freedom of information).

As in past years, concerns about customer service made up the largest proportion of our complaints overall. However this year complaints about charges and fees more than doubled. We also received almost 200 more complaints about the way agencies had handled complaints. See figure 31.

There were considerable changes to administrative arrangements during the year, particularly the mergers that created mega departments such as the Department of Commerce, the Department of Infrastructure, Planning and Natural Resources, and the Department of Energy, Utilities and Sustainability. To record how individual written complaints were dealt with, Appendix C lists a number of agencies that existed when we received a complaint but have since been abolished.

See case studies 37-45 for examples of some of the outcomes we have been able to achieve this year.

Figure 29: Oral complaints and inquiries received by our general team

Subject	02/03	03/04
Local government	2226	2194
Corrections	3133	3418
Freedom of information	367	309
Other public sector agencies	3719	4161
Outside our jurisdiction	9316	7825
Requests for information	3397	3343
Total	**22158**	**21250**

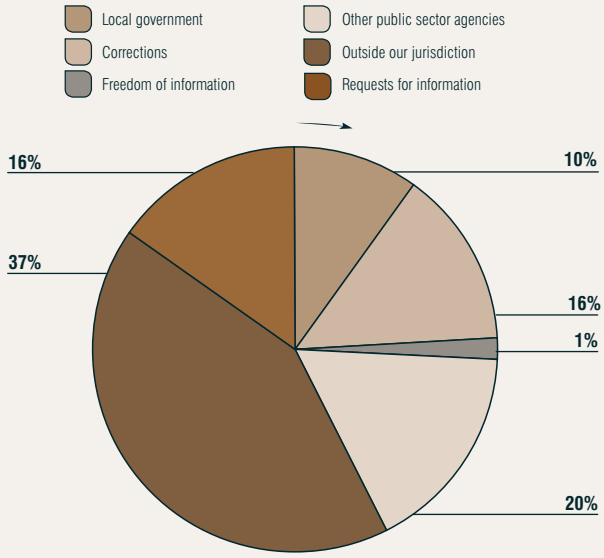


Figure 30: Written complaints received by our general team

Subject	02/03	03/04
Local government	774	840
Corrections	336	467
Freedom of information	140	139
Other public sector agencies	1280	1390
Agency is outside our jurisdiction	550	537
Total	**3080**	**3373**

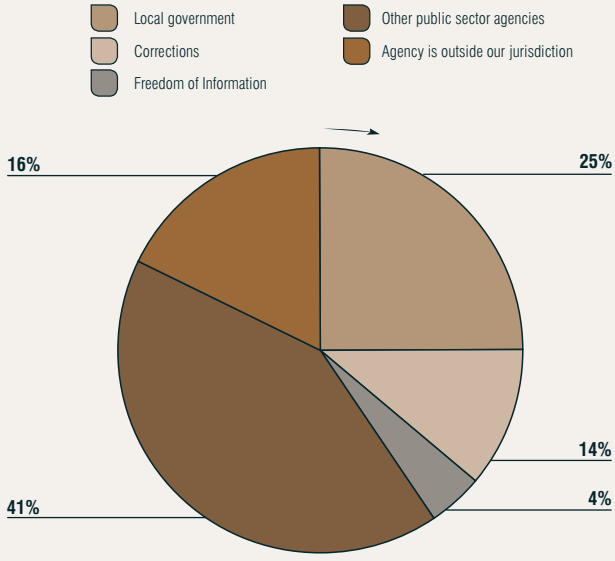


Figure 31: What people complained about - public sector agencies

This figure shows the complaints finalised by the general team this year concerning NSW public sector agencies other than councils, the Department of Corrective Services, Justice Health (formerly the Corrections Health Service), the Department of Juvenile Justice, and complaints about freedom of information, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Customer service	226	832	1058
Charges/fees	183	788	971
Complaint-handling	176	454	630
Enforcement	199	317	516
Object to decision	80	359	439
Approvals	107	247	354
Policy/law	62	235	297
Contractual issues	59	215	274
Information	116	154	270
Other	19	201	220
Outside our jurisdiction	81	116	197
Natural justice	23	102	125
Misconduct	38	70	108
Management	19	59	78
Child abuse related	2	10	12
Agency related issues	0	1	1
Child protection (non-employment related issues)	0	1	1
Total	**1390**	**4161**	**5551**

Performance indicator 1: Time taken to assess complaints

Target	02/03	03/04
90% within 48 hours	89.4%	93.4%

Interpretation: Our general team aims to assess the majority of complaints received within 2 days. This year we met our target.

Performance indicator 2: Average time taken to finalise complaints (not including complaints about FOI)

Target	02/03	03/04
7 weeks	5.2 weeks	5.1 weeks

Interpretation: Our general team aims to take on average 7 weeks to finalise complaints. This year we were able to finalise complaints within 5.1 weeks.

casestudy37

We received several complaints about delays in assessing objections to land valuations. We wrote to the Valuer-General asking for further information on the number of objections still awaiting assessment in each region, details of the strategies put in place to deal with the backlog, and an estimate of the time it will take to clear the backlog in each region. We also raised concerns about the lack of a contact name or telephone number on correspondence from their office. No information about the backlog or the delay was being given to people lodging objections.

The Valuer-General told us he would implement several strategies to deal with the backlog. These included recruiting high-level valuation staff, sharing valuing resources between regions, and introducing a pilot program to trial alternative methods for reviewing objections. He advised these strategies would result in the backlog being processed by the end of February 2004. The Valuer-General also agreed to advise objectors of the existence of the backlog and the likely delay in reviewing their valuations.

casestudy38

A Western Sydney father complained that a local high school had punished his son by placing him in a locked room for the whole school day over several consecutive days, with only a camera monitoring him. The son had since left the school. We were concerned as what had been alleged suggested conditions more like a prison than a school.

We visited the school and found the room was occasionally used for isolating students from classes for periods of up to three days. School staff showed us that the CCTV camera was linked to monitors in the deputy principals' offices. The images could not be recorded. Senior staff explained they had only monitored in this way after trying a variety of other ways to monitor offending students. They also said the door was always left open when students were in the room. The deputy principals were readily available to students and the students were allowed to leave the room to ask the deputies questions about their school work.

The department's guidelines on disciplinary matters provided little advice on how long a student could remain isolated within school or how they should be monitored. We also visited and made inquiries of a number of other schools and learned there were widely varying interpretations of the department's guidelines. In some cases, school policies permitted internal suspensions for longer periods than allowed by the department's policy for short-term external suspensions - without the same accountability and review mechanisms.

Following our inquiries we met with departmental representatives who told us the department's policy was being reviewed in order to clarify how long students can be placed in isolation. They were also considering whether formal written guidance should be given to schools about the use of cameras in these rooms.

At the time of writing we are awaiting confirmation about action the department has taken to mandate minimum standards for the use of isolation rooms.

casestudy39

A high rise unit resident complained that a supplementary environmental impact statement (EIS) the RTA had prepared for a modification of the major cross city tunnel project did not address key issues or meet the requirements of the Director-General of Planning NSW.

We reviewed the EIS in detail. Some of the complainant's concerns could be allayed. For example, we could assure him that the possibility of structural damage to buildings in eastern Sydney was to be the subject of further testing and the RTA would bear the expense.

However, we felt that the RTA could have prepared a better EIS. Two of our suggestions were as follows:

- There were no longitudinal scale diagrams of the modified development proposal in the EIS. Even though these were not required, it would be helpful to provide the public with information about the proposed depth of the tunnel at its various points - especially how close the tunnel would be to landmarks above.
- There were no health risk assessments for a number of chemical compounds, as required. We made inquiries and learned that the compounds in question were all polynuclear aromatic hydrocarbons. Instead of reporting a health risk assessment for each individual compound, the EIS included a human health risk assessment for the chemical compounds as aggregated. This assessment concluded that these compounds would not be present in dangerous levels. We felt that it was understandable that a person not an expert in this field would have mistakenly thought that the health risk assessment had not been included. We suggested that the RTA could have noted in the EIS that the chemical compounds had been aggregated and explained why this had occurred.

The RTA have told us they will examine our suggestions to make sure that in future environmental impact statements information is presented in a way that is more meaningful for the public.

casestudy40

We received a complaint from a man who had made a protected disclosure in 1997. After he had made the disclosure, he had been transferred to a separate workplace within the agency to prevent the possibility of detrimental action being taken against him.

The complainant was alarmed when he was sent a letter by the agency after a restructure, appointing him to a position for which he had not applied and where he would have similar duties to those he had performed before making the disclosure. Although he was not being returned to the same workplace, we learnt the agency had failed to make inquiries about whether there might be some staff now employed at the new location who would be aware that he had made a protected disclosure in the past. Subsequent inquiries by the agency indicated there were grounds to believe this was well known at the proposed workplace. As a result of our inquiries, the man was offered a substantive position at his current workplace instead of being transferred.

casestudy41

A MP complained on behalf of a number of parents whose children were enrolled at a childcare centre run by the Northern Sydney Area Health Service (NSAHS). The centre was operated to assist in recruiting appropriate staff to local medical facilities, but a number of local families also used the centre. The parents complained they had not been advised of the centre's priority access policy that gave preference to children of staff of the local hospitals and other area health services.

We confirmed this policy was within government guidelines as long as NSAHS had made it clear to local parents, when first enrolling their children, that they might be asked to vacate a place for a child of a parent in a higher priority category.

NSAHS sent us documents showing that all the parents had signed an agreement to abide by the centre's policies, including the priority access policy. However, NSAHS admitted the policy was possibly not clear enough for parents to appreciate that a child's access to the centre is reviewed annually and that they could be asked to give up their place after such a review.

Given this possible confusion, NSAHS told us that any children who were currently enrolled at the centre would have continued access to a place. By the time NSAHS gave this undertaking, they had already started reviewing their policy and procedures to ensure parents of new placements at the centre clearly understood the priority policy.

casestudy42

An elderly couple of non-English speaking background complained about the Western Sydney Area Health Service's (WSAHS) unreasonable withdrawal of services for their daughter. The parents were left for three months without any nursing assistance or support for their daughter who is a client of the Ventilator Dependent Quadriplegic Program. During this period the parents had to use their own savings to employ carers to help them with the 24-hour a day care their daughter needs.

We discovered that a private contractor provided nursing staff to all clients of this program, and it was the contractor who had withdrawn the nursing assistance. We were told this was a matter outside the control of WSAHS, but no clear explanation was given why WSAHS had made no other provision to help the elderly couple during the three-month period. We also learned that WSAHS receives funding each year for the care of a patient on the program. As a result of our involvement, WSAHS decided to provide their own nursing staff to help the complainants until contract issues could be adequately resolved.

The complainants sought reimbursement from WSAHS for two sums of money, firstly, for the care that they had personally provided for their daughter and secondly, for the fees they had paid to private carers during the three-month period. In November 2003, we were notified that the Department of Health had authorised WSAHS to make a one-off ex-gratia payment of $20,555 to the parents for the care that they had personally provided.

The parents have not been reimbursed for the fees they had paid to private carers because they had not provided WSAHS with enough information to prove the amount they paid or to whom it had been paid. We are of the view that it should be up to the Department of Health to decide whether it should make another payment to the parents. We suggested that they could ask the Director-General of the Department of Health to reconsider their case.

casestudy43

A woman complained about the way the Health Care Complaints Commission (HCCC) had handled her complaint about a doctor. It emerged that a great deal of confusion had arisen because she had not received a letter from the HCCC setting out the detailed results of their review of her case. We resolved this by sending the woman a copy of this letter.

She was also most unhappy that a copy of her complaint had been sent to the NSW Medical Board, despite advice that the HCCC would seek her consent before referring her complaint to another organisation. This advice was not well phrased. We were told the HCCC does seek the consent of complainants before referring a complaint to organisations other than the relevant registration authority but, under the *Health Care Complaints Act 1993*, the HCCC is obliged to consult with the relevant registration authority. The HCCC undertook to review the advice they send to complainants about how their complaints are handled to avoid repeating the confusion and anger that this misunderstanding caused.

casestudy44

A legal centre complained that the Department of Housing unreasonably and possibly unlawfully billed tenants for repairs to property damage for which they were not responsible.

The centre initially acted for an elderly client in inner city Sydney who claimed that 'at 3.30am vandals threw a brick through his window'. The department sent a series of letters requiring payment for repair costs, ignoring the man's letters protesting that he had nothing to do with causing the damage. His case was resolved after we wrote to the department and they withdrew their bill.

The *Residential Tenancies Act 1987* provides that tenants are only responsible for damage that they or their guests cause by intention or negligence. They are not responsible for damage caused by fair wear and tear or for vandalism by a third party. The Act provides that the Consumer, Trader and Tenancy Tribunal may determine liability if there is a dispute.

Information from the complainant and from our initial inquiries suggested the department continued to send letters requiring payment even when the tenant disputed liability. While their first form letter stated they would go to the tribunal if the tenant did not pay, they did not do so and the follow-up form letters did not mention the tribunal.

We considered this practice appeared unreasonable and began a formal investigation. The department's response was extremely constructive. They sought legal advice which suggested that some aspects of their current procedures needed to be reviewed. They also set up a working party to examine those issues, including matters raised by the complainant, and are close to finalising a new policy. At our request, the department has agreed to offer us and the complainant an opportunity to comment on the final draft of the new policy. The department's actions met our concerns so we discontinued the investigation.

casestudy45

A far north coast man complained that a NSW Lotteries promotion run in conjunction with Tourism NSW was misleading.

The 'Short Breaks' promotion on $2 Instant Scratchie tickets offered '1 night free with 1 night's paid accommodation'. To take up the offer the player had to buy four tickets each with a winning motel symbol on the stub and then purchase the accommodation from a special Tourism NSW promotional brochure.

The complainant alleged the prices in the promotional brochure exceeded those in the then current standard Tourism NSW brochures. We compared all the promotional brochure prices against those in the standard brochures and found that the majority of the promotional rates exceeded the standard rates by more than 50%. In seven cases, two nights accommodation via the standard brochures cost less than one night from the promotional brochure.

We formed a preliminary view that such price differences undermined the 'buy one get one free' promise of the promotion and began an investigation.

NSW Lotteries claimed that they did not know how promotional room rates were calculated and had left Tourism NSW to handle that. Tourism NSW stated promotional rates could not be compared to their own rates as there are a myriad of room-rates in the marketplace. They claimed promotional prices were based on the rack rate, not on their own brochures, so the promotion was not misleading. They added that the seven promotional room rates that were more than double their standard rates were errors that should have been picked up before the promotional brochure was released. They amended the promotional brochure and offered to refund anyone who had purchased this accommodation.

The promotional scratchie tickets were withdrawn from sale shortly before the promotion ended. For this reason we decided there was little useful purpose in pursuing the investigation and discontinued it. We made suggestions to both authorities about the need to ensure the integrity of future promotions.

universities

Over the past five years, formal complaints to the Ombudsman about university administration have more than doubled. Many of these complaints come from university staff and we treat those as protected disclosures. See the 'protected disclosures' section for further details of our work with whistleblowers from public sector agencies.

Many of our investigations into universities have been resource-intensive and involved complex issues. We continue to receive a range of complaints and have ongoing concerns about the complaint-handling systems of several universities.

In August 2003 we received a complaint from a University of NSW council member. He alleged that unwarranted disciplinary action was being taken against him as a staff member in reprisal for his persistent questioning in council of the university's handling of certain complaints of maladministration. Those complaints related to the mismanagement of the Educational Testing Centre (ETC) and alleged scientific fraud committed by Professor Bruce Hall, both of which we reported on in past annual reports.

We decided to conduct two formal investigations into the University of NSW. In the first investigation, we examined how the university had handled the complaint against the council member that had led, in his view, to unwarranted disciplinary action. We found a range of problems with the university's complaint-handling procedures so decided to do a second investigation into these procedures, using the handling of the complaints about the ETC and Professor Hall as key case studies. Our aim was to focus on the complaint-handling issues in these cases, not re-examine the substance of the original complaints.

We are also incorporating in our second investigation a survey of complaint-handling procedures at all NSW public universities. We plan to produce a compendium of the best practice features from the ten universities as the basis for a model complaint-handling system that could be adopted by all.

We hope to finalise these investigations in the coming year.

See case studies 46, 47 and 48 for examples of the work we have done with universities this year.

casestudy46

A University of Newcastle PhD student complained to the university that an honours student had, in her thesis, plagiarised the earlier honours theses of both himself and another PhD student. When the university appeared unwilling to act seriously on his complaint, the PhD student went to the ICAC who referred the complaint to us. We made extensive inquiries.

The offending thesis was submitted in May 2000, gaining the honours student first class honours and a PhD scholarship, but the complainant did not identify the plagiarism until March 2002. He reported it immediately and the head of school was alerted. The complainant made repeated efforts to find out what action had been taken, but without success. Finally, a threat to seek legal advice elicited a single paragraph letter from the Deputy Vice-Chancellor (Research) in September 2002 concluding with 'I have to advise that your complaint was found be [sic] substantiated and action has been taken in accordance with the University's policy on plagiarism.'

The complainant told us that following his complaint he was subject to a variety of reprisals. These included staff and fellow postgraduates shunning him, unusual problems in accessing a laboratory, equipment and desk space, and open hostility from some staff, including the head of school labelling him a troublemaker. We obtained some corroboration for these claims.

We discovered that in July 2002 the Vice-Chancellor had directed that the offending student be counselled 'with advice on "regular" methods of preparing theses'. No other action was taken.

In late 2002 the complainant made further allegations to senior staff, including both Deputy Vice-Chancellors, that the offending thesis had plagiarised even more sources.

The university did nothing about the further plagiarism claims for over eight months. They only asked the complainant to put his allegations in writing after the *Newcastle Herald* published a large news item on the complaint in early August 2003 with examples of the alleged plagiarism. In his written complaint, the complainant identified 57 examples of plagiarism. The complaint was referred to a Student Discipline Committee (SDC).

At the end of August, in response to separate allegations of a cover-up about plagiarism by 15 of its overseas students, the university commissioned the St James Ethics Centre to examine plagiarism issues at the university. One of the cases to be examined was a matter we investigated - see case study 1 in last year's annual report. We were pleased that the university was at last acknowledging that they had serious problems in dealing with plagiarism. The university's approach to date appeared to be motivated more by a desire to avoid damage to its reputation than to impartially investigate allegations.

The SDC considered the complainant's allegations in December. It confirmed the Vice-Chancellor's earlier finding of plagiarism and found 'more examples of poor referencing than were noted in 2002', but did not agree these represented an extent of plagiarism far greater than that alleged in 2002. They imposed no further penalty in addition to the counselling directed in 2002. We thought this decision was flawed and that the SDC might have reached a different decision had they had a chance to consider the St James report. Unfortunately that report was not issued until a few days after the SDC made their decision. The St James report did not consider 'poor referencing' to be an acceptable excuse for plagiarism.

Because of the university's commitment to implement the St James report recommendations and our current examination of complaint-handling in all NSW public universities, we did not take any further action on this matter. We did however emphasise the need to provide whistleblowers with every reasonable support and encouragement. In this case, the university ultimately facilitated the transfer of the complainant's PhD enrolment to another university.

casestudy47

In April 2004 we successfully conciliated a complaint by a professional association about a university, in connection with a major agreement governing their relationship.

The association had run professional education programs for their members for some time, but in 1990 agreed that the university would take over the programs and establish an appropriate masters degree. The association also transferred most of their assets as their contribution to the creation of the university's professional education centre. Under the agreement, all members of the association's council (together with some university representatives) were to be on an advisory board that could make recommendations on 'any matters' concerning the centre. There was also to be a management committee for the centre whose membership would include the chair of the advisory board – by definition, a member of the association – and another member nominated by the advisory board.

Over the years, and against the background of various developments within the university, tensions developed between the association and the university over the role and operations of the advisory board and the management committee. This conflict led to a seriously strained relationship and the possibility of litigation. The association was prompted to complain to us when the university council resolved to establish a new constitution for the centre. This constitution changed the membership of the advisory board and made no reference to the management committee. The association complained that the new constitution breached the terms of the original agreement and that, in a variety of other ways, the university had acted unreasonably and improperly.

We considered there was scope for us to conciliate the complaint - to help both parties resolve existing tensions and improve their relationship. We also suggested it might be possible to negotiate amendments to the original agreement, particularly in relation to the membership and role of the advisory board. Both sides agreed to participate.

We held separate meetings with the parties that allowed them to frankly explain their perspectives on the matter, followed by a formal facilitated meeting between both parties. The parties made an 'in principle' agreement about key matters to be covered in a new agreement and a process and timeframe for its preparation. We understand that their working relationship has improved and that a new draft agreement has been prepared.

casestudy48

A student complained about information provided by the University of Western Sydney (UWS) to students of the Master of Commerce (Valuation) course. UWS claimed this course was designed for students 'seeking to meet the valuation registration requirements of the Department of Fair Trading' (DFT). A student attempted to confirm this information with UWS on a number of occasions during his studies and on each occasion was told negotiations with DFT were progressing.

The student completed the course but DFT refused him registration as a valuer because this course was not recognised as meeting the requirements for valuation registration and UWS had previously been informed of this.

In assessing the student's complaint, we were advised by UWS that other students had been registered as valuers and would be happy to talk to us. Although one such student did contact us, it appeared he might have been registered because of his previous experience in the field rather than as a result of completing the UWS course.

Following our inquiries UWS told us they were consulting with DFT about what changes needed to be made to the course. They undertook to revise the course materials so that all students would be able to be registered after completing the course.

UWS also met with the complainant and reached a private settlement.

the fine enforcement system

consolidation of fine enforcement agencies

While we continued to receive a large number of complaints about the fine enforcement system, especially about the operations of the Infringement Processing Bureau (IPB), there have been some positive moves by the IPB and the State Debt Recovery Office (SDRO) to address the systemic issues we identified last year.

From October 2003, administration of the IPB was transferred from NSW Police to the Office of State Revenue (OSR) which already included the SDRO. This gave the two agencies an opportunity to rationalise parts of their operations. This year we met with Mr Brian Robertson (now head of both agencies) and senior IPB management at Maitland and were able to observe the IPB's operations first hand.

Increased resources have allowed the IPB to dramatically reduce the average waiting time for people phoning their call centre. They are also proposing to upgrade their system to allow them to respond to public inquiries and concerns more quickly and effectively. They now also accept payment of fines through Australia Post. This provides a convenient way for many people to obtain an important item – a receipt - previously only available to those able to pay their fines online.

payment of late fines

A major improvement made possible by consolidating both agencies into the OSR is the new procedure for dealing with a late fine payment. Until this year, the IPB would refer the administration of a fine to the SDRO once the due date was past. If the person subsequently paid the fine to the IPB, this information often was not given to the SDRO in time to stop the SDRO from threatening to suspend the person's licence unless they paid the original amount of the fine plus additional enforcement costs.

Although the IPB would eventually refund the money that had been paid, this often took several months. Having to find additional money (often a substantial amount) to pay for a fine already paid understandably angered people who knew they had paid 'the government' which should be able to make any necessary internal transfers of the money.

Under the new system, this is exactly what happens. A person who has made a late fine payment to the IPB is now only liable to pay the SDRO their additional enforcement costs.

remedying administrative errors

Another concern we have had was the lack of adequate remedies for alleged administrative errors by the SDRO. These include their failure to lift sanctions on driving licences and their processing of historical matters - that is, fines imposed before the creation of the SDRO. This year we were advised that the SDRO has now dealt with all historical matters.

We also support recent amendments to the *Fines Act 1996*. These provide an opportunity for redress against administrative errors and incentives for people to clear their debts by entering time-to-pay agreements. The changes (not yet in force at the time of writing) include the creation of a Hardship Review Board, independent of the SDRO, empowered to consider applications from fine defaulters to lift sanctions, write-off fines or allow further time to pay.

If the board is able to effectively resolve problems caused through administrative error or individual hardship, it will have a significant impact on our work in this area. Our policy is not to investigate matters if an alternative and satisfactory means of redress is available. We anticipate the board will provide complainants with such an option and importantly, unlike us, will have the power to direct the SDRO to act.

The amendments also include other options for redress. Applications to the SDRO to annul enforcement action and refer the matter to court will first be referred back to the issuing authority. This will enable the issuing authority, such as the police or a council, to decide if they want to proceed with court action or withdraw the matter.

In addition, the amendments give legal force to current SDRO procedures for waiving fines if the person can show the fine was issued in error. This could be, for example, because they did not own the vehicle at the time, they are not the person named in the penalty notice, or the matter has already been dealt with.

We recognise that the fine enforcement system generates an enormous volume of work and that inevitably the system will produce disgruntled people. However we hope that the agencies concerned will continue to improve the way they handle complaints and we will be able to assist where necessary. This year we have helped a number of people who have been affected by poor judgement or administrative failure. See case studies 49, 50 and 51.

Performance indicator 3: Complaints resolved through the provision of advice or constructive action by public sector agency

Target	02/03	03/04
65%	64.0%	61.1%

Interpretation:

Our general team aims to resolve 65% complaints through:

- providing the complainant with information or advice on applicable law or procedures
- suggesting to complainants how they may resolve the complaint directly with the agency concerned
- the agency taking some action to resolve the complaint themselves following our preliminary inquiries or other intervention
- formal conciliation.

This year we were slightly under our target.

casestudy49

An elderly mid-north coast man received a penalty reminder notice for an incident that occurred in Sydney. He was puzzled as he had not been within 300 kilometres of Sydney during the year. He explained this to the IPB but contacted us after receiving no answer for more than six months. Our inquiries showed that the problem arose from the issuing officer's handwriting, with a 'U' mistaken for a 'V'. Although the IPB had detected the mistake and had pursued the matter with the actual driver involved in the incident, they had neglected to respond to the complainant. The IPB agreed to respond to the man with an explanation of what had occurred.

casestudy50

A Corowa man complained about difficulties he experienced in paying a fine. He tried to pay on the IPB's web site but an error message said this payment option was not available to him. He subsequently sent a cheque, only to find later that both his credit card and cheque account had been debited. He wrote to the IPB to tell them this had happened. Their reply stated the infringement had been lawfully issued. This response did not address the issue of him having paid the fine twice. Following our inquiries, the IPB agreed to refund the additional payment urgently and write to the complainant to apologise for the inconvenience caused.

casestudy51

A solicitor complained his client had sold a car and six months later received a fine in the mail for camera-detected speeding. The person informed the IPB he had sold the car several months earlier, but the IPB replied that records indicated he owned the car at the time of the offence. Shortly after, on the SDRO's instructions, the RTA cancelled his licence. Despite the solicitor's submissions, the SDRO still sought the enforcement order.

Some months later the RTA informed the SDRO that the person had indeed sold the car before the offence and should not be responsible for the fine. The SDRO acknowledged this advice from the RTA but refused to act on it and continued to seek payment of the enforcement order. The person's solicitor then made FOI applications to the RTA and SDRO to obtain as many documents as possible to support his client's case. The RTA handled their FOI application well, but the SDRO returned theirs to the solicitor.

Our inquiries prompted the SDRO to obtain advice from the Crown Solicitor. This advice stated that enforcement orders could be withdrawn under the Fines Act if an administrative or clerical error has been made. The enforcement order was then withdrawn. The SDRO previously believed only the Minister could annul orders older than one year. Our inquiries also resulted in the adoption of a new procedure for resolving old enforcement orders where an administrative error had occurred. We believe the SDRO should have accepted the RTA's initial advice that the speeding fine was wrongly issued. Instead the person involved had to spend considerable amounts of money to have the enforcement order withdrawn. We suggested the solicitor consider pursuing compensation from the SDRO for his client's costs.

☐ Senior staff in our general team meet regularly to discuss the work of the team and general issues.

Performance indicator 4: Reports recommending changes to law, policy or procedure

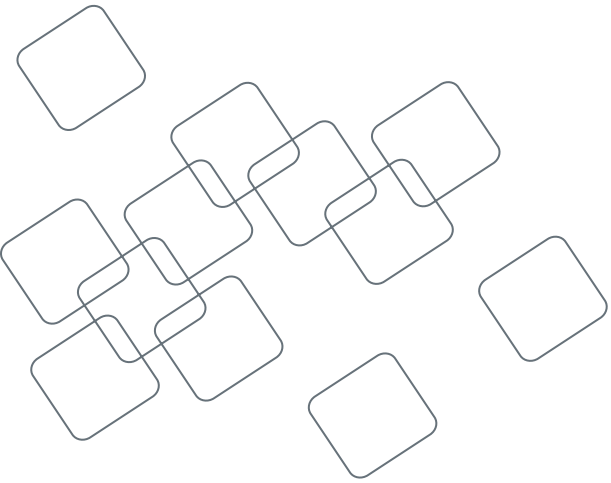
Target	02/03	03/04
90%	92.3%	85.7%

Interpretation: We aim to recommend changes to law, policy or procedures in 90% of our final investigation reports. This year we were slightly under our target.

Performance indicator 5: Recommendations implemented

Target	02/03	03/04
90%	100%	93.3%

Interpretation: We aim to have 90% of all recommendations that we make at the end of our formal investigations implemented. This year we met this target.



mystery shopper audit – government information service

This year we conducted another in our ongoing series of customer service audits of a range of NSW state and local government agencies. We posed as members of the public making inquiries about NSW government activities and services to test the performance of the Government Information Service (GIS).

The GIS includes the TeleInfo Service and the NSW Government Bookshop. It is part of the advertising and information business unit of the office of government procurement in the Department of Commerce. Its principal functions are to provide comprehensive government information to the public.

Our aim was to provide a snapshot of the GIS's general standard of customer service, not an in-depth evaluation of their organisational performance. The audit was conducted between 23 February 2004 and 23 July 2004 and involved 54 separate customer/agency transactions – 29 telephone calls to the TeleInfo Service, ten face-to-face visits to the NSW Government Bookshop and 15 emails to the GIS email address.

telephone

We made 28 phone calls to the TeleInfo Service metropolitan phone number and one to the toll free number for regional callers. Our calls were basic requests for information about NSW government activities or services that would normally be received by the GIS.

Our mystery shoppers were connected in a relatively short time; 66% were connected within three rings. However 52% of calls were put in a holding queue. Of those, seven waited for 80 seconds or less and six waited over two minutes.Three waited for more than six minutes in the queue and two waited 11 minutes. We felt this was a mediocre performance.

The initial greetings given to our telephone callers were of a high standard. The name of the GIS and an appropriate greeting was given in 90% of cases, although the name of the staff member was only provided in six out of the 29 phone calls. Giving your name helps customers if, in the future, they need to refer to the person who provided the information. It also helps create a positive relationship between the caller and the service and contributes to the caller's confidence in the person providing the information.

Our mystery shoppers felt that most of the staff taking their calls were 'pleasantly courteous'. However, the interest shown in their inquiries by these staff was rated as neutral in 62% of cases and unhelpful in 10% of cases.

Best practice inquiry handling involves the first contact person being able to answer the majority of inquiries, and referring a caller only once if they cannot help them. The GIS performed well in this regard. Only one of the calls was actually referred to a second person to answer. However for 72% of calls some consultation, either with other staff or sources of information, was undertaken during the call.

Of concern was the low level of calls (55%) in which relevant, accurate and complete information was provided. While another (21%) were somewhat relevant and correct, 24% provided inaccurate or no information. This was a disappointing outcome and indicates a need for improvement.

On balance, while the TeleInfo Service provided a quick, courteous and accurate response in a little over half the calls, mystery shoppers were only given the minimum amount of information and callers who expected more were not assisted. There is scope to further lift the levels of interest and assistance and to personalise transactions more by staff providing their first names.

email contacts

We sent 15 email requests for information to the GIS between 2 March 2004 and 15 June 2004. The emails covered relatively simple requests for information about who to contact about different scenarios in which government services were likely to be involved. All the emails were phrased in such a way as to require a reply.

We received a response to 12 (73%) of the 15 emails sent. The average response time was 2.9 days with the majority (10) receiving responses within 2 days. This was well within the 3-4 days considered acceptable.

Generally, the email responses tended to provide more information than was given to our mystery shoppers over the phone. In one case of outstanding service, the person received a total of three emails. The two additional emails provided helpful information that showed the GIS staff member had made a considerable effort to help. In another case, a fairly lengthy explanation was provided which was of excellent assistance. In only one instance was part of a response incorrect.

Overall the GIS performed well and provided the information in an efficient and appropriate manner. We felt that they might improve their service if the staff member included at least their first name in their email response.

face-to-face contact

This part of the audit involved 10 mystery shoppers visiting the NSW Government Bookshop in the Goodsell Building, Chifley Square, Sydney between 3 March 2004 and 20 July 2004. Each shopper was allocated a book or publication that a member of the public could reasonably expect to either find in the bookshop or be given advice about how to obtain. The aim was to assess both the level and nature of the service provided and the facilities in this public contact area.

Every mystery shopper had negative comments to make about their experience. The facilities overall were rated as only adequate and the book display was rated poor to average. While the facility was not unsuitable for people with disabilities, the service counter and inappropriately sized signage reduced the overall rating.

Generally our mystery shoppers found the facility unappealing in terms of the amount of product displayed, the type of product displayed and the atmosphere. Some comments indicated that the bookshop did not really feel like a bookshop and felt like it was about to be closed down. While staff were friendly and helpful, they too seemed to be affected by the ambience of the place.

Staff members made eye contact with seven of our mystery shoppers and gave appropriate greetings to eight of them. This was not unreasonable but could have been better. No staff in the bookshop wore a name tag.

Counter staff were rated on average as being business-like to pleasantly courteous and were perceived as communicating an active interest and willingness to help our mystery shoppers. This was a good result.

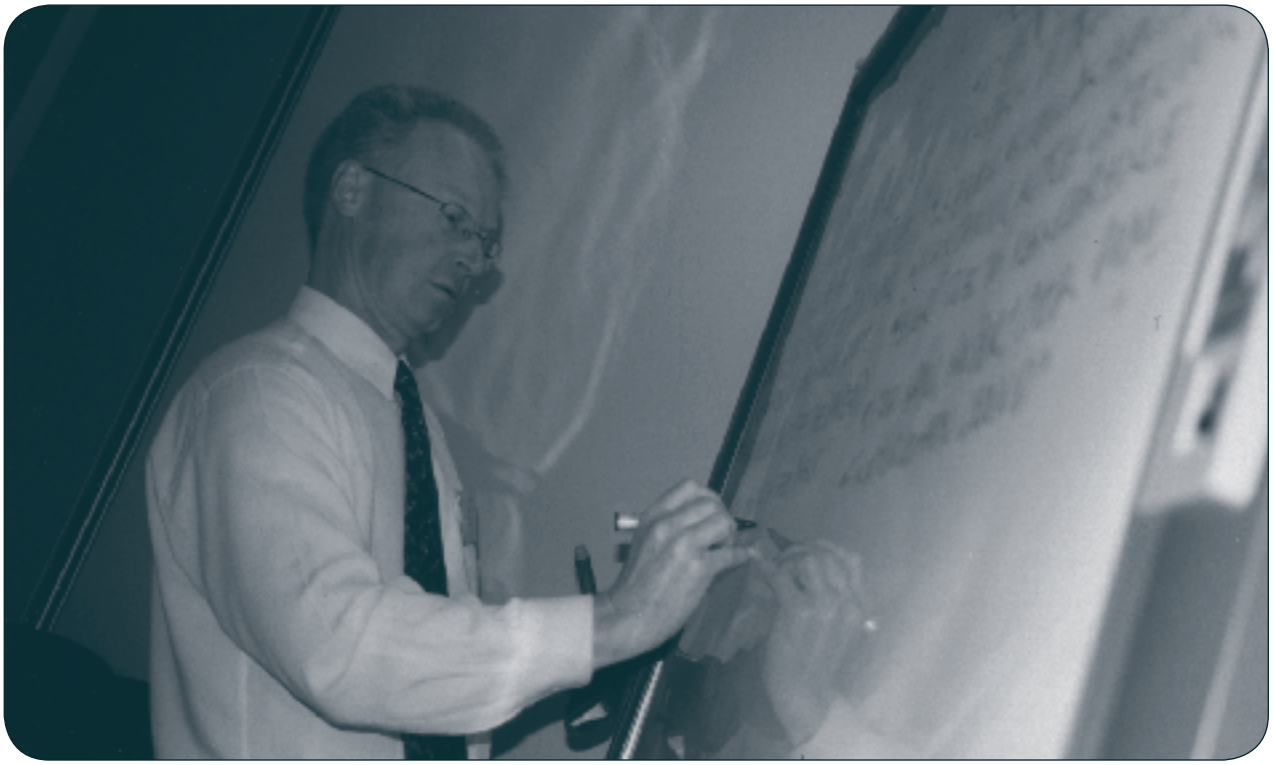
Nine out of our ten inquiries were handled at first contact and served immediately. This is best practice customer service in terms of both customer response and time and cost to the organisation. Only three of our mystery shoppers had to wait to be served longer than two minutes which was also good customer service. However the bookshop could not be regarded as a busy retail area by any measure.

Finally, the level of satisfaction of our mystery shoppers in achieving their goal in visiting the bookshop was reasonably high. Eight of them found that staff were able to assist them.

The Department of Commerce responded positively to our report on the audit, with the Director-General stating that:

'The customer service audit provides comprehensive and valuable information that [we] will use to improve the level of service that the TeleInfo Service and the Government Bookshop provide to the public.

I have asked for a number of initiatives to be implemented immediately, including recorded messages about [our] services for callers on hold, links to the TeleInfo Service and Government Bookshop from the NSW Government Homepage portal and examining options to implement teletex services. We will use the other audit findings to inform decision-making about future service improvements.'



David Watson, an investigation officer in our general team, presents training to people from public sector agencies on topics such as complaint-handling.

local government

complaint trends and outcomes

This has been a busy year for local government. We have had local government elections, structural reform and council amalgamations. There have also been public inquiries into Warringah Council, Liverpool City Council, Rylstone Shire Council and Walgett Shire Council. All four councils were subsequently dismissed and administrators appointed.

Figure 32: Five year comparison written complaints about local government received and finalised

	99/00	00/01	01/02	02/03	03/04
Received	848	959	760	774	840
Finalised	823	956	809	791	865

Total complaints received in 2003 - 2004

Oral	2194
Written	840
Total	**3034**

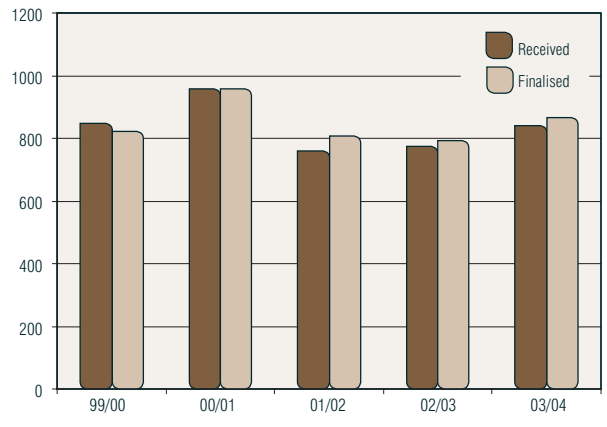


Figure 33: What people complained about - local government

This figure shows the complaints received by the general team about local government, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Corporate/customer service	329	471	800
Development	147	554	701
Enforcement	110	266	376
Environmental services	47	194	241
Engineering services	62	160	222
Rates charges & fees	44	161	205
Object to decision	27	95	122
Misconduct	29	83	112
Uncategorised	9	79	88
Outside jurisdiction	12	44	56
Strategic planning	11	35	46
Community services	8	31	39
Management	5	21	26
Total	**840**	**2194**	**3034**

Although the 2194 oral complaints we received about councils in 2003-2004 was close to last year's total, formal written complaints increased 8.5% to 840. See figure 32.

In 2002-2003 we reported an increase in complaints about development issues. This year numbers of such complaints remained steady. There was however a significant increase in the number of complaints about corporate or customer service issues. These included complaints about delays, inaction, failure to reply, rudeness, poor service, complaint-handling, refusal to disclose information or the inappropriate disclosure of information, notification and consultation procedures, wrong advice, denial of liability, unreasonable use of legal advice and the conduct of council meetings. See figure 33.

Of the 494 formal complaints that were the subject of preliminary or formal investigations, we were able to achieve 267 forms of redress. These included the council admitting and correcting errors, mitigating consequences of decisions already taken, providing reasons for decisions, reviewing matters and changing decisions, providing information, reviewing internal processes, negotiating settlements, making apologies, reviewing cases, changing policy or procedures and providing training for staff. See the case studies in this section for examples of the positive outcomes we helped achieve this year.

tape recording of council meetings

Many councils in NSW tape record their meetings. Members of the public sometimes seek access to these tape recordings, often to find out exactly what was said during council debates on, for example, development applications, objections or complaints made to the council.

In May 2004, Privacy NSW issued a user manual to provide advice for councils about the tape recording of council meetings. The manual concluded with recommendations that tape recordings of meetings should:

- only be used for verifying the accuracy of minutes
- not be made available to the public except as allowed under ss. 18(1) and 19(1) of the *Privacy and Personal Information Protection Act 1998* (PPIP Act) or under legal compulsion
- be destroyed as soon as the original purpose is served or three months after their creation, except where some other legal requirement applies.

After reviewing this manual, we wrote to Privacy NSW and later to the Minister for Local Government expressing our concern that the advice in the manual could lead to confusion, uncertainty and inappropriate decision-making by councils.

Our concerns included that:

- the manual ignores relevant obligations on councils under the *Freedom of Information Act 1989* (FOI Act) - the PPIP Act does not lessen any obligation on a public sector agency or rights of an FOI applicant under the FOI Act
- the manual adopted a narrow view of why councils tape record their meetings, failing to recognise certain other valid purposes
- the recommendations made in the manual were stated to apply to the full tape recordings of council meetings, whereas the requirements of the PPIP Act are only relevant to those limited parts which contain 'personal information' - that is 'information or an opinion about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion'
- the manual fails to consider the impact of s. 4(5) of the PPIP Act which provides that personal information is not 'collected' by a public sector agency if receipt of the information by the agency is 'unsolicited' - a clear distinction can be drawn between a council inviting people to attend and speak on issues flagged in the agenda, and a council inviting people to attend a meeting to provide 'information or an opinion about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion'
- the manual does not address the application of the provisions of s. 4(3)(b) of the PPIP Act which exclude from the definition of 'personal information' any 'information about an individual that is contained in a publicly available publication' - such as the minutes of and business papers for council meetings or relevant notices in local newspapers.

We suggested to the Minister that he should consider giving councils some information to clarify the current situation, and amend s. 12 of the LG Act to make it clear that the Information Protection Principles in the PPIP Act are not an impediment to releasing information under that section.

charges for inspecting documents

Under s. 12 of the *Local Government Act 1993* (LG Act), councils are required to make their documents available for inspection free of charge. Section 12B makes it clear that this right includes a right to take away a copy of the documents. However, it allows councils to require a person to pay reasonable copying charges. This scheme aims to ensure openness and transparency in local government.

We have dealt with a number of matters revealing that councils have tried various ways of requiring people to pay to inspect council documents. We are concerned that these practices breach s. 12 and have the potential to enable councils to avoid proper accountability.

Three specific practices that have come to our attention are:

- Some councils have neglected to tell people of their entitlement to access council documents free of charge under s. 12, and instead advise them to apply under the *Freedom of Information Act 1989*, a separate and inconsistent legislative scheme that allows the council to charge an application fee.
- Some councils have charged people 'retrieval costs' to inspect council documents (see case study A).
- Some councils have charged excessive photocopying fees. For example, we are currently investigating allegations that a council has been charging the public 50c per page to provide copies of the first ten pages of any file and $1 for all pages over ten. This translates to $95 to copy 100 pages.

As is set out in the Ombudsman's FOI Policies and Guidelines, in our view a reasonable photocopying cost that public agencies, including councils, should charge members of the public is 20c per A4 page. We recognise that s. 12 may place some burdens on councils when responding to requests for copies of large numbers of documents, particularly where multiple requests have been made. However, these kinds of problems should not be addressed by introducing excessive photocopying fees. We are concerned that excessive fees will discourage people from exercising their right to look at council documents.

We will continue to monitor council practices in this area.

casestudy52

This year we completed a formal investigation of South Sydney City Council's practice of charging a retrieval fee for access to documents. We are of the view that such practices breach s. 12 of the LG Act. The complaint arose from a dispute between Sydney City Council and South Sydney City Council relating to the proposal to alter the boundaries of the two councils. Sydney complained that South Sydney had failed to provide them with access to documents under s. 12 that they needed to prepare for any change of boundaries.

Sydney wrote to South Sydney requesting access to the documents. South Sydney's solicitors replied saying they would make the necessary arrangements for Sydney to inspect the documents, but required Sydney to disclose the basis of their application.

After further correspondence from Sydney, South Sydney replied noting that the request for access was framed in terms of the new boundary proposed by the Local Government Boundaries Commission report. South Sydney observed that as, at that time, this report had been declared a nullity by the Land and Environment Court, the request was now 'deemed invalid'.

After receiving the complaint, we contacted the general manager of South Sydney to express our concern that the status of the Boundaries Commission report was an irrelevant consideration in determining Sydney's application under s. 12. We also observed that failure to give Sydney access to the documents constituted a breach of South Sydney's obligations under the LG Act and was potentially 'wrong conduct' under the Ombudsman Act 1974. The general manager told us he intended to process Sydney's application within 30 days.

South Sydney subsequently wrote to Sydney advising they were 'welcome to inspect documents pursuant to section 12' but advised of retrieval costs of $40 per hour for documents from South Sydney's current records and $110 per hour for those retrieved from archives. These costs appeared to have been charged under council's fees and charges policy. We later discovered that South Sydney also charged their residents these retrieval costs to inspect documents.

Two Sydney City Council employees attended South Sydney's One Stop Shop to inspect the documents. They were told the files were available for inspection but South Sydney would insist on charging the fees. Having insisted on Sydney's right to inspect the documents free of charge, the Sydney staff left without having done so.

At South Sydney's next ordinary council meeting, the general manager reported to council his 'reasons' for restricting access to the documents sought by Sydney, purportedly in compliance with s. 12A(1) of the LG Act.

These reasons were that:

- 'Provision of the information is contrary to the public interest of the people of the South Sydney local government area.
- The work involved in extracting and compiling the requested information would substantially and unreasonably divert Council's resources away from their use in the carrying out of Council's functions.
- The information is requested on the presumption of the result of current legal proceedings and is inappropriate at this time.'

Council approved and adopted the general manager's minute.

After starting a formal investigation, we told South Sydney we proposed to recommend that they provide the documents sought by Sydney free of charge, amend their fees and charges policy to remove the retrieval fee, and refund fees collected under the policy. South Sydney agreed to amend their policy and refund the fees collected under it. They told us that all of the information sought by Sydney had been supplied after the boundary adjustment had been proclaimed.

Although we found South Sydney was not entitled to charge for access to its documents under s. 12, we also concluded that, if it was lawful to do so, it would not be unreasonable for a council to charge a fee to recoup any actual retrieval costs associated with recovering documents from archived storage. We therefore recommended that the Minister for Local Government consider amending the LG Act to permit councils to charge a reasonable retrieval fee for archived documents. The Minister's view was that any significant changes to the legislation should ideally be considered in the context of the inquiry into access to information being conducted by the Parliamentary Committee on the Office of the Ombudsman and the Police Integrity Commission.

casestudy53

A Strathfield Municipal Council resident complained that council did not notify him of a development application for units next door. He only became aware of the development application after council put a notice in the local paper saying it had been approved.

The resident complained to council that he had not been notified and asked for a further opportunity to object to the development. Council did not respond for five months.

Our inquiries showed that the complainant had not been notified due to an administrative error. Council had not responded to the complainant's letter promptly because they were awaiting legal advice.

We wrote to council to express concern about the tone and content of their reply. We thought it was legalistic and defensive. We were also concerned that council did not offer an apology and referred them to our publications on offering apologies.

Council circulated our letter to relevant council staff and said they would consider offering apologies in the future. They also told us they had included an additional procedure in their notification process to prevent the error from occurring again.

casestudy54

A Quirindi Shire Council resident complained of inaction by council in relation to noxious weeds on his land and adjacent Crown land. Although the complainant owned the relevant land, his neighbour controlled it under a 'give and take' fence arrangement along a river.

Council told us that the Central Northern County Council (CNCC) was responsible for noxious weeds in the area. Our inquiries revealed that CNCC was working with the complainant's neighbour to control the weeds.

Council told us they had not told the complainant this because they believed they were prevented from doing so by privacy legislation. We disagreed. As a result of our inquiries, council agreed to write to the complainant to confirm they had advised the neighbour of his responsibilities and were monitoring the situation. Council told us they would update the complainant in a few months on the progress of the matter.

casestudy55

A resident of Snowy River Shire Council complained that, during an extended absence from his property, council carried out weed eradication on his land and charged him for the work.

Council has the power to do this under the *Noxious Weeds Act 1993*. However, the resident complained they did the work without attempting to contact him. He claimed he had notified council of his new address and said that, if he had known he had noxious weeds, his wife and sister would have removed the weeds as they had on a previous occasion.

Our inquiries showed that council had sent the required notices and orders to the property, not to the complainant's alternate address. Council initially told us the complainant had not notified them of his change of address. However the complainant gave us documents that showed council had contacted him at his alternate address, so council agreed to look into the matter further.

Council found that they had two files for the property. One was held in the development section and the other in the environmental services section. The files had different addresses. The complainant had notified council of his change of address but they had only updated the development file.

To resolve this matter, council agreed to waive the charges. Their computer system has since been updated and they do not believe a similar problem could occur again.

casestudy56

A Maclean Shire Council resident complained of council's failure to notify her of a development application for a second storey addition to the house next door.

Council's Development Control Plan exempted certain development applications from notification. These included minor alterations that are not unusual or contentious. Council considered that second storey additions in residential areas were exempted from notification under their policy, but we disagreed. Second storey developments are often contentious because neighbours are concerned about privacy, overshadowing and obstruction of views.

As the development had already been approved there was little more we could do to assist the complainant. However council agreed to review their policy.

case**study**57

Residents of a new high-rise development in Burwood's business district wrote to us about Burwood Council's failure to act on their complaints about noise from the existing shopping centre.

The complainants had written to council on several occasions. One resident kept a diary of the activities causing the problems. These included noise from air conditioner and refrigeration units, cars as they drove over old speed humps, trolley collections, and trucks idling in 'no standing' zones before early morning deliveries.

Our inquiries revealed council had issued orders and started legal action against one of the commercial tenants at the shopping centre about the noise levels of the air conditioner and the refrigeration units. The tenants repaired the units and told council the noise levels had been reduced. However further readings showed noise levels remained unacceptably high. Council issued a notice requiring the tenants to soundproof the units and provide noise readings after this had been finished.

In response to our involvement in this matter, council negotiated with the shopping centre management about the other noise problems. As a result, the management replaced the metal speed humps with rubber ones, agreed that trolley collections would be completed before 9pm, and fitted rubber lining to the collection trailer to reduce the noise.

Council's traffic committee also recommended that the 'no parking' and 'restricted parking' signs on streets backing on to the shopping centre be changed to 'no stopping' to prevent delivery trucks from stopping and idling their motors while waiting to make deliveries.

case**study**58

Coffs Harbour City Council residents complained about the level of the developer services contribution they had been required to pay council.

The complainants lodged a development application with council for a subdivision. This was approved on 16 April 2003. However, under council's policy, the consent required the signature of the director of planning and the mayor. The signatures were obtained and a notice of determination was issued on 1 May 2003.

In the meantime, council had reviewed their policy on developer services contributions under s. 64 of the LG Act and s. 306 of the *Water Management Act 2000*. On 17 April 2003, they adopted a revised plan requiring increased developer contributions to take effect from 1 May 2003.

Council's delay in issuing the notice of determination meant the applicants had to pay an additional $30,000. They asked council to review their contributions, but council insisted the contribution payable under the revised plan applied.

We asked council to reconsider the matter. As a result, council agreed to apply the contribution payable under the plan in force at the time approval had been given on 16 April 2003 rather than the higher revised rate.

case**study**59

A scout group complained that Wyong Shire Council had illegally imposed water service charges on them. They said that as a registered charity they were exempt from charges under the Water Management Act.

The Act specifically prevents 'water service charges' being imposed on land used by charities. However our inquiries revealed council had imposed 'water service fees' on the scout group, not 'water service charges'. Council said they could impose the fees under another provision of the Act. This allowed them to 'impose fees and charges for any service or thing supplied or provided by them in the exercise of their functions'.

Council told us they had a longstanding policy that all users of water and sewerage services should contribute to their cost. They had therefore imposed water and sewerage fees on all exempt properties. These included properties used by 13 scouting groups. Council said that the Independent Pricing and Regulatory Tribunal (IPART) had set council's water service charges and fees and the Minister had approved them. Council had also received legal advice confirming the legality of these fees.

We were concerned that council had inappropriately used the provision of the Act allowing it to impose fees to avoid the prohibition against water service charges being imposed on exempt properties.

We raised our concerns with the Ministry of Energy and Utilities. They told us the Minister had sought advice from the Crown Solicitor and was considering the policy implications of the matter. They also gave us a copy of the Crown Solicitor's advice. This considered the scope and limits of council's powers to impose water service charges and water service fees. We asked the Ministry to seek additional advice on whether the fees imposed by council on exempt properties were legal. They agreed to do so.

The Ministry told us that the validity of the water service charges and fees imposed by council raised wider policy issues that would be considered by a review team involving the Ministry, IPART and the Department of Infrastructure Planning and Natural Resources. The Minister also discussed the issues with the two councils that are water supply authorities under the Act - Wyong Shire Council and Gosford City Council. A working group has been established to consider the matter further and we will continue to monitor the issue.

notification of development applications

In recent years we have noticed an increase in the number of complaints concerning notifications of development applications. In 1999–2000, we received 12 formal complaints about notification issues. This year we received 53 written complaints and hundreds of oral complaints.

In our experience this increase does not necessarily reflect worsening council practices. Rather, it appears to be a product of rising community expectations about the extent to which councils ought to consult in making planning decisions. It has also been prompted by increased medium density development in metropolitan areas, rising property values, development pressures in coastal and certain regional areas arising from demographic change in those areas, and a trend towards growing assertiveness and community activism.

We have found that complaints about notifications tend to arise in situations where:

- a council's notification policy or development control plan (DCP) does not require notification in circumstances where it should
- a person is not notified by council due to an administrative oversight or because their contact details are out of date
- the information notified is incorrect or misleading
- a person's expectations of being notified or of the amount of information provided with the notification are not met
- a person receives a notification late, reducing the time available to them to prepare a submission
- an applicant considers that the processing of their application has been unreasonably delayed by unnecessary and excessive notification or consultation.

We also receive a number of complaints about the way councils handle the submissions they receive following notification.

These complaints are often because:

- a person's expectation that a council will reply to their submission is not met
- the council fails to inform a person making a submission when the matter is to come before council or a committee of council or notify them of the decision made
- a person's expectation of the level of consultation the council is required to undertake with them in making a final decision is not met
- a person has an unreasonable expectation that a council is compelled to make a decision that reflects the position articulated in their submission
- a person objects to their submission being disclosed in the council report or publicly discussed by council with no prior warning.

We believe that councils improve their decision-making on development applications by notifying all affected parties and taking into account submissions received. This maximises the opportunity for all relevant matters to be considered. However, the need to consult sometimes needs to be balanced against the right of the applicant to develop their land in a manner consistent with the applicable planning instruments and policies and to have their application determined as quickly and efficiently as possible.

Given the diversity of councils across NSW, it would not be appropriate to impose uniform notification practices on all councils. However we would suggest that, as a bare minimum, council notification policies and DCPs should require them to notify all residents that the development will have a tangible and immediate or direct impact on. The same test should apply to notification of s. 96 applications seeking an amendment to conditions of consent.

Many of the complaints we have received about notification issues could have been avoided if the council concerned had better managed the expectations of the person notified.

Councils can minimise the potential for complaints by giving people the following advice.

- Receiving an objection does not compel the council to reject the development application. A council is only required to consider any submission received insofar as it raises matters that must be taken into account in determining the application under s. 79C of the *Environmental Planning and Assessment Act 1979*.
- Council will not respond individually to issues raised in submissions. Any relevant matters in the submission will be addressed in the assessment report, a copy of which can be obtained from council.
- Personal information in the submission, including the name and address of its author, may be accessible by members of the public and may be disclosed in an open council meeting. People making submissions should be asked to indicate if they do not want this information to be disclosed.

Councils can also minimise the potential for complaints by notifying anyone who lodged a submission when the application is to be considered at a meeting of council or committee of council, and then notifying them of the decision made.

conflicts of interests

Public confidence in local government decision-making can easily be lost when conflicts of interests intrude into council deliberations. One investigation we conducted during the year highlighted this problem.

Like many other councils, Mosman Council's code of conduct provides clear and prescriptive advice about conflicts of interests. It says that non-pecuniary conflicts of interests can be triggered by private or personal friendships and exist where it is likely a person will be prejudicially influenced in the performance of his or her public duty by that personal interest, or that a reasonable observer would believe that the person could be so influenced. It particularly notes that it is the public perception of how a person deals with any conflict that is important.

In this case, the complainants obtained development approval to demolish an existing dwelling and rebuild a waterfront residence. Their adjoining neighbour subsequently made at least 39 complaints to Mosman Council about construction activities and non-compliance with the approved plans. Over the following 30 months, council deliberated about issuing an order for compliance, a subsequent appeal against the order and a s. 96 application to modify the development consent. They also considered unauthorised works on the neighbour's property and a subsequent development application (DA) for a privacy screen built to counteract the overlooking from an alleged non-complying window that had become the focus of the dispute.

The complaint was that two councillors in particular had acted in a biased, partial and discriminatory manner in these deliberations and had improperly used their positions due to personal associations with the adjoining neighbour that they had failed to declare.

The neighbour had stood on one councillor's ticket at the previous local government elections. This councillor had declared a conflict of interests and had withdrawn from the voting during deliberations on the original DA because of her relationship with the neighbour who was the most vocal objector. However she then participated and voted when council deliberated on all subsequent matters.

We found that it was not a case of the councillor being a disinterested decision-maker dealing in unavoidable business. Her contact with the neighbour increased during this period. She had contact outside council meetings, she provided advice, visited her property, made representations to council staff on her behalf and assisted the neighbour to review council files associated with the complainant's property to better pursue her complaints and objections.

It is our view that the councillor should have been consistent in voluntarily disbarring herself from any involvement in the matter. Her conduct was more culpable given that she had been directly put on notice by a complaint about the very issue but failed to respond to it. Given the terms of council's code of conduct at that time, it was the councillor's responsibility to deal with the ongoing conflict by making a public statement before council to clarify her position.

This she failed to do - confirming in the complainant's mind that she not only had a continuing conflict of interests but that she was partial. Her failure to adequately deal with the conflict and continued participation in the matters tainted the integrity of the subsequent decision made. Such conduct brings local government into disrepute in the eyes of the community and is deserving of the strongest censure.

The more serious conflict of interests related to another councillor who took a significant role in advocating for the neighbour's concerns during council's deliberations.

Initially, his role was just that of a councillor responding to a resident's concerns. However by the time council was dealing with the appeal over the order and considering the s. 96 application, as well as the developments on the adjoining neighbour's property, the councillor's situation had changed. He was then advocating on behalf of someone with whom he had developed a close personal relationship. A casual social relationship, started through membership of a local bowling club, changed to one where the councillor and the neighbour became close companions. During a six-month period they took two interstate holidays together and also went on a cruise. Two of the holidays also benefited the councillor financially because he was given free accommodation by the neighbour.

On every occasion that this councillor formally dealt with matters at council during this time, he failed to declare a conflict of interests even though the code of conduct required it. He also ignored complaints lodged by the complainant claiming a conflict of interests existed. While the true nature of the relationship was a secret to most if not all other councillors and staff, a number had firm suspicions and a perception that a close personal relationship existed. They were simply too polite to confront the councillor about this.

While we did not question the councillor's belief that he approached the matters on their merits, we were satisfied that his relationship with the neighbour coloured his assessment of the issues so that his advocacy became partial and unbalanced. We were satisfied that a number of letters and complaints lodged by the councillor during the proceedings were in fact prepared by the neighbour – he effectively became her inside mouthpiece in relation to these business items. His conduct corrupted the fair and impartial treatment of the agenda items relating to the properties that came before council from late 2002 until November 2003 when they were finalised. This conduct was a serious breach of his obligations as a councillor and raises serious questions about his fitness to hold the office of an elected member.

the local government amendment (discipline) bill 2004

In previous years we have discussed councillor misbehaviour and the lack of a statutory disciplinary scheme for councillors.

Under the LG Act, whole councils can be dismissed after a public inquiry. This happened recently with Warringah Council and Liverpool City Council. However, apart from the pecuniary interest provisions of the LG Act, there is no statutory basis for disciplinary action against individual councillors for misbehaviour.

Councillor misconduct is currently regulated under individual council's codes of conduct. All councils are required to have a code, but the contents are not currently prescribed so there is often considerable variation. Generally, the most a council can do to discipline a councillor for breaches of their code of conduct is to censure them or require an apology. In cases of disorder at council meetings, they can expel them from the meeting at which the disorder occurred.

This has made it difficult for us and for councils to find appropriate remedies for individual councillor misbehaviour.

In our 2001-2002 annual report, we discussed a case in which a councillor was accused of downloading pornographic images onto his council laptop including images depicting children.

In that case, the most the council concerned could do was to censure the councillor as that was the most serious sanction available under their code of conduct.

In last year's annual report we discussed our investigation of Queanbeyan City Council. That council, having experienced years of conflict amongst councillors, tried to strengthen their code of conduct to deal with councillor misbehaviour. They incorporated sanctions that enabled them to suspend councillors and not pay their annual fee for any period of suspension. We found that a number of other councils with similar histories of conflict had also considered amending their codes of conduct along similar lines out of frustration.

However councils do not have the power to do this. We were also concerned that such sanctions could potentially be misused against minority councillors.

We therefore recommended that the Minister for Local Government make amendments to the LG Act to empower an independent person or body to suspend councillors for serious or repeated misbehaviour, including serious and repeated breaches of a council's code of conduct.

The Minister subsequently introduced the Local Government Amendment (Discipline) Bill 2004 which aims to amend the LG Act along the lines we recommended. The Bill was passed in September 2004 and is currently awaiting assent.

case**study**60

An MP complained to us on behalf of residents about the compensation process for damage to private property from the construction of the Eastern Distributor.

We reviewed the process for considering claims. This consisted of a panel of inquiry by the Commissioner of Inquiry, the subsequent establishment of an independent technical investigation team, and a further review of those claims for which settlement could not be reached.

There were significant delays in finalising some claims. We considered this delay arose from the failure to undertake pre-construction property dilapidation surveys, the need to make individual property inspections, and difficulties in establishing causal links between construction and damage.

It appeared the review process had evolved in response to disputes. We believed that if the review process had been established and notified at the outset it would have sped up the consideration of claims and offered greater certainty. However, as the consent processes for later infrastructure projects had been designed to address the problems revealed by the construction of the Eastern Distributor, we did not consider it necessary to formally investigate the process or make recommendations.

During our inquiries, we reviewed the consent conditions for the cross-city tunnel project. At the request of the Department of Infrastructure, Planning and Natural Resources, we also gave advice on the proposed terms of reference for the property impact assessment panel set up to consider claims arising from the Parramatta rail link project. We made a number of suggestions on matters such as giving reasons, allowing legal or technical representation, making binding decisions and giving advice at the outset about the review and appeal processes.

case**study**61

A Lane Cove Council resident complained to us about council's failure to respond to his complaints about his neighbour's encroaching bamboo.

Bamboo is classified as a noxious weed under the Noxious Weeds Act. Council therefore had the power to enter the property, remove the bamboo and charge the owner of the property the costs of doing so.

Our inquiries revealed council had first been made aware of the problem in 1991. Despite ongoing complaints, agreements with the neighbour to remove the bamboo that were subsequently not honoured, and the commencement of enforcement action against the owner of the property, the bamboo had not been removed. The encroachment had apparently caused damage to the complainant's property.

After we began a formal investigation, council agreed to enter the property and remove the bamboo. They also agreed to consider a claim from the complainant for any damage suffered as a result of council's failure to act. We considered this resolved the matter.

The new Bill:

- mandates provisions of a model code of conduct
- provides a statutory basis for councils to formally censure a councillor for misbehaviour
- establishes a formal disciplinary process whereby a councillor can be suspended by the Director General of the Department of Local Government for up to one month for misbehaviour, and by the Pecuniary Interest and Disciplinary Tribunal for up to six months.

Under the proposed amendments the disciplinary process can be initiated by a request by a council, by a request from the Director General for a report from a council on a councillor's alleged misbehaviour, or by a report made by the ICAC or us.

As part of the reform process, we participated in a working group convened by the Department of Local Government to draft a new model code of conduct. If passed, the amendments will mean that we will be able to investigate councillor misbehaviour and, if we feel there are grounds for suspension, recommend that the Director General suspend them for up to one month or, where appropriate, refer the matter to the Pecuniary Interest and Disciplinary Tribunal for a longer suspension.

casestudy62

Residents of Wyong Shire Council complained about council's failure to act on their complaints about the alleged illegal use of a caravan park. The residents claimed that, among other things, non-residents were using the caravan park restaurant in breach of the zoning. They were concerned council had not acted on their complaints because a former mayor was a director of the company that owned the park.

The current zoning of the caravan park prohibited a restaurant but allowed restaurant facilities for residents. Council claimed the site enjoyed existing use rights that allowed the restaurant to be open to non-residents.Existing use rights allow the continuation of a use of land even though subsequent changes to zoning have made that use illegal.

However it was unclear whether zoning of the site had ever permitted a restaurant. Also, the original use may have intensified over time and any existing use rights enjoyed by the site may have been abandoned.

In response to our inquiries, council approached the operators of the park and took statements about the history of the use of the site. Council considered these statements, together with previous reports by council, were sufficient to demonstrate existing use rights.

We disagreed. In response to our further inquiries, council sought legal advice which confirmed the site did not enjoy existing use rights. However council's solicitors also recommended that no action be taken against the unauthorised use of the restaurant as such action would be unlikely to be successful.

Council is entitled to rely on their legal advice to take no further action. However we were concerned about council's failure to initially require the operator of the site to demonstrate it enjoyed existing use rights. This was of particular concern given the perceptions created by the involvement of the former mayor.

The onus lies with the occupier of a site to provide evidence of existing use rights. If they cannot do so, council needs to consider enforcement action. If the occupier has supplied such evidence, we suggest that councils create an existing use rights register. This prevents councils from having to refer back to the occupier every time a question is raised about use of the site.

Council told us they were considering creating an existing use rights register and would continue to investigate complaints about the use of the caravan park.

casestudy63

A resident of Liverpool City Council complained about council's failure to act on unauthorised uses of neighbouring properties.

The resident initially complained to us in 1998 of council's failure to act on his complaints about offensive noise from operations on a site opposite his home outside the hours permitted under the development consent. The site was used for the storage and maintenance of trucks and associated equipment. He also complained that council failed to act on his complaints about the unauthorised use of another site for storing shipping containers. After we made inquiries, council agreed to take enforcement action.

When the resident complained to us again in September 2002 alleging council had still not taken appropriate enforcement action, we made further inquiries. After we received no response after many follow up calls, we formally investigated council.

Our investigation revealed compelling evidence of breaches of development consent and unauthorised activity on both sites. The complainant had provided council with four videotape recordings of truck movements outside the approved operating hours at one of the sites. It was also clear that shipping containers were stored at the other site.

Council clearly recognised these unauthorised activities affected neighbours. They had referred one of the matters to mediation and later to an external agency for further investigation. Council had also negotiated with those allegedly engaged in unauthorised activity and obtained undertakings from them. Council later issued notices of intention to serve an order and followed this up by issuing an order to the owners of one of the sites. However when these measures failed, council was reluctant to take further action.

During our investigation, council finally took action to shut down the unauthorised activity and began to police breaches of development consent by the trucking business more rigorously. They also wrote to the complainant to apologise.

This year we handled a 9% increase in oral complaints about correctional centres, juvenile justice centres, Justice Health and the departments that administer those institutions (from 3,133 to 3,418). We also dealt with 39% more written complaints (from 336 to 467). See figure 34. Some examples of the positive outcomes we were able to achieve in this area are:

- changes to Department of Corrective Services (DCS) policy to avoid repeating a situation where an inmate was required to share a cell with someone who had previously sexually assaulted another inmate (see case study 74)
- inmates no longer being subjected to unnecessary and humiliating body searches (see case study 76)
- money that was incorrectly deducted from inmates' accounts being refunded (see case study 69).

corrections

correctional centres

Our focus in the area of corrections is to improve the administration of correctional centres and promote more humane conditions for people in custody.

People who commit certain crimes are punished by taking away their liberty — their freedom to come and go as they please and to make decisions about what they do with their lives. It is widely recognised that this is, in itself, a major form of punishment. People who are in prison should therefore be otherwise treated humanely — with dignity and respect for their personal safety.

We have had jurisdiction over correctional centres (or prisons, as they used to be called) since our office started taking complaints in 1975. During that time we have issued 13 special reports to Parliament about correctional issues.

Although we do not act as an advocate for inmates, our experience has shown that correctional centres run more effectively and with less disruption when inmates' legitimate concerns are addressed promptly.

Living in an institutional setting is very different from living in the outside world. Inmates are required to follow strict rules and routines and live within physical barriers. Our regular visits to centres give us the hands-on knowledge that we need to understand the nature of complaints and why certain matters need to be resolved quickly. One of the things we have learnt from almost 30 years' experience is that correctional centres have the potential to become volatile environments if inmate dissatisfaction is not addressed quickly.

Our personal contact with correctional staff and management allows us to build constructive relationships that support improvements in the way centres are run and the way inmate complaints are handled by correctional centres themselves.

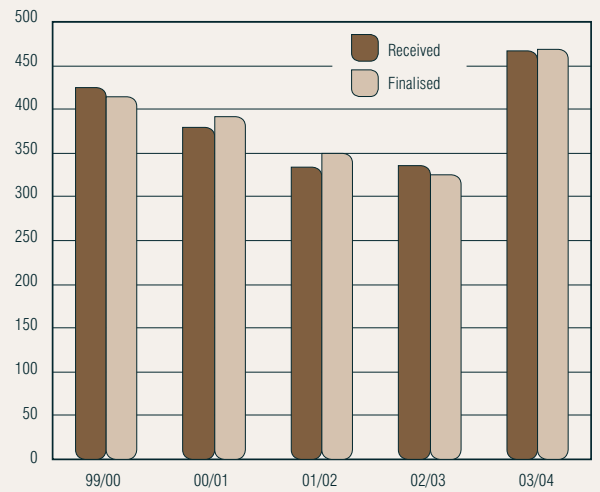
Figure 34: Five year comparison written complaints about corrections received and finalised

	99/00	00/01	01/02	02/03	03/04
Received	424	379	334	336	467
Finalised	414	392	349	326	469

Total written and oral complaints received in 2003 - 2004

Oral	
about correctional centres, DCS and GEO Australia	2773
about juvenile justice centres and DJJ	318
about Justice Health	327
Total oral complaints received	**3418**

Written	
about correctional centres and DCS	412
about juvenile justice centres and DJJ	25
about Justice Health	30
Total written complaints received	**467**
Total complaints received	**3885**



our corrections unit

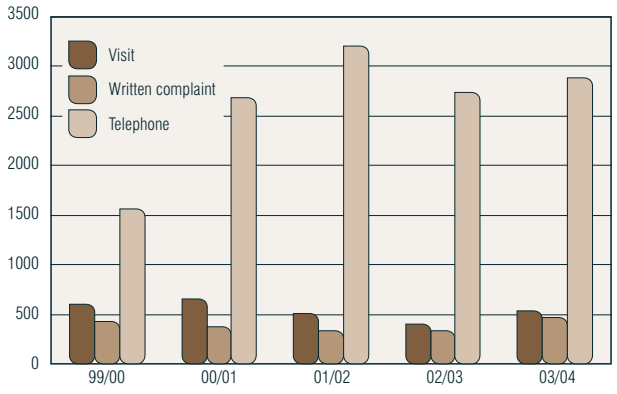
A major change this year has been the setting up of our specialist corrections unit. This was prompted by the closure of another watchdog agency - the Inspector General of Corrective Services. The legislation creating the Inspector General was subject to a sunset clause. After a statutory review of its work, which found many of its functions duplicated by other bodies, the government in late 2003 decided that the Inspector General should cease to exist. Its complaint-handling functions were transferred to our office, as we already had such responsibilities and had continued to receive far more complaints from inmates than the Inspector General.

We were given additional funding to help us manage the extra work resulting from the closure. We employed three extra staff and now have a total of five investigators working exclusively on corrections issues. They are supported by our general inquiry staff.

Having more staff with in-depth knowledge and understanding of correctional matters has led to an improvement in our responsiveness to both individual and system issues.

Figure 35: How inmates contacted us - a five year comparison

	99/00	00/01	01/02	02/03	03/04
Visit	604	649	512	406	528
Written complaint	424	379	334	339	467
Telephone	1567	2682	3203	2734	2890



working productively with the Department of Corrective Services (DCS)

It would be fair to say that the external watchdog role of the Ombudsman in respect to correctional centres is well accepted by senior management of the Department. That is not to say it is always welcomed or that our views are always accepted. Like other public sector agencies, the Department of Corrective Services may be compelled to co-operate in investigations because of our coercive powers, but they can also reject our recommendations and are under no obligation to implement them.

To assist in bringing about improvements and adding value in the correctional system, we have to be persuasive and be seen to be knowledgeable and fair to all parties. This requires us to work cooperatively with DCS and for everyone to have a good understanding of our different roles and responsibilities.

We have quarterly liaison meetings with the Commissioner and his senior officers. This year we have met at head office and in correctional centres, where DCS has taken the opportunity to show us new areas or features such as the new wing at Parklea, new facilities and programs for intellectually delayed inmates at Long Bay, and Dillwynia, the new centre for women at Windsor.

These meetings give us an opportunity to keep up-to-date with what is happening in correctional centres and the system as a whole. We can monitor new developments and programs, develop our knowledge and understanding of correctional issues, and observe the extent to which our recommendations have been implemented.

We can also share information about each other's projects and express our, sometimes differing, points of view. We have used these meetings to raise concerns about the living conditions of certain inmates and DCS has generally been responsive to our concerns.

We also have regular contact with centre governors and key staff which helps us to better negotiate the resolution of individual complaints. All parties concerned, including the correctional centre, usually want the complaint to be dealt with as quickly and with as little formality as possible.

→ so what do our corrections unit staff do in a typical week?

- Talk to about 50 inmates over the phone and respond to their inquiries and complaints. It is not unusual for callers to ring us simply for reassurance – to independently confirm advice they have already been given about policies, procedures or rights by correctional or professional staff within centres.
- Respond urgently if, for example, the complaint concerns issues of safety or impending irreversible action, or is likely to lead to greater management problems unless it is attended to quickly. We may contact someone at a correctional centre, at Justice Health (formerly called Corrections Health Service), or at DCS's head office to ask for information. We will also see if there is a way to solve the problem or if there is anything else that can be done.
- Handle a number of written complaints that often raise more complex or serious matters. We may make inquiries of the centres concerned or perform other investigative activities.
- Visit a correctional centre and meet with staff and management.
- Plan our activities, share information and experiences within the team, and update the reference information we keep on correctional issues.

case**study**64

When a man was detained at a metropolitan police station his property, including a wallet containing $455.25 cash, keys, medication, cigarettes and a tie, was taken from him. He was taken to the metropolitan reception and remand centre (MRRC) where he remained until he was released on bail at 10.30pm that night. He was told that his property had been brought with him to the centre but it could not now be located. As a result, he had difficulty getting home without cash and had to break into his house as he had no keys. Later, he had to replace a glass window and change the locks.

The man complained to DCS but they did not resolve the matter, so he contacted us. A senior officer at the centre told us that, although the property could not be located, the cash had already been returned to the man who by then was in the correctional system. The officer acknowledged that procedures had not been followed and that there was a dispute between two areas of the department over responsibility for the loss of the other property.

Because the complainant maintained he had never received the money, we asked the seconded police in the corrective services investigation unit to investigate the matter. Their investigation concluded that there was no evidence of any criminal offences, but they compensated the man for the missing cash and an officer was reprimanded. Financial compensation was also offered to the complainant for the loss of other property and the expenses he had incurred.

case**study**65

An inmate had been told he was to be transferred later that day to another correctional centre where he believed there was a significant possibility he could be killed or badly beaten by other inmates. He had tried to raise his concerns with correctional centre staff, but had been unable to get a response. He then called us and we arranged for a correctional officer to interview him. This officer accepted there was a reasonable prospect of danger to the inmate if he was transferred as planned, so the transfer was cancelled and an alternative placement arranged.

case**study**66

Two inmates who had been dismissed from their jobs at Junee correctional centre called us when they were told they would have certain privileges withdrawn for 21 days. Correctional staff told them one of the privileges to be withdrawn was that their family could not deposit money into their account for this period. The inmates were worried that, at the end of the 21 days, they would have no money for phone calls. After checking the regulation, we believed that it was not within the power of the centre to make this decision. We contacted the centre and were told that, after reconsidering the policy, they agreed with our interpretation of the regulation. We were assured the problem would not happen again.

Although our relationship with DCS is generally cooperative, there are times when the communication process fails. This year a correctional officer failed to do what he had told us he would do to resolve a complaint. When we resolve a complaint informally, we rely on undertakings given to us and the truthfulness of information provided by DCS staff. The officer's actions threatened our trust in the department so we wrote to the Commissioner with our concerns. He responded positively by issuing an order to all staff about their responsibility to cooperate with us to resolve inmate complaints.

Coordination of the official visitor program was given to DCS when the Inspector General's office closed. We value our good working relationship with official visitors and, wherever possible, provide them with assistance and seek their help in managing inmate inquiries. This year we spoke at the official visitor annual conference which gave us the chance to answer questions and discuss issues of mutual concern.

the Corrective Services Support Line (CSSL)

In January 2003, DCS introduced an internal telephone inquiry system to deal with inmate grievances. The CSSL pilot period ended in January this year. We understand that CSSL staff submitted an evaluation of the system's operations to the Commissioner in late April 2004. The Commissioner has since decided to continue and expand the service pending a further review in June 2006.

Between September and December 2003 the service was extended to include not only the Metropolitan Remand and Reception Centre (MRRC), Lithgow and Mulawa but also Emu Plains, Long Bay Hospital (now including Long Bay Hospital 2) Metropolitan Special Programs Centre, Parklea, Goulburn and Cessnock correctional centres. While the service initially met some resistance by inmates at some centres, it appears now to be quite commonly used. One of the main aims of the CSSL was for DCS to handle more of their own complaints and avoid the need for inmates to access external complaint-handling bodies, like us. This appears to be happening.

Calls to our office from the participating centres fell overall by 19% in 2003-2004. However, we still received slightly more calls from those centres than the CSSL did. More calls seem to be being made by inmates overall - this may be a positive sign that they have found the CSSL to be accessible and able to resolve their grievances effectively.

Another likely reason for the increase in calls is the closure of the Inspector General's office, which previously would have dealt with some of these matters.

Also, some inmates call both our office and the CSSL about the same matter. They often ask for our advice before contacting the CSSL. We generally refer inmates to the CSSL in line with our memorandum of understanding with DCS, and the CSSL sometimes refers inmates to our office. This may be when they cannot pursue an inmate's complaint or inquiry any further and the inmate wants someone else to look at the issues.

We believe that the CSSL is an important initiative that provides inmates with another avenue for having their complaints resolved and gives DCS an opportunity to obtain useful feedback about their operations.

complaint trends and outcomes

With the closure of the Office of the Inspector General of Corrective Services, the number of complaints made to us rose substantially. See figure 34.

The complaints we receive mainly feature aspects of daily life in an institutional setting. See figure 36. Typical grievances include property being lost, reasonable requests being ignored, information not being readily given and communication breaking down. These can all lead to frustration and sometimes difficult behaviour. See case studies 64-67.

Our involvement with complaints about DCS or GEO Australia (a private company that took over Australasian Correctional Management and now runs Junee correctional centre) has achieved a variety of outcomes.

Of the 314 formal complaints that were the subject of preliminary or formal investigations, we were able to achieve 268 forms of redress. These included the agency admitting and correcting errors, mitigating consequences of decisions already taken, providing reasons for decisions, reviewing matters and changing decisions, taking disciplinary action against staff, providing information, reviewing internal processes, negotiating settlements and offering apologies, reviewing cases, providing monetary compensation, changing policy or procedures and providing staff with training. See Appendix E for:

- details of the actions we took in relation to each of the 469 written complaints about corrections that we finalised this year
- a breakdown of the complaints we received by the institution being complained about (correctional centres and juvenile justice centres).

formal investigations

Although we prefer to try to resolve complaints with the people directly involved, such as the correctional centre governor, some issues warrant a formal investigation. In these cases we use our coercive powers under the Ombudsman Act to require the provision of information or documents. At the end of these investigations we prepare a detailed report of any wrong conduct we have found. This report goes to the Minister, the Commissioner (or GEO for matters concerning Junee correctional centre) and the complainant. Usually we only prepare a formal report if the matter is complex or serious and this is in the public interest.

Because formal investigations involve a statutory process of notification, procedural fairness consultation and Ministerial consultation as well as practical information gathering and report preparation, it is often a long process. The process also includes making formal findings and recommendations that the agency is obliged to consider and respond to.

Case study 68 gives an update on our investigation into DCS's application of their policy on imposing visitor sanctions (see case study 23 in our annual report 2002 – 2003). Also see case study 69.

casestudy67

A woman rang us because she had been unable to organise a visit with her son who had recently arrived at the MRRC from a country centre for a court video link appearance. The mother had tried to arrange the visit, but was told visits had to be booked seven days in advance. She explained that her son had only arrived at the centre the day before for a court video link and would be returning to the country centre as soon as the court appearance was over. Her attempts to speak to someone senior about her plight were unsuccessful. She told us that her son was intellectually disabled and she had not visited him in the last year because she did not have the financial means to travel to the country centre. As she only lived a short distance from the MRRC, she saw this as a ideal opportunity to visit him.

We contacted the centre and spoke with the person in charge of visit bookings. We were told that the general rule is that all visits should be booked seven days in advance, but consideration can be given to allow a visit at short notice under 'special circumstances'. The officer agreed that this was such a case and arrangements were made for the complainant to visit her son the following morning.

Figure 36: What people complained about — correctional centres

This figure shows the complaints received about correctional centres, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Daily routine	61	414	475
Property	42	303	345
Visits	39	208	247
Officer misconduct	41	190	231
Records/administration	38	176	214
Transfers	18	186	204
Classification	22	166	188
Other	7	149	156
Work and education	7	107	114
Buy ups	14	95	109
Unfair discipline	7	96	103
Case management	18	78	96
Medical	14	79	93
Mail	11	79	90
Segregation	15	74	89
Probation/parole	5	78	83
Legal problems	7	67	74
Food and diet	4	49	53
Security	17	34	51
Failure to ensure safety	8	34	42
Information	8	32	40
Day/other leave/works release	5	32	37
Outside our jurisdiction	3	28	31
Periodic/home detention	1	16	17
Community programs	0	2	2
Court cells	0	1	1
Total	**412**	**2773**	**3185**

case**study**68

We examined the application of the DCS policy on 'Restricting and prohibiting visits to inmates and correctional centres' with the aim of suggesting improvements. Although the number of visiting incidents resulting in sanctions is extremely small - less than 1% of all visits - sanctions can have profound negative effects on the ability of inmates to sustain supporting relationships with key family members and friends. Like other administrative actions, the DCS's management of this process needs to be consistent, reasonable and fair.

The policy has a hierarchy of sanctions and explicitly encourages the use of discretion. It also requires the reasons for any decision to be recorded.

We audited 227 cases where restrictions or bans on visits were imposed or visitors were cautioned. This was each case in every second month of the 12-month period ending 30 September 2002. We assessed these cases against the process and apparent spirit of the then current policy.

Our key findings included:

- Reporting of visitor incidents and the determination of sanctions was done in an efficient and timely fashion.
- The quality of officer incident reports was adequate in two thirds of the cases.
- There were minimal records of the actual assessment process – not one record explained why the type and length of the applied sanction was appropriate to the particular case.
- Despite a policy that encouraged the use of discretion, there seemed to be a high degree of arbitrariness in decisions made. Over 91.5% of all sanctions involving the detection of contraband resulted in a prohibition from visiting all correctional centres for at least the maximum recommended period.
- Only 4.4% of sanctions were restrictions, even though restricting visitors to no-contact visits could be considered an appropriate response to deal with the potential risk associated with a detected event involving contraband.
- There were inadequate warnings of the sanction process and the likelihood of visit bans for the scheme to be an effective deterrence to inappropriate conduct.
- The policy was inadequate because it did not clearly set out its purpose. It did not provide sufficient guidance on the weighting of relevant considerations, and the mandatory considerations were not sufficiently comprehensive to enable a proper risk assessment.
- The policy was out-of-date in terms of the department's actual practice - it was generally implementing a zero tolerance approach to drug related visitor incidents and failing to exercise the range of discretion provided for in the policy.

Although DCS objected to our findings, they responded positively to our recommendations. They agreed to undertake a complete review of the policy and to adopt new practices. These included:

- properly recording details of visiting minors and developing guidelines on the care and management of all children on and in the vicinity of correctional centres
- developing checklists to ensure essential information about visiting incidents is provided to decision makers and to assist the assessment and review process and its recording
- developing new information packages and warning signs for visitors that advise of the potential for visiting sanctions to be applied for contravention of visiting rules.

So far DCS have shown us new posters and other information for visitors to correctional complexes and advised us that work is continuing on our other recommendations, including the revised policy and supporting processes.

case**study**69

A criminal conviction under NSW law attracts a victims compensation levy at a rate of $30 for each local court and $70 for each district court conviction. Inmates pay this levy in weekly instalments based on their income. The levy is imposed on any person found guilty of crimes punishable by imprisonment and is used to fund the statutory compensation scheme. It is in addition to any pecuniary penalty or order for payment of compensation imposed for the same offence.

A number of inmates at Junee correctional centre complained to us that the levy had been incorrectly deducted from their private cash accounts. They claimed they had completed paying it at other centres and that Junee had not responded to their inquiries about this.

Over a period of some months, Junee either did not respond or responded unsatisfactorily to our informal inquiries on these matters. We were told that the problem had been identified, but not what was happening to resolve it or the complaints we had received.

Our records showed that we had received complaints about this issue dating back to 1998. Over the years, all individual matters were addressed but we were concerned that this issue kept recurring. On 20 April 2004 we issued investigation notices to GEO Group Australia Pty Ltd, Junee's parent company, about Junee's administration of deductions and inmates' inquiries about these deductions.

The investigation is still ongoing but GEO's response to our inquiries has been swift and positive. The individual inmates' complaints are all but resolved, with one inmate receiving a refund of over $180 of wrongly deducted levy. The systemic problem involving the integrity and maintenance of electronic data received from DCS that led to the inaccuracies is also being fixed.

visits to centres

There are 30 correctional centres in NSW now but only 28 were open durning 2003-2004. We cannot visit every centre every year, but we try to visit a range of minimum, medium and maximum security centres and usually see 17 in each six month period. We visit some centres twice a year - depending on the inquiries and complaints we have received, the programs being run, any changes to particular centres and the general level of access inmates have to alternative means of redress. This means we tend to visit maximum security institutions such as Goulburn, Lithgow, Junee, MRRC, the Long Bay Complex and Mulawa far more often than minimum security centres.

In 2003 – 2004 we spent 111 person days conducting visits to 21 different correctional centres.

When we visit regional centres, such as Goulburn correctional centre, we generally stay a few days as our visits tend to be less frequent. Visits to centres in Sydney, such as Silverwater correctional centre, can often be conducted over a day. The most inmates we have spoken to on a single visit is around 70. The length of our visit will vary depending on the complexity of the centres and the number of inmates who want to speak to us. During each visit we meet with the governor and other staff, discuss programs, visit the clinic, inspect the centre and talk to inmates. At the end of a visit we talk to the governor about our observations and the issues brought to us and agree on ways individual inmate complaints will be handled.

Sometimes we observe particular processes. For example during one of our visits to Parklea correctional centre this year, we were invited to observe a case management team meeting for an inmate in the security threat group intervention program. It was helpful to be able to see how this system works in practice, rather than just reading about it in a policies and procedures manual.

We also use our visits to centres to monitor ongoing issues of concern, including changes to segregation and protection procedures and the use of special management area placement (SMAP).

segregation and protective custody

This year we found that most administrative tasks relating to the amended segregation and protective custody procedures appeared to be being properly completed. However we have some concerns about the increasing number of inmates being kept in segregation for extended periods. Many of these inmates were involved in highly publicised criminal activities outside of the system, and potentially pose a threat to good order and security if they were to live in the mainstream population of a correctional centre. We will continue to monitor this issue.

In last year's annual report we wrote about segregation, protection and SMAP at Junee correctional centre. On our visits this year we again noticed that some centres are unable to sufficiently separate SMAP inmates from those on more restrictive forms of protection. This sometimes means that SMAP inmates are not getting adequate access to amenities and entitlements.

For example the special purpose unit at Grafton accommodates protection, segregation and SMAP inmates. The building is physically unable to cater for the varying needs of the inmates living there and staff are confronted daily with problems of providing access to services. The governor is aware of the problems but has few, if any, options available to him.

We plan to make this an area of focus in our visits in 2004-2005.

high risk management unit at goulburn correctional centre

We have dealt with a number of complaints about conditions at the high risk management unit this year and are currently conducting a formal investigation into certain aspects of its operation and general program.

Complainants have raised various concerns about the unit, including problems with access to fresh air and daylight.

This unit is different to other correctional centres – the routine is very strict, the privileges are few. It is a highly controlled and secure environment and is relatively isolated, with very few people visiting. The entire unit is air-conditioned and most cells have both yards and day rooms. Except for lock downs, inmates have access to their day room during 'out of cell hours'. They also have access to the yards attached to the cells for a number of hours on most days. These yards are open to the fresh air. There is also some access to sports yards, but that depends on staff availability, inmate privilege and association levels.

The air conditioning is perhaps one of the worst physical aspects of the unit. Many buildings relying solely on air conditioning experience problems – vents block and don't blow air, the air is too hot or too cold. Although housed in a relatively new building, the unit has periodically experienced such problems. They are exacerbated by the placement of vents immediately above the inmates' beds. The air conditioning has recently been the subject of a technical review and steps are being taken to improve it.

When the door to an inmate's rear yard is open, they have ready access to fresh air and daylight. But when the door is closed, daylight is limited to that coming through a strip window as wide as an adult hand and at the height of the door. In terms of total area, these windows would not be too dissimilar to the size of external windows in normal maximum security cells. Despite this being the only source of natural light, we observed a number of inmates had used clothing and other material to cover these windows. Inmates are also able to operate the lights in their own cells. We will continue to monitor these issues.

court cells

The complaints we received this year about court cells no longer focused on the amount of time people spent before being transferred to a correctional centre. This year's complaints showed us how simple things can adversely impact on the people confined in the cells and those who work with them. Case study 71 is a good example.

urinalysis

The punishment for a positive - or deemed positive - urinalysis result can have a major impact on an inmate's access to amenities, their classification and their ability to participate in programs. When we consider the amount of urinalysis testing done in the correctional system each year, complaint numbers are fairly low. Case study 72 illustrates the effect on an inmate when DCS gets it wrong.

complaints leading to policy and procedural change

We try to resolve individual problems for inmates who contact us, but we also want to make sure the same problems do not recur and affect others. Wherever possible we try to identify defects in correctional practices and recommend changes to 'fix the system'. Case studies 70, 73, 74, 75 and 76 are examples of some of the positive outcomes we have achieved this year.

case**study**70

An inmate complained to us during a visit to the MRRC in May that he had applied for an alert to be removed because it was affecting his access to welfare and other services. He showed us the application stating it was refused.

An alert may be placed on DCS's offender management system to ensure that staff dealing with that person are aware of potential problems and can take necessary precautions. In this case the alert was about the inmate having a history of taking correctional centre staff hostage. This meant he was not allowed into an area where other inmates would go to see welfare and other program staff.

We checked his case file which gave no information for the basis of the alert. However his file did have other documents about his management where the alert was noted. We then raised the issue with the governor who made various inquiries. As a result, no information was found to support the need for the alert and it was removed. An appropriate file note was also placed on the inmate's case file and advice given to relevant staff.

case**study**71

We appreciate it is not possible for court and police cell complexes to predict the needs of people coming into their custody. However we decided to write to the Commissioner after we received a complaint about the food provided at a regional court cell complex being inappropriate because of an inmate's religious needs.

The inmate was Muslim and was offered only a ham sandwich. This meant the inmate went hungry and he was also upset about the lack of consideration for his religious dietary needs.

The Commissioner agreed this was avoidable and noted that religious and dietary information should be gathered during the initial reception into custody. He also issued an instruction to DCS court and police cell complex staff, reminding them of their responsibility to find out about such needs and, wherever possible, provide appropriate food.

case**study**72

An unhappy MSPC inmate contacted us because a decision had been made to charge him with a correctional centre offence because he returned a positive result in a random urinalysis test. He alleged that the substance in his urine was caused by medication he was taking on a daily basis, as prescribed by the centre's doctor.

We asked for evidence of the positive reading and it was clear that appropriate procedures had not been followed to find out if the inmate was taking prescribed medication at the time of the test. We made further inquiries through the Commissioner and he acknowledged that there was a 'reasonable doubt' the inmate was not guilty of the offence.

Action was taken to rescind the previous decision and the inmate's records were appropriately amended. We are still making inquiries with Justice Health about other matters relating to the reporting of prescription medication.

case**study**73

A legal aid solicitor complained to us about DCS's failure to comply with s. 54A of the *Bail Act 1978*. His client was granted conditional bail that he was unable to meet at that time, and stayed in prison until he was re-presented to the court one month later.

DCS's operational procedural manual notes that s. 54A requires the governor of a correctional centre to notify the court within eight days when an inmate has remained in custody because a condition of bail has not been complied with. The court then decides whether the bail conditions should be changed to allow bail to be met.

We made lengthy inquiries with the Commissioner about this case and the systems in place at correctional centres to comply with the Bail Act. We were told DCS was unable to say with any certainty whether or not a notice was issued in this case - copies of the forms issued at that time had been destroyed. The case revealed some apparent deficiencies in DCS's procedures relating to the obligations under s. 54A. The maintenance of records of forms generated and sent to courts, and the long-term retention of those records, were identified as problem areas.

The Commissioner responded by issuing an instruction providing a more structured process for the generation, completion and recording of s. 54A forms. The director of the sentence administration unit was also asked to develop an independent checking mechanism to allow central monitoring so that it would be possible to confirm that forms had been issued.

It was not possible for us to change the experience of the person whose case brought this problem to our notice, but we hope our inquiries and DCS's action will mean others are not affected in the same way.

casestudy74

An inmate complained to us that he had been sexually assaulted by another inmate at Lithgow correctional centre. We wrote to DCS and found that a failure in their administrative process had led to the complainant being placed in a cell with someone who had previously sexually assaulted another inmate. Following our inquiries, DCS initiated their own investigation which resulted in amendments to their inmate accommodation policy. The amendments are designed to ensure staff complete all necessary checks before placing inmates into shared accommodation. They also provide guidance on what factors should be considered when inmates are placed together.

We followed up our initial inquiries with further questions about the supports available to inmates who are the victims of sexual assault in custody. DCS is now drafting a policy to use when one inmate alleges sexual assault by another inmate. The policy will focus on the 'rights of the victim and management of the suspected perpetrator/s'. We will monitor the development and implementation of this policy.

casestudy75

A child visit assessment program (CVAP) has been introduced by DCS and applies to certain classes of inmates. An inmate at Kirkconnell correctional centre complained to us that he had been denied visits with children until he had complied with the CVAP requirements. The CVAP policy is very specific in defining those inmates to be included in the program and this inmate did not believe he met the criteria. After we read the policy and the information supplied by the inmate in his complaint, we agreed he did not seem to meet the criteria in the policy. When our attempts to resolve the matter at the local level failed, we wrote to the Commissioner.

The Commissioner responded to our inquiries and acknowledged the centre had incorrectly administered the policies and procedures of the CVAP. DCS subsequently expressed regret to the inmate and child visitor restrictions were removed from his records. Clarification of the policy was sent to the correctional centres accommodating inmates to whom the CVAP applies.

casestudy76

A number of inmates from Cessnock correctional centre complained to us about the way in which strip searches were being conducted by the local security unit. In particular the inmates were concerned they were being routinely asked to part their buttocks as part of the search. The inmates understood the officers had the ability to include this in a strip search but they believed they needed to have a 'reasonable suspicion' before the direction was given - it was not a routine part of a search.

We raised the issue with the Commissioner. This resulted in an internal inquiry which led to a review and change to DCS's operational procedure manual.

In March 2004 we were told that inmates must not be instructed to part their buttocks during the course of a strip search unless intelligence, previous history of contraband being secreted on the body or their behaviour leads staff to believe that a more intrusive search is needed. In all searches where inmates are required to part their buttocks, the officer in charge must now provide a report to the governor regarding the reasons for the search.

justice health

(formerly Corrections Health Service)

We are in regular contact with Justice Health about complaints and inquiries from inmates about health related issues. The email protocol outlined in last year's annual report enables us to quickly investigate and resolve complaints. It continues to work well for both our organisations and for the inmates.

We still find the best way to pass on feedback about clinic services and answer inmate inquiries is through our visits to correctional centres.

We often receive complaints from inmates about problems with access to medical or dental treatment and special transport requirements. See case studies 77, 78 and 79.

Figure 37: What people complained about - Justice Health

This figure shows the complaints received about Justice Health, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Standard of medical care	13	161	174
Access to medical care	6	80	86
Dental care	5	49	54
Issues relating to the methadone program	3	29	32
Officer misconduct	0	3	3
Information	0	2	2
Security	1	1	2
Daily routine	1	0	1
Food and diet	0	1	1
Other	0	1	1
Records/administration	1	0	1
Transfers	0	0	0
Total	**30**	**327**	**357**

case**study**77

A Long Bay Hospital 2 inmate was awaiting medical treatment for a bulging disc and pinched nerve. In extreme pain and receiving nightly morphine injections, his appointment with a specialist was cancelled and he was told he was being returned to his regional correctional centre the next day. He was concerned about travelling a long distance in an ordinary escort truck. He had tried to speak to Justice Health at the centre but was told they couldn't help as his truck was leaving early the following morning.

We contacted Justice Health and asked if he should be assessed for fitness to travel by normal transport. We were contacted shortly after and told the nursing unit manager had initiated a medical hold on the inmate and taken action to have him placed back on the list to see the physiotherapist and doctor.

case**study**78

An inmate had been issued with a medical certificate for special transport as he suffered from anxiety and claustrophobia and required transport in a van with windows. However, despite presenting the certificate to court escort security unit (CESU) officers before transport, he had been placed in a van without windows on two separate occasions. The inmate complained to us and we were assured by the CESU that if he had a current medical certificate specifying his transport needs he should not have a problem again. However the inmate contacted us again when in December 2003 he was forced into a van without windows after he presented his medical certificate that was valid for another five months.

We made inquiries with DCS who advised that CESU officers had made every effort to assist the inmate but the certificate was not valid - certificates of this nature are only valid for two months.

However DCS acknowledged that the area manager had made a mistake when recording the certificate on the offender management system (OMS) which may have caused the confusion.

Justice Health told the CESU that they had no record of the certificate being extended or a new one being issued.

However, after our inquiries, Justice Health were more forthcoming and acknowledged that the correct procedures had not been followed.

- Justice Health medical and nursing staff at the centre were not aware of the policy that special transport certificates should only be valid for two months.
- Justice Health staff did not fax the certificate to Justice Health administration for approval by the director of clinical and nursing services, but placed it in the inmate's medical file.
- DCS officers did not contact the director of clinical and nursing services or the doctor at MRRC who issued the certificate to clarify the need to have the certificate reviewed or extended.
- A medical alert had been posted on OMS stating that the inmate was not to be transported by truck due to panic attacks and claustrophobia, so DCS officers should have been aware of the special transport need.
- Justice Health staff did not record whether they had sent the certificate to DCS.

As a result of this complaint, Justice Health and DCS have changed their procedures to ensure that inmates with special transport requirements are not placed in a van if there is a discrepancy with the medical certificate. Officers must now contact Justice Health to ensure they have the correct information before transport, especially in the event of transport at short notice when the inmate may not have the opportunity to obtain a certificate.

case**study**79

An inmate at Lithgow correctional centre called us after waiting for nine months to see a dentist. He had been told five times by the dental appointment line he was on the list to see the dentist. We asked Justice Health to look into the matter.

Justice Health agreed that the inmate had every right to complain. They could not work out what had happened to his appointment or how it had been cancelled. He was originally on the dental list but each of his five appointments were cancelled. Justice Health arranged for him to be seen the next day.

juvenile justice

our priorities

We continue to receive complaints about a wide range of issues from detainees of juvenile justice centres. See figure 38. This year our priorities continued to be detainee safety, access to education and training and family contact. The need to protect the physical and mental wellbeing of detainees is clearly important (see case studies 80, 81, 82 and 83). We consider that education and family contact are equally important because the detainees are children and young people.

We visit each of the nine juvenile justice centres in NSW twice each calendar year, talking to detainees and staff, examining centre records, inspecting the centres and looking at programs and activities.

record-keeping

We are still finding examples of poor record-keeping at some centres, despite recent changes of responsibility for ensuring the quality and accuracy of these records. The responsibility for unit based record-keeping used to lie with the centre manager, but has now been passed down to the residential unit managers and coordinators.

Poor record-keeping reduces accountability. One of the more common problems we have found is periodic observation records written in a way that suggests they have been written at a single sitting. This gives rise to the concern that observations on detainees at risk of harming themselves may not have been carried out properly. Poorly written use of force reports can also make it difficult to determine what happened in a serious incident.

case**study**80

On a visit to Cobham juvenile justice centre we were approached by a very distressed young detainee. He told us he had been threatened by a detainee who had moved into his unit that day. He took the threat seriously as he knew the detainee from another centre. The newly arrived detainee believed that the complainant had provided information about his alleged involvement in an assault on a young female worker at the other centre. The complainant told us he was so afraid that he had attended a sewing class that morning but would soon have to return to his unit with the other detainee.

We spoke to the unit manager who was amazed that the detainees had been placed together in the same unit. He immediately ordered the new detainee be moved to another unit and undertook to approach another centre to get the young complainant moved out of a potentially volatile situation.

case**study**81

A detainee at Frank Baxter juvenile correction centre called complaining that he had received a written threat against his life by another detainee. Although staff at the centre had reported the threat, the boy claimed that no steps were taken to ensure his safety in the interim.

We made inquiries and were told that centre staff viewed the boy as extremely manipulative. They explained that he had used various tactics to get what he wanted, including hunger strikes and requesting other boys assault him to assist with his transfer application. On the basis of this history, they felt that the alleged threat might be a new tactic so they did not believe that he was currently in danger. We were aware of some of his history as the boy had rung us many times throughout the year from various centres, making threats about hunger strikes and alleging threats by others. We had made inquiries on those matters at the time. Despite his history of making similar allegations we outlined to staff at Frank Baxter the danger of allowing a current threat to be dismissed solely on the basis of past behaviour. Senior centre management agreed that the boy might have sincere fears for his own safety, but put these fears down to his mental illness and paranoia.

During further conversations with centre management we received assurances from them that they would speak with the detainee about his concerns. They stated that they had fulfilled their obligations to ensure his safety as he already had additional staff support. We advised the centre that this assurance would be noted on our files and advised that it should also be recorded on theirs. Centres need to accurately and fully record any decisions about actions taken on alleged threats against detainees, even if they believe the person is 'crying wolf'. The mere act of recording reasons for decisions holds decision-makers to account and forces them to reflect on whether the decision is justifiable.

We advised the detainee to contact us if any assault was threatened or acted upon. No further complaints were received from the detainee about this issue.

case**study**82

A young Aboriginal detainee in a regional juvenile justice centre attempted suicide. Fortunately, due to the actions of the centre staff, he was unsuccessful. However the centre failed to notify the boy's family for several days. This meant they did not have contact with him immediately after this very traumatic event. We received a complaint from an Aboriginal legal service about the time taken to tell the family about the incident and the centre's failure to take adequate action to prevent the incident occurring.

During our initial inquiries we became concerned that centre management was seeking to justify their actions, rather than trying to resolve the legal service's concerns. We considered a more proactive approach should be taken to resolving the issues and provided a copy of our brochure about providing apologies.

Our initial inquiries with the centre were unsuccessful in achieving a resolution, so we wrote to the department about the matter. As a result the centre manager met with the boy's mother and a further meeting with a key staff member has been arranged. We are pleased that the department is actively seeking to resolve the problem but are concerned that the centre did not do so when the opportunity first presented itself.

We brought these matters to the attention of the Director General at a recent liaison meeting and asked him to consider auditing the quality and consistency of record-keeping on a regular basis. We will continue to monitor these record-keeping practices.

case**study**83

A female detainee contacted us to complain that the centre would not give her correct size underwear. She claimed that new underwear wasn't ordered until the old stock had run out and, at the moment, the centre only had large sizes which were too big for her.

We spoke to the assistant manager who agreed that this was unacceptable. She arranged for more stock to be ordered and took action to ensure that different sizes were always kept in stock.

case**study**84

We received a child protection notification that two workers in a regional juvenile justice centre had deliberately failed to intervene to prevent, and later stop, a fight between two detainees. The notification arose from a complaint made by the smaller of the two detainees who felt he had been effectively set-up by one of the workers. The Department of Juvenile Justice contracted an external investigator who found that the allegations were unsubstantiated. The department reviewed the report and decided that there was insufficient evidence to support the allegations.

We advised the department that the allegation did not involve reportable conduct under Part 3A of the Ombudsman Act. However, we requested a copy of the documentation relating to the investigation to assess whether the allegation amounted to wrong conduct by the youth workers.

The documentation showed that the investigation was highly flawed. The external investigator had completely ignored contemporaneous staff reports, given to him during the investigation, that supported the detainee's version of events. The records of interview indicated he also ignored basic good investigative practice. For example, he interviewed the subjects of the complaint before he interviewed the complainant and other witnesses, and he interviewed the complainant in the presence of one of the witnesses. It appeared to us that he had failed to interview other witnesses and failed to provide the investigative records required by the department's own policy. The apparent deficiencies in the investigation were such that we considered it highly possible that the outcome of the investigation had been affected. We were particularly concerned that the department did not pick up these deficiencies before making their decision.

We wrote to the department about our concerns and are currently waiting for their response.

issues arising from child protection notifications

Traditionally we have gained an understanding of individual problems within the juvenile justice system through complaints and our visits to centres. In recent years the Department of Juvenile Justice has had to notify us of certain child protection issues under Part 3A of the Ombudsman Act. Those notifications give us more information about the work of the department.

Case study 84 is a good example of the need for agencies to appoint suitable investigators – whether they be internal or external – and ensure their work is rigorously reviewed.

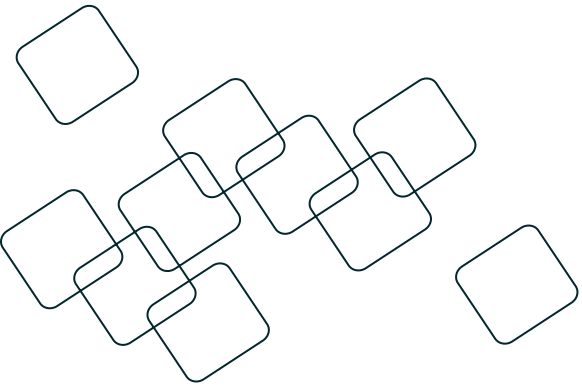
classification policy

We hold regular liaison meetings with the Director General of the Department of Juvenile Justice and senior staff as well as meeting with other staff to discuss specific issues. This year we have discussed the department's new classification policy. This policy has the potential to enable decisions about the placement of detainees within the system to be made on an objective and more consistent basis. We understand it is to be implemented in 2004 – 2005 and look forward to observing it in practice.

Figure 38: What people complained about - juvenile justice centres

This figure shows the complaints received about juvenile justice correctional centres, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Daily routine	1	70	71
Food and diet	0	45	45
Officer misconduct	5	31	36
Transfers	4	32	36
Visits	1	22	23
Fail ensure safety	3	19	22
Unfair discipline	0	21	21
Other	1	15	16
Property	0	10	10
Case management	0	9	9
Outside our jurisdiction	4	4	8
Segregation	1	7	8
Security	0	6	6
Work and education	1	5	6
Medical	1	4	5
Day/other leave/works release	0	4	4
Buy ups	0	3	3
Mail	0	3	3
Classification	0	2	2
Community programs	0	2	2
Information	1	1	2
Legal problems	0	2	2
Records/administration	2	0	2
Probation/parole	0	1	1
Child abuse related	0	0	0
Total	**25**	**318**	**343**



legislative review

We have a significant role in reviewing the implementation of new legislative powers by police and other government agencies. Although most of our legislative review work involves police officers and is carried out by our police team, the general team is undertaking two projects relating to the corrections area which we discuss in this section. Our other legislative review projects are discussed in chapter 6 - police team.

transfer of young people from juvenile justice to adult correctional centres

The *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001* commenced in January 2002, with a requirement that its 'operation and effects' be scrutinised by the Ombudsman for three years.

The Act was introduced to ensure that anyone convicted of a serious indictable offence as a child is transferred from a juvenile justice centre to an adult correctional centre by the age of 18 years, unless the court considers there are special circumstances that justify them staying in juvenile detention. No juvenile offenders sentenced since the start of the Act are eligible to stay in a juvenile justice centre beyond the age of 21 years.

Our review included:

- interviewing detainees before and after they transferred from juvenile detention to adult correctional centre
- interviewing departmental staff and other stakeholders
- monitoring information about detainees and inmates provided by the Departments of Juvenile Justice and Corrective Services
- examining detainee and inmate case management files
- checking court transcripts, particularly for sentencing submissions and comments by judicial officers.

In April 2004 we released a discussion paper asking for submissions from key stakeholders and the public. This prompted 21 submissions from various departments, organisations and individuals.

The review period ends in early 2005 and we will then prepare a report on the outcome of our review.

correctional officer powers and the parole board

The *Summary Offences Amendment (Places of Detention) Act 2002* and the *Crimes (Administration of Sentences) Amendment Act 2002* came into operation in February 2003.

The first amendment:

- 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.

The second amendment gives victims of serious offences the right to make an oral submission to the parole board when the offender is being assessed, without having to get prior approval from the board.

We are reviewing the operation of the amended legislation for two years. So far we have:

- examined information and documents from the courts and the Department of Corrective Services
- visited a number of correctional centres
- observed correctional officers stopping, searching and detaining people entering correctional centres
- interviewed staff from the Department of Corrective Services and GEO Pty Ltd, the company that manages Junee correctional centre
- sent a questionnaire to the governor of each correctional centre.

We have also:

- observed a number of parole board hearings
- conducted interviews with various stakeholders, including victims groups
- surveyed members of the parole board.

We will issue a discussion paper in 2004-2005 raising some of the issues that have emerged from our review and ask for submissions from those who have an interest in the implementation of these two pieces of legislation.

freedom of information

our role

We have a role under the *Freedom of Information Act 1989* (the FOI Act) to 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.

FOI applications are made by members of the public wanting to access information or amend records of personal information held by the agencies. It is an area that can become highly politicised, particularly when interest groups and political parties use the FOI Act to obtain information from government agencies. We do not perform our functions for political reasons. 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 finalised 129 written complaints. Most of the matters were either finalised on the basis that there was no or insufficient evidence of wrong conduct or were resolved 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 identified.

The majority of complaints we received in 2003-2004 were about agencies refusing access to documents. People also complained about a range of other matters including incorrect procedures and charges. See figure 40.

In some cases we do not find fault with the way the agency has handled the FOI application concerned, but we do uncover other deficiencies in their decision-making and systems. See case study 85 for an example.

Figure 39: Five year comparison written complaints about freedom of information received and finalised

	99/00	00/01	01/02	02/03	03/04
Received	158	137	138	140	139
Finalised	139	188	157	145	129

Total complaints received in 2003 - 2004

Oral	309
Written	139
Total	**448**

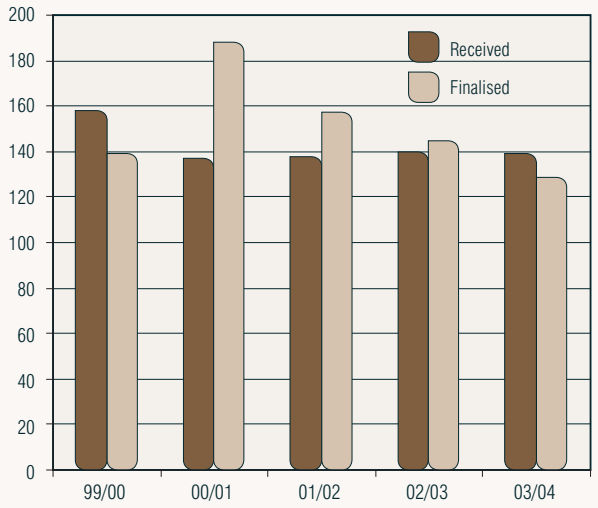


Figure 40: What people complained about - freedom of information

This figure shows the complaints finalised by the general team about freedom of information, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Written	Oral	Total
Access refused	80	37	117
Pre application enquiry	0	65	65
General FOI enquiry	0	61	61
Agency enquiry	0	60	60
Wrong procedure	26	17	43
Pre internal review enquiry	0	32	32
Documents not held	9	10	19
Charges	9	8	17
Third party objection	4	4	8
Amendments	4	3	7
Documents concealed	2	4	6
Information	1	4	5
Outside our jurisdiction	4	1	5
Documents lost	0	2	2
Documents destroyed	0	1	1
Investigation/prosecution misconduct	0	0	0
Other misconduct	0	0	0
Total	**139**	**309**	**448**

casestudy85

In 2001 the former Minister for Education and Training announced that he intended to close Beacon Hill High School. At the same time he advised of his intention to close various other schools, including Hunters Hill High. Beacon Hill High closed at the end of 2002. A parent of children attending Beacon Hill High was concerned that the Department of Education and Training (DET) had not followed the proper process to close the school and applied under FOI for all documents relating to the decision. She complained to us about DET's handling of her FOI application as she believed she had not been given all the documents she requested.

We found that DET had released all the documents the applicant had asked for, but we discovered several deficiencies in the way they had handled the school closure.

Section 28 of the *Education Act 1990* sets out a procedure that must be followed (except in particular circumstances) before a government school can be closed by the Minister. The section requires an open process that allows the parents who will be affected by a school closure the opportunity to have that decision reviewed by a 'school closures review committee'.

Section 28(3) requires the Minister to establish this committee and write to the principal and president of the parents organisation of each school to tell them of the proposed decision to close the school. If the majority of parents write to the Minister within a certain time asking for the decision to be reviewed, the committee must review the decision and make recommendations to the Minister.

DET's documents indicate that a letter had been sent to the principal of Beacon Hill High on 14 June 2001, but there was no evidence to show that any letter had been sent to the parents organisation. A small public notice had been put in the *Sydney Morning Herald* on 15 June 2001, just above a separate public notice advising of the Minister's intention to close six other schools. Another notice had been put in the *Daily Telegraph* that day advising of the Minister's intention to close the six other schools, but this did not list Beacon Hill High.

We believe Beacon Hill High parents did not have a chance to ask for the decision to be reviewed because they were not given sufficient notice of the Minister's decision.

DET claimed that this was not the case — that in fact the committee had been set up to complete any reviews requested in relation to all of the school closures that had been announced at that time. They acknowledged that it would have been better practice for the documentation relating to the committee to have mentioned Beacon Hill High.

DET also claimed that, in any event, they had not been under any obligation to comply with s. 28 because s. 28(10) provides that the procedure outlined in the section does not apply if the majority of the parents of children attending the school approve of the closure, and they believed that this was the case in relation to Beacon Hill High. We found that none of DET's documents on this matter contained any evidence to support this view.

DET acknowledged that there had been problems with the way they went about closing Beacon Hill High and that this was similar to the closure of Hunters Hill High School.

We wrote about the closure of Hunters Hill High in last year's annual report (see case study 37). As DET had taken steps to improve their procedures after our investigation into Hunters Hill High, and as Beacon Hill High had been closed for well over a year, we decided to take no further action. The complainant advised us they intended to take action to stop the school site being developed or the existing school buildings cleared in the hope that the land could be used for a public purpose or the school eventually reopened.

casestudy86

A complaint was made to us by the CEO of Business Central Coast (BCC). BCC was set up by Wyong and Gosford Councils and the NSW government to stimulate economic growth, employment prospects and tourism in the central coast area. They complained to us about a FOI determination by Gosford Council to give the *Central Coast Herald* access to minutes of meetings of the BCC held in 2002. The *Herald* claimed that these minutes could indicate the BCC had not lived up to its public responsibilities.

The *Herald* had previously complained to us about Gosford Council refusing to give access to minutes of earlier meetings of the BCC. In that case, at our suggestion, Gosford Council had agreed to release the minutes.

The BCC argued that the minutes of their 2002 meetings should remain exempt for various reasons. They contained sensitive information that was commercial in confidence, the meetings were not open to the public and the public could not inspect the minutes. We agreed with council's determination to release the minutes and felt that disclosure would enhance the accountability and transparency of the BCC.

We could find no sensitive commercial in-confidence information in the minutes. We also noted that the minutes apparently showed that the BCC did not appear to have always met the obligations of their charter. We made clear our view that it was generally contrary to the public interest for unsatisfactory conduct of a publicly accountable agency to remain secret. We took no further action about the complaint, but advised the BCC of their right of appeal to the Administrative Decisions Tribunal (ADT).

implementation of the FOI Act

We conducted our seventh audit of FOI reporting by reviewing agency annual reports for 2002-2003. The results of this review are available on our website www.ombo.nsw.gov.au.

Our audit showed that, while the numbers of FOI applications reported to have been made to audited agencies has increased significantly since 1995-1996 (by 45%, from 8,328 to 11,937), the percentage of applications approved in full has decreased significantly (by approximately 16%) over the same period. In 1995-1996 audited agencies reported fully disclosing documents in over 80% of cases, but by 2002-2003 this had fallen to only 51%. 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 numbers of matters refused in full remained largely the same.

We also found that agency compliance with mandatory 'summary of affairs' reporting requirements in June 2004 was at its lowest since our audits began in June 1997.

review of the FOI Act

Since the early 1990s, most Acts have included a standard provision requiring the responsible Minister to review the Act after a maximum of five years. The FOI Act commenced on 1 July 1989 and has now been in operation for 15 years, but it has never been reviewed.

For over 10 years, we have been calling for a comprehensive review of the Act by a current or former judicial officer with wide terms of reference.

The world has changed significantly over the past 15 years. Technology has advanced, government does its business very differently, and members of the public have different expectations from public sector agencies. Many agencies have moved to electronic record-keeping systems, some agencies share their corporate services and others share databases.

Under the FOI Act, documents held by public sector agencies can be accessed and scrutinised by members of the public. The original scheme assumed that most agencies kept paper records and only held information about matters concerning their own business.

Numerous amendments have been made to the Act to try to adapt it to changing circumstances. Parliament has taken a piecemeal approach, resulting in a fragmented Act that does not provide consistency or proper guidance for those trying to implement it, and is not effective in keeping agencies accountable to the public.

Since 1989:

- The FOI Act has been amended by 48 Acts of Parliament.
- Nine of the original 71 sections have been repealed (including six substituted with new provisions), seven new sections have been added and 23 sections have been amended.
- The original Schedule of 20 exemption clauses has now grown to 25, not including the expansion of various exemption clauses to cover new classes or kinds of documents eg cl 4(3A), (3B), cl 18(2) and cl 20(1)(c),(d),(e), (f), (g), and the inclusion of exempltions in other legislation.
- The original list in Schedule 2 of seven bodies and offices that were wholly or partially exempt from the provisions of the Act has grown to 24.

The other compelling reason for a review of the Act is that there are now several separate and largely inconsistent schemes under which members of the public can access information held by public sector agencies. These schemes have been established under:

- the FOI Act
- the *Privacy and Personal Information Protection Act 1998* (ss.13-15)
- the *Health Records and Information Privacy Act 2002* (clauses 6-8 of Schedule 1) which came into operation on 1 September 2004.
- the *Local Government Act 1993* (s.12)
- the *State Records Act 1998*

We have outlined in previous annual reports the confusion and practical difficulties these different schemes create for both members of the public and public sector agencies. This year we have also dealt with complaints about councils exploiting this confusion by advising people to apply for access to documents under the FOI Act, under which they can charge an application fee, rather than telling them that they have a right under the Local Government Act to access those same documents free of charge.

These schemes need to be rationalised so that members of the public have a clear and practical way to access information held by public sector agencies. The Privacy and Personal Information Protection Act is currently being reviewed and the Health Records and Information Privacy Act has just commenced. We therefore believe that the coming year is an ideal time to review all of the access-to-information regimes, including the FOI Act.

deficiencies in complying with the FOI Act

failure to make a determination

A number of complaints this year involved an agency's failure to make a determination – to tell people the outcome of their FOI application. In all cases applicants had paid the application fee and in one case the applicant had paid a substantial advance deposit.

In some cases the agency concerned misunderstood their obligations under the FOI Act. Some believed they had dealt with the matter in another way and there was no need to make an FOI determination. In one case, the agency did not hold any documents relating to the application.

The FOI Act requires agencies to notify applicants in writing of the determination of their FOI application. They must also tell applicants if they don't hold the document or documents covered by the application.

case**study**87

We received a complaint from a former police officer who had made a review application to the ADT in relation to an FOI application to NSW Police. In their decision, the ADT had expressed concerns about the way in which NSW Police carried out searches for documents applied for under FOI.

In August 2003 the Auditor General reported on their freedom of information performance audit of the Ministry of Transport, the Premier's Department and the Department of Education and Training. We recognised that the Auditor General's recommendations about how agencies should search for documents could help NSW Police improve their systems. We wrote to the Police Commissioner requesting that they implement those recommendations.

We also asked the Commissioner to write to all region and specialist commanders emphasising the need for NSW Police to be open and cooperative with their FOI unit in their inquiries about documents requested under FOI. The Commissioner agreed to implement all our suggestions. This not only resolved the complaint but should lead to a better outcome for members of the public who make FOI applications to NSW Police in the future.

case**study**88

In August 2003, the *Daily Telegraph* applied to the Metropolitan Local Aboriginal Land Council for access to documents showing any grants to the boxer Anthony Mundine for the previous six months. The *Telegraph* got an acknowledgment from the land council advising that their application had been received, but no further correspondence. When the *Telegraph* rang the land council to find out about the progress of their FOI application, they were told to ring a firm of solicitors representing the land council. When they did so, they received no useful information on the progress of the application so they wrote to the land council applying for an internal review.

When they received no response they complained to us. We wrote to the land council requesting information about the delays. We also asked if the documents applied for were in fact held and, if so, whether they could be released. In response, the land council advised the *Telegraph* that they did hold contract documents between Anthony Mundine's representative company, Black Venom Investments Pty Ltd, for a grant of $20,000 for the land council's logo to be displayed during a fight between Mr Mundine and Antwon Echols in 2003.

The *Telegraph* was happy with this information and the complaint was resolved.

We were concerned about the land council's claim that they would not release these contract documents because their legal advice was that the documents were exempt. We told them that any such decision should only be made in a proper determination under the FOI Act and suggested they apologise to the *Telegraph* for the delay and lack of response in dealing with their FOI application.

case**study**89

A journalist complained about the former Tallaganda Shire Council's handling of his FOI application. He had applied for documents relating to funding for road works in the shire in the early 1990's. The council refused him access to all documents, claiming that dealing with the application would unreasonably divert resources from their normal day-to-day functions.

When we raised the matter with council, the general manager could only identify two pages covered by the journalist's FOI application. We were of the view that council's reason for refusing access was therefore unjustified. The general manager agreed to release these two pages which resolved the complaint.

case**study**90

We received a complaint from a manager of a shipping firm that operates a vessel that formerly shipped goods to Lord Howe Island. When it was servicing Lord Howe Island several years ago, the complainant's ship spilt about five litres of engine oil into the island's waters. All the oil was trapped and apparently caused no environmental damage.

The complainant's shipping firm was subsequently prosecuted under the *Marine Pollution Act 1987* for the oil discharge. The firm defended the case as they argued the spill occurred as a result of wear and tear to oil hoses and pipes and not because of negligence. The original Land and Environment Court hearing found the firm had caused the oil spill, but ordered no penalty based on the wear and tear argument. The state of NSW appealed this decision to every higher court, including the High Court. All the courts ruled that the shipping firm should not be penalised because of the wear and tear argument and the fact that the oil spill was so small and no damage occurred. The complainant claimed that the legal action against his firm was taken for improper reasons, but the state claimed it was pursuing the matter as it was concerned about setting a precedent. A party that caused a major oil spill resulting in environmental damage in the future might try to rely on this wear and tear argument. The various legal appeals by the state cost hundreds of thousands of dollars.

The complainant applied under FOI for all documents held by the Waterways Authority detailing the state's costs in pursuing the case against his firm. Waterways exempted most of the documents under the personal and business affairs and internal working documents exemption of the FOI Act. They argued that their legal costs and those of their barristers and solicitors would be an unreasonable disclosure of their and the lawyers' affairs, as well as an unreasonable disclosure of internal working documents.

We met with Waterways and argued that it was in the public interest for such legal costs to be released. It would not be unreasonable for the public to know what barristers and solicitors had charged Waterways during the litigation. Waterways agreed to change their determination, release all their own costs and give any dissatisfied private lawyers their right of appeal to the ADT. This resolved the complaint to our satisfaction.

inappropriate use of exemption clauses

Under s. 25(1) of the FOI Act, an agency may refuse access to a document if it is an 'exempt document' - that is, a document listed in Schedule 1 to the Act. Section 25(4) makes it clear that an agency must not refuse access to an exempt document if it is practicable to give access to a copy of the document with the exempt matter deleted and it appears that the applicant would wish to be given access to this copy.

The underlying purpose of Schedule 1 is to give agencies some guidance about the kinds of documents that it may be in the public interest to keep confidential. However, the Act specifically does not require agencies to keep documents confidential if they are listed in Schedule 1. It is up to the agency themselves to decide what is in the public interest in each case. Our view is that agencies should initially assume it is in the public interest to provide access to all documents - including exempt documents - and only refuse access if it is in the public interest in the particular case to do so.

This year we dealt with a number of complaints from people disputing an agency's decision to refuse access to a document on the basis that it was an exempt document. In some cases the agency concerned had not properly assessed what would be in the public interest in making their decision, and simply relied on the document being exempt.

We found that agencies most frequently relied on the following clauses in Schedule 1 to claim that the documents sought were exempt:

- clause 9 - internal working documents
- clause 6 - documents relating to personal affairs
- clause 13(b) - documents containing confidential information
- clause 4 - documents affecting law enforcement and public safety
- clause 10 - documents the subject of legal professional privilege
- clause 7 - documents relating to business affairs.

clause 4 – law enforcement and public safety

In some cases agencies have relied on clause 4 to refuse access to documents relating to investigations without considering whether there was likely to be any adverse effect on the process of justice or a risk to public safety or property if the documents were released. We believe that documents relating to an investigation should generally be released if:

- the investigation has been finalised
- the subject matter was not sensitive
- the investigation dealt with subjects that have changed or have ended
- there is no evidence of likely prejudice to the process of justice
- there is no evidence of possible danger to the public or property.

clause 7 – business affairs

Some agencies have relied on clause 7 to refuse access to a range of documents containing information that in some way relates to the business, professional, commercial or financial affairs of a person or agency, without properly assessing the public interest. In most cases we feel it would be in the public interest that such information is released.

We believe that documents should generally be released if:

- they contain information about so-called 'trade secrets' that are not in fact secret
- the commercial value of the information is not demonstrated
- the claims about the business, professional, commercial or financial affairs of parties is based on speculation or conjecture
- the agency cannot demonstrate a reasonable expectation that disclosure would adversely affect those affairs
- the agency cannot demonstrate how the future supply of such information to the government would be prejudiced.

failure to provide detailed reasons

During the year we dealt with several complaints about determinations where the agency did not give specific reasons why access was refused, but just restated or quoted from an exemption clause in Schedule 1 to the FOI Act.

Section 28(2)(e) of the FOI Act requires agencies to:

- give reasons why release has been refused in each particular case
- specify their findings on any material questions of fact underlying the reasons
- refer to the sources of information on which the findings are based.

agency resources

Delays by agencies in dealing with FOI applications are not uncommon, but sometimes we become particularly concerned.

It seems that some agencies are failing to allocate appropriate levels of staff and resources to their FOI units. This not only affects their accountability but also disadvantages the public and places great stress on existing FOI staff. We have recently become aware of two large agencies that have actually reduced the number of staff within their FOI units.

FOI and open government will only work when agencies properly resource the areas that deal with FOI applications.

During the year we raised these concerns with NSW Police. The numbers of FOI applications made to them has increased by around 40% each year over the last three years – from 2,920 in 2001-2002, to 5,000 in 2002-2003 and 8,505 in 2003-2004. If this increase continues, the projected number of applications for 2004-2005 will be around 11,500.

Although there has been a significant increase in the last 18 months in the numbers of applications processed each month, we are still concerned about their capacity to cope with the increasing numbers of applications.

We met with and then wrote to the Commissioner of Police to raise our concerns. We also prepared comparative information about FOI resourcing in a range of NSW agencies and the Victorian Police - they also experienced an increase in FOI applications by around 40% last year. While there are differences in the nature of the information held by agencies which affects the amount of time required to process FOI applications, it is still interesting to compare the approximate number of applications dealt with in a year by individual members of staff in each organisation.

Department of Health	56.5
Department of Community Services	63.5
Department of Corrective Services	200
Victoria Police	236
Workcover	303
NSW Police	**1186**

At time of writing we are awaiting the Commissioner's response.

Over the coming year we will continue to examine FOI complaints to see if unreasonable delays in dealing with FOI applications are due to inadequate resourcing.

casestudy91

A legal firm representing a waste disposal worker employed with Fairfield Council applied under FOI for various documents relating to his employment, in particular about his worker's compensation claim. Council referred the application to their private legal advisers. They wrote to the FOI applicant asking for details about the section of the FOI Act that was being relied upon to seek access to the documents, and also noted that all costs in dealing with the FOI application would need to be reimbursed.

We believe that the approach adopted by council's legal advisers was in breach of the FOI Act and contrary to the public interest. We contacted council to raise our concerns and to advise that the FOI Act required them to make the determination on the FOI application. In response, council reviewed the matter and agreed to release all the documents to the applicant.

Council's legal advisers stated they did not consider such documents should be released under FOI and were only doing so under direction by council.

the protection provisions of the FOI Act

We have recently written to the Premier raising our concerns about the scope of the protections against defamation in s. 64 of the FOI Act. If an agency gives access to a document under the FOI Act, that could be taken to be a 'publication' of the document under the *Defamation Act 1974*. This means that potentially a person could sue the agency or the author of the document for defamation over words in the document. Section 64 essentially provides that no action for defamation can be brought against the agency or the author of the document in such a case.

Our concerns about the effectiveness of s. 64 have recently been brought to a head by several court proceedings arising out of a disclosure of information under the FOI Act.

The document concerned was a letter that Mr Les Burden wrote to the then Minister for Police in 1993 urging him to investigate certain issues he claimed had arisen in court proceedings involving Mr Leonard Ainsworth. At the time Mr Burden was working as a consultant with NSW Police.

Some years later Mr Ainsworth applied to NSW Police for access to certain documents under the FOI Act. These documents included Mr Burden's 1993 letter.

NSW Police released the letter without first consulting Mr Burden as required by s.31 of the FOI Act.

After Mr Ainsworth read Mr Burden's 1993 letter, he lodged a statement of claim suing Mr Burden for damages in defamation. The substance of this case has yet to be heard, but the matter has already been the subject of five actions in the NSW Supreme Court, two appeals to the NSW Court of Appeal and one application to seek leave to appeal to the High Court (which failed).

These proceedings raise an important matter of principle. In one of those court proceedings, *Ainsworth v Burden* [2002] NSWSC 620, Justice Simpson made the following observations:

'…the purpose behind the Freedom of Information Act supports the notion that the author of a document is protected in respect of the original publication of that document, where the plaintiff comes into possession of the document as a result of the Freedom of Information Act . This simply means that the legislature determined that the Freedom of Information Act would not become a source of material to be used against individuals providing information to government Ministers or agencies; and that such persons should not be deterred, by reason of the Act, from doing so.' (at 15)

We believe that it is clearly in the public interest that members of the public are able to write to government agencies and ministers without fearing that they might be sued for defamation for what they say. One of the objects of the Defamation Act itself is 'to ensure that the law of defamation does not place unreasonable limits on the publication and discussion of matters of public interest and importance.'

We have recommended that the Premier give serious consideration to amending s. 64 of the FOI Act to provide absolute protection against defamation proceedings being brought against the author of a document sent to a government agency or Minister. We are awaiting a response.

reduction in FOI processing fees

If someone makes an FOI application for documents that do not relate to their personal affairs, the agency is entitled to ask for processing fees of $30 per hour. Depending on the number and complexity of the documents the applicant has requested, this can result in a rather expensive FOI application.

Under the Freedom of Information (Fees and Charges) Order 1989, agencies must give a 50% reduction in fees and charges to applicants who have asked for documents that contain information which it is in the public interest to make available.

The Ombudsman's FOI Policies and Guidelines and the Premier's Department's FOI Procedure Manual set out factors that should be considered by agencies in deciding whether to give this reduction.

Some of these factors are:

- whether release of the documents would further the objects of the FOI Act
- the capacity of the applicant to use the information requested in a manner that furthers the public interest
- the level of value or benefit that will extend to the public if the documents are released
- whether the release of the documents or information is likely to benefit a small or large section of the public - the wider the section of the public that is likely to benefit by release of the information, the greater the public interest will be in the reduction being given.

We dealt with a recent complaint about RailCorp from a journalist who applied under FOI for documents and was asked to pay the full processing fee. One reason RailCorp gave for refusing a 50% reduction was that the journalist represented a commercial media outlet that was seeking the information for commercial gain.

If RailCorp's reasoning was correct, it would appear that only media organisations such as the ABC and SBS would be granted the reduction.

We disagreed with their reasoning. Our view is that the appropriate test was whether it was in the public interest for the information in the requested documents to be released. As a result of our involvement RailCorp changed their view, granted the fee reduction and released various documents to the journalist.

The Premier's Department's view on this issue is outlined in its FOI Procedure Manual, which states that a fee reduction should not be automatically granted by agencies to MPs and journalists for that reason only. An agency will need to make its own assessment of what is in the public interest.

We also received a complaint from an MP who was seeking documents from an agency relating to funding for certain of its functions and units. The MP concerned claimed she had reliable information that certain funding within this agency was improperly allocated from one unit to another. The agency refused to give her a fee reduction, claiming her position as an MP did not automatically entitle her to it and her FOI application had not been made in the public interest.

While we do not know whether the MP's suspicions were valid, there is clearly a public interest in MPs or any other member of the public being able to check if funding within an agency has been properly allocated.

We are concerned that if appropriate fee reductions are not granted, accountability and transparency of government may suffer. Overly and unreasonably expensive FOI applications are not in the public interest and do not promote the objects and spirit of the FOI Act.

FOI manual

In 1998 we agreed to produce a joint FOI procedural 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. Last year we reported that we hoped to have this publication finalised and published before the end of 2003. However, the completion of this project has taken longer than expected due to the pressure of work in The Cabinet Office, and we anticipate that it will be available in 2004-2005.

casestudy92

We dealt with a complaint from a property owner in North Sydney who had been taken to court on numerous occasions by North Sydney Council for failing to pay her rates and other issues. She applied to the council under FOI for documents about council's legal action against her, many of which council provided. However council refused to give her documents detailing legal costs arising out of their litigation against her. Council claimed these documents were subject to legal professional privilege, based on legal advice from a prominent law firm.

We were concerned about council's decision, particularly as they were seeking an order for costs against the applicant. In our view it was inappropriate for a public sector agency, such as North Sydney Council, to rely on legal professional privilege to keep secret the amount of public money they spend in taking legal action against any person or organisation.

We started a formal investigation and, in our final report, recommended that all documents relating to legal costs incurred in proceedings against the applicant should be released. We also recommended that council stop relying on the legal advice they had received which claimed that legal costs are subject to legal professional privilege. We also found that council had breached the Local Government Act 1993 by failing to publish in their last three annual reports the details of the legal cases taken against the complainant and the costs to council in those cases.

As a result of our report council released all relevant documents, acknowledged that legal costs were not subject to legal professional privilege, and agreed to publish the details of legal costs and legal cases in future annual reports.

protected disclosures

This year was the tenth anniversary of the *Protected Disclosures Act 1994*. For almost a decade, public sector whistleblowers in NSW have had statutory protection if they come forward to complain about the state of affairs inside their own workplaces.

Whistleblowers are important to workplaces. They are often best placed to see what is going wrong inside an organisation and, by bringing these problems to light, they give organisations the opportunity to fix things and improve their service to the public.

Whistleblowers should be encouraged to come forward. These kinds of actions are part of being a responsible and effective employee. Indeed, many employees draw attention to organisational problems as part of their day-to-day responsibilities – they are called supervisors. However if people make criticisms about a colleague, or skip a link in the chain of command to make a complaint, they are often called 'dobbers' or troublemakers. Many people do not speak up for fear of being labelled or suffering reprisals.

In 1994, the NSW Parliament attempted to change the culture inside the public sector by introducing a scheme through which people could report corruption, mismanagement and waste - and not suffer reprisals. Our experience with the scheme established by the Protected Disclosures Act is that it has not achieved its original objectives.

In April 2004 we published an issues paper called *The Adequacy of the Protected Disclosures Act to Achieve its Objectives* (discussed later in this section). We hope that this paper will generate discussion about this important issue and prompt a review of the Act that leads to improvements to the scheme.

Our work with protected disclosures includes:

- investigating and resolving complaints by whistleblowers
- providing agencies with advice, guidance and training in how to deal with these kinds of complaints themselves
- working with the steering committee to monitor the implementation of the Act
- making suggestions to the government about ways the scheme might be improved.

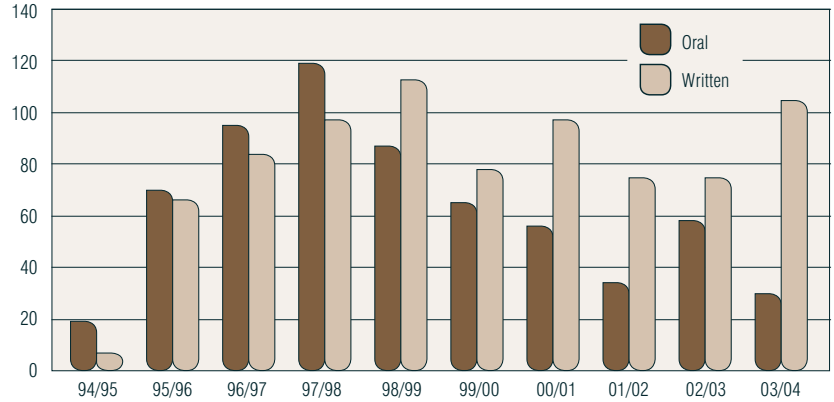
handling complaints

Since the Act came into operation on 1 March 1995, we have received a total of 1430 complaints - 633 oral complaints and 797 written complaints. Figure 41 shows how the number of complaints has fluctuated over that time, with a peak in the two years 1997–98 and 1998-99. This year we received 105 written complaints, 30 more than last year.

We handle complaints made by public sector staff about maladministration, but a large part of our work is investigating or trying to resolve complaints about the way that agencies have handled protected disclosures. For example, see case study 93. One problem that we have encountered is agencies who have not treated complaints as protected disclosures where it appears they should have. Case study 94 is an example of how a situation can escalate if a complainant is not kept informed and their concerns are not treated seriously. Handling complaints at least in the spirit of the Act can help avoid this kind of situation. Also see our discussion of an investigation into the University of NSW under 'universities' and case study 40.

Figure 41: Protected disclosures received - ten year comparison

	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	Total
Oral	19	70	95	119	87	65	56	34	58	30	633
Written	7	66	84	97	113	78	97	75	75	105	797
Total	**26**	**136**	**179**	**216**	**200**	**143**	**153**	**109**	**133**	**135**	**1430**



Note: The Act commenced on 1 March 1995 so for the year 94/95 the figure shows the numbers of complaints received during the 4 month period 1 March 1995 - 30 June 1995.

case**study**93

An employee of a government agency internally reported an allegation of corrupt conduct against colleagues. The report constituted a protected disclosure under the Protected Disclosures Act but the agency did not identify this.

We made inquiries and found that the agency had an internal reporting policy, but did not have adequate systems in place to ensure that the policy was complied with. There was also limited awareness of the policy among staff.

We conducted an information session with key staff from the agency. We explained the benefits to the agency, staff, clients and the public of protected disclosures being encouraged, identified and promptly investigated. We provided advice as to how to best manage and investigate protected disclosures, and are providing ongoing advice to the agency about their investigation of the protected disclosure in question.

The agency has more readily identified subsequent protected disclosures and investigated them more promptly and efficiently. We are satisfied that the agency appreciates the objectives of the Act, but we consider that they still need to educate staff about their internal reporting policy and actively encourage them to make protected disclosures where appropriate.

providing training

We are encouraged by requests from agencies this year for us to train their managers on how to best manage protected disclosures. In 2003-2004, we provided training to staff from the Department of Juvenile Justice, State Rail / RailCorp and the Attorney General's Department.

We also gave several presentations on the topic of whistleblowing to, for example, a visiting delegation from the Legislative Bureau of the House of Councillors of the Japanese Parliament, the Institute of Internal Auditors, and the 4th Regional Anti Corruption Conference for Asia-Pacific in Kuala Lumpur.

confidentiality

Over the past ten years we have significantly altered our views on the best way for agencies to protect whistleblowers. The long held and widespread view has been that confidentiality is the best protection. If no one knows you have come forward, you cannot suffer reprisals. The requirement to keep a whistleblower's identity confidential is one of the core provisions of most whistleblower legislation - it is also often the first thing that whistleblowers themselves ask for.

There are three main things that may be kept secret. These are the fact of the disclosure, the identity of the whistleblower and the allegations themselves, including the names of the individuals concerned. In some cases it may be possible to keep all three confidential and still handle the disclosure effectively. This certainly provides the best protection for the whistleblower.

case**study**94

A teacher at a TAFE college made allegations to a TAFE director about his supervisor. He alleged corruption, maladministration and bullying. In particular he alleged that the daughter of the college director had been employed in a position which had not been advertised, for which others were better qualified and for which she was paid at an inappropriate rate.

The allegations were investigated by the Department of Education and Training (DET) but the matter was not treated as a protected disclosure. The department found that although the employment of the daughter of the college director could have been managed better, there was no evidence of corruption or serious maladministration. They took some action to pay the daughter at the appropriate rate.

The teacher complained to us that after he made these allegations he was forced to transfer to another TAFE college against his wishes. He believed that this decision constituted detrimental action for making a protected disclosure.

Although he successfully appealed the decision and was transferred back to the original college, we were nevertheless concerned about the way DET had handled the teacher's complaint. During our inquiries we found no documentation indicating why DET had decided not to treat the matter as a protected disclosure or to show that the teacher had been given reasons for this decision. We also found he had not been consulted or given clear reasons for his transfer. This has caused the teacher some distress and he continues to have concerns about his work environment.

We felt that the matter could have been much better managed and told DET that:

- we disagreed with their assessment that the allegation should not be treated as a protected disclosure, since it raised an issue of potential corruption
- at the very least they should have recorded the reasons for their decision.

Importantly, the teacher should have been given clear reasons why his complaint was not being treated as a protected disclosure and why he was being transferred.

We advised DET that, given the history of this matter, they should take steps to make sure that the teacher was not subjected to victimisation, harassment or detrimental action on his return to work at the original TAFE college.

In practice, however, there are two main problems with expecting confidentiality to protect a whistleblower from retribution.

- Firstly, an agency may not be able to realistically guarantee confidentiality. The choice may be between doing nothing and ensuring confidentiality, or doing something and breaching confidentiality. It is sometimes difficult to even make preliminary inquiries without alerting other staff to the fact that allegations have been made. This alone is often enough for the identity of the whistleblower to be disclosed or guessed. Also, to ensure procedural fairness, anyone who is the subject of allegations should be given an opportunity to answer them. This will of course reveal both the fact of the disclosure and the allegations themselves. It may also be difficult if the whistleblower has previously raised their concerns publicly.
- Secondly, even if the agency is able to take all measures to ensure confidentiality, there is no way they can know for sure if those measures have succeeded. They may not be aware that revealing some information may be enough to identify the whistleblower to others.

Our new approach is to suggest different ways of handling protected disclosures depending on whether the agency thinks confidentiality is likely to be maintained. We discuss these issues in detail in the 5th edition of our *Protected Disclosures Guidelines* published this year. In the guidelines we outline:

- the minimum steps agencies should take in relation to all protected disclosures
- the approach to take where confidentiality is a reasonable and practical option
- the options available if maintaining confidentiality is not realistic.

If confidentiality is not a realistic option, we recommend pro-active intervention. This is where the disclosure and its author are acknowledged and management takes adequate steps to actively support and protect the whistleblower [see paragraph 1.5.3 in Part C of our guidelines].

The guidelines are available from our office or on our website at www.ombo.nsw.gov.au.

a review of the Act

The Protected Disclosures Act was assented to on 12 December 1994 and was required to be reviewed within 12 months and then every two years after that (s. 32). Only two of the six reviews that should have been conducted have been undertaken. Of the 33 recommendations made in the reports of those two reviews, only nine have been fully implemented and three partially implemented.

In anticipation of the next review, we undertook a project to compare and contrast all whistleblower legislation currently in force in Australasia. Our review included:

- comparing the various types of provisions in the legislation
- identifying alternative approaches to common issues
- ranking the scope of each Act on the basis of a range of measures
- surveying the experience in each jurisdiction.

We looked at all the information available to assess the adequacy of the Protected Disclosures Act to achieve its objectives and found several deficiencies. In an issues paper called The *Adequacy of the Protected Disclosures Act to Achieve its Objectives,* we discussed our findings and provided options to address the deficiencies identified. This paper was distributed widely to government agencies and other interested parties and is available on our website at www.ombo.nsw.gov.au.

We believe that whistleblower legislation will only be effective if it can:

- protect whistleblowers
- ensure their disclosures are properly dealt with
- facilitate the making of disclosures.

Some of the deficiencies we found with the Protected Disclosures Act are:

- there is no obligation on senior management to protect whistleblowers or establish procedures to protect whistleblowers
- there is no central agency responsible for monitoring how well the scheme is working - this includes collecting data on how many protected disclosures are being made to particular agencies, how many have been made since the Act commenced, and how those disclosures are being handled
- it is the only Australasian whistleblower legislation in which the whistleblowers themselves have no direct right to seek damages for detrimental action.

The government has since called for the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission to conduct a further review of the Act. We hope that the concerns we raised in our issues paper will be considered in that review.

working with the steering committee

Our Deputy Ombudsman, Chris Wheeler, is the chair of the Protected Disclosures Act Implementation Steering Committee. This committee was set up in 1996 to encourage and facilitate the disclosure of corrupt conduct and other forms of misconduct by strengthening the scheme established by the Act. The other members of the committee are representatives from the Independent Commission Against Corruption, the Audit Office of NSW, the Police Integrity Commission, the Department of Local Government, NSW Police (Internal Witness Support Unit) and the Premier's Department.

In November 2003 the committee provided a report on its activities for the period 2000-2003 to the Premier. These activities include providing advice, guidelines and training to agencies and successfully lobbying the government to improve the scheme via legislative amendments.

In April 2004 the committee also wrote to The Cabinet Office requesting the following amendments to the Act.

- An amendment to s.12B to provide that complaints made to the Director General of the Department of Local Government will be protected if they are made in accordance with the Local Government Act 1993 and if they disclose information that show or tends to show corrupt conduct, maladministration, a serious and substantial waste of local government money or a contravention of the pecuniary interest disclosure requirements of the Local Government Act.
- An amendment to s.32 to require the Act to be reviewed every five years, instead of every two, to provide Parliament with a more realistic and practical timetable.

The Cabinet Office has suggested that we raise these proposals during the review of the Act.

a research project

In February 2004 we became involved in a cooperative national research project called Whistling While They Work: Enhancing the Theory and Practice of Internal Witness Management in Public Sector Organisations. This project is being conducted by Griffith University with participation from other universities and public sector agencies around Australia. The aim of the project is to identify and expand 'current best practice' systems for the management of professional reporting, public interest disclosures and internal integrity witnesses in the Australian public sector. The researchers plan to study the experiences of organisations operating under different public interest disclosure regimes across the Australian public sector. We have contributed $25,000 to this project and our Deputy Ombudsman, Chris Wheeler, will be involved in conducting some of the research.

covert operations

introduction

We have a specialised group within our general team who handle the work we do in keeping law enforcement agencies accountable when they are conducting covert operations.

There are three pieces of legislation that authorise law enforcement agencies to commit acts within NSW, as part of an investigation, that would otherwise be illegal. These agencies include NSW Police, the Crime Commission, the Independent Commission Against Corruption and the Police Integrity Commission.

The three Acts are the:

- *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 do a range of things as part of a covert operation. They can intercept telephone conversations, plant listening devices or 'bugs' to listen to and video conversations and track positions of objects, and carry out controlled or 'undercover' operations that may involve committing breaches of the law, such as 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, have quite different accountability processes. There are two significant differences. The first is that to plant a bug or intercept a telephone conversation, you have to 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 controlled operation, you only need to apply to the chief executive officer of your agency.

The second difference is that the Ombudsman monitors compliance with the accountability schemes set up for telephone intercepts and controlled operations, but there is currently no external monitoring of compliance with the Listening Devices Act by the Ombudsman or any other independent oversight body. 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, but there have been no further developments since then.

controlled operations

There is a strict accountability regime for controlled operations that 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 in monitoring the approval process.

Agencies are required to notify us within 21 days if an authority has been granted or varied, or if 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. This includes the records of three federal agencies that are permitted to conduct controlled operations under the NSW Act - the Australian Federal Police, the Australian Crime Commission and trhe Australian Customs Service. We have the power to inspect their records at any time and make a special report to Parliament if necessary. We report on our monitoring work under the Law Enforcement (Controlled Operations) Act in a separate annual report which is available on our website or from our office. As well as ascertaining compliance with the Act, our report also includes details on the number of controlled operations conducted by each agency, the type of criminal conduct targeted in those operations, the number of people who were authorised to undertake controlled activities and some information on the results of those operations.

A review of the Act was completed by the Ministry of Police and tabled in Parliament in June 2004. The review recommended a number of changes to the controlled operations regime that will require legislative amendments. The review did not recommend any fundamental changes to the Ombudsman's inspection role under the Act, but implementing a recommendation to create a lower tier of operations with a streamlined authorisation and accountability process will most probably require a change to Part 4 of the Act. That is the Part detailing our monitoring functions.

During the year, the Standing Committee of Attorneys-General and Australasian Police Ministers Council Joint Working Group on National Investigative Powers also proposed model provisions for controlled operations and the use of surveillance devices in cross border investigations. In both instances the model provisions include an inspection role by an independent body such as an Ombudsman in the various jurisdictions where these investigations are carried out.

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. However we do audit the records of agencies carrying out telephone interceptions. These records document the issue of warrants and how the information gathered was used. 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 make sure that these provisions are complied with. We are required to inspect each agency's records at least twice a year and have discretionary power to inspect their records for compliance at any time.We report the results of our inspections to the Attorney General. Under the Telecommunications (Interception) (NSW) Act, we must not include any information about what we do, or omit to do, under that Act, in our annual report or any other public report prepared by the Ombudsman.

witness protection

witness protection act 1995

The Ombudsman is responsible for hearing appeals about the exercise of certain powers under the *Witness Protection Act 1995* and handling complaints from people participating in the program.

hearing appeals

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 the Ombudsman. The Ombudsman must determine an appeal within seven days of receiving it and our decision overrides the Commissioner's decision. This is our eighth year in this role and we heard four appeals. One appeal concerned a termination from the program and three were from refusals to be accepted onto the program. One appeal was upheld and three dismissed.

handling complaints

Complaints usually relate to management practices and personality conflicts between participants and their case officers. We usually try to conciliate these complaints because of the need to maintain the ongoing relationship between the participants in the program and the officers responsible for their protection. The management of the program has become more sophisticated over the years and the number of complaints received has been decreasing.

The Assistant Ombudsman (General) and Senior Investigation Officer (Secure Monitoring Unit) were invited to the 2004 Australasian Heads of Witness Protection Conference hosted by NSW Police. Law enforcement personnel responsible for witness protection programs in a number of Australian states and overseas countries provided an overview of their programs. It was clear that the NSW witness protection program and its oversight mechanism is one of the most sophisticated in the world.

child protection (offenders registration) act 2000

Under the *Child Protection (Offenders Registration) Act 2000,* people convicted of certain offences against children must 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 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 an authorised police officer, rather than report to a police station.

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.

workshops & training sessions

Our general team runs a number of workshops to enable public agency staff to better handle complaints. In 2003-2004 we conducted 13 workshops, five of them in regional areas. Agencies whose staff attended included the Rural Fire Service, Registry of Births, Deaths and Marriages, Department of Housing, Department of Health, State Rail, local councils and NSW Police. The courses that we ran this year were as follows.

complaint-handling for frontline staff

This very popular workshop provides staff with skills and strategies for managing customers effectively, while being aware of what customers' underlying needs may be. It is designed specifically for those coming into regular or high-volume contact with customers either by telephone or face-to-face. The skills taught in this workshop empower staff to resolve complaints at the frontline.

dealing with difficult complainants

This course is a specialised, advanced skills course providing a matrix for dealing with difficult customers and clients while still trying to meet their needs. Participants are taught skills for analysing client behaviour that is difficult to handle and effective communication skills for difficult circumstances. We also discuss debriefing after difficult scenarios and we provide participants with strategies on how to manage stress.

the art of negotiation

This course provides a thorough grounding in negotiation skills and strategies, with ample opportunity to practice. It focuses on interest-based negotiation. The day is structured around a series of trainer inputs followed by group exercises and discussion. In this way participants are provided with a framework within which they can plan and successfully carry out negotiations, including how to manage unexpected negotiations.

Sheila O'Donovan (right) , who works for both the general team and the police team, regularly conducts workshops for people from public sector agencies.