7. DEPARTMENTS AND AUTHORITIES

Highlights

- We achieved a total of 686 positive outcomes from the 631 preliminary or formal investigations we conducted into complaints about government departments and authorities.
- As a result of our inquiries regarding delays, WorkCover scanned all applications for the new National Certificate of Competency into a database, sent a letter to each applicant apologising for the delay in processing the applications and told them when they could expect to have their application processed. WorkCover also increased the number of staff assigned to processing the applications and updated its website to advise of the delay.
- The RTA agreed to inspect wheelchair-accessible taxis in response to a complaint we received that some taxis do not comply with disability standards. The Ministry of Transport has also agreed that if any taxis requiring compliance are identified as not meeting the standard, it will remove the vehicles from operation until they comply.
- As a result of our investigation into the termination of a long-term tenant's lease, the Department of Housing trained its staff in decision-making and record-keeping. A new electronic document record management system is being developed and additional training for staff about implementing departmental policies and procedures relating to sustaining tenancies for high need clients is also taking place.

Introduction

In this chapter we discuss some of the issues arising from our work with a wide range of NSW public sector agencies. These include large organisations such as the Department of Housing, the Roads and Traffic Authority and the Department of Lands, as well as smaller authorities such as the Office of the Protective Commissioner. Our specific work relating to police, local government, the adult correctional and juvenile justice systems and community services are dealt with in other chapters.

Our role has expanded considerably over the years, but our traditional function of dealing with complaints from members of the public about government agencies is still an essential part of our day-to-day work. We achieve a range of outcomes in relation to the complaints we handle. These outcomes include changes to decisions or policies, and complainants being given better reasons for decisions or refunds and ex-gratia payments when things have gone wrong.

During 2006–07 we received 1,158 complaints in writing (which we call 'formal' complaints) and 3,465 complaints over the telephone or in person (which we call 'informal' complaints). Twenty two percent of these complaints were made by people concerned about planning, property and housing issues that directly affected them. Complaints about business regulation and taxing or fine decisions were the next major category of complaint, followed by grievances about law and justice issues and transport and utility providers (see figure 31 over page). As in previous years, almost a quarter of these complaints made allegations of poor customer service and poor complaint-handling (see figure 33 over page). In that context, the emphasis in the State Plan on improving customer service and complaint-handling in the public sector is a welcome initiative.

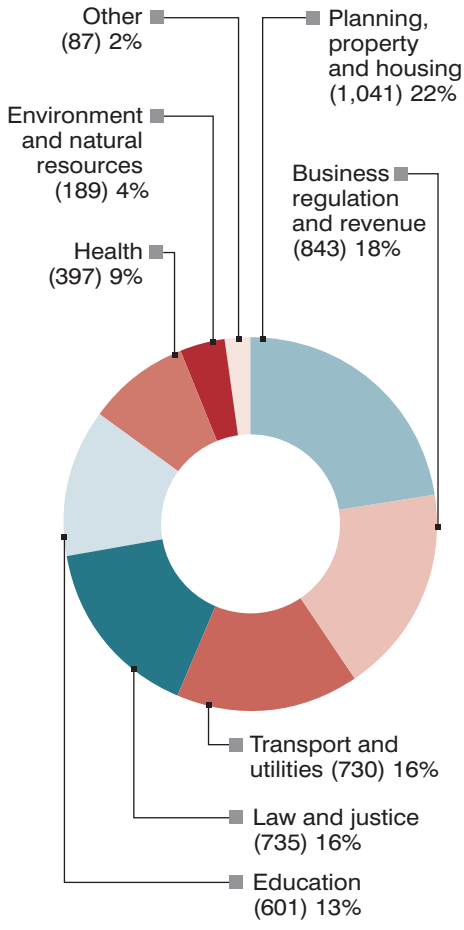
Overall there was a decrease in complaints received about these government services compared to the previous year (see figure 32 over page). This year we finalised 624 formal complaints through preliminary or informal investigations and seven complaints through a formal investigation that involved the use of the Ombudsman's coercive investigation powers (see figure 34 over page). We achieved 686 positive outcomes from these matters which included agencies providing reasons for their decisions, admitting and correcting errors, changing decisions, conducting case reviews, giving apologies, changing policy and procedures, paying compensation and initiating staff training and disciplinary action.

In addition to resolving individual complaints as often as we can, we also identify instances where problems raised in complaints are likely to affect a larger number of people. In this way, we aim to make a difference to as many people as possible. (Please see Appendix D for a full list of agencies we received complaints about this year and how we dealt with these complaints.) Some examples where we have identified broader systemic issues from individual complaints are outlined in the case studies below.

Formal and informal complaints received — by agency category — fig 31

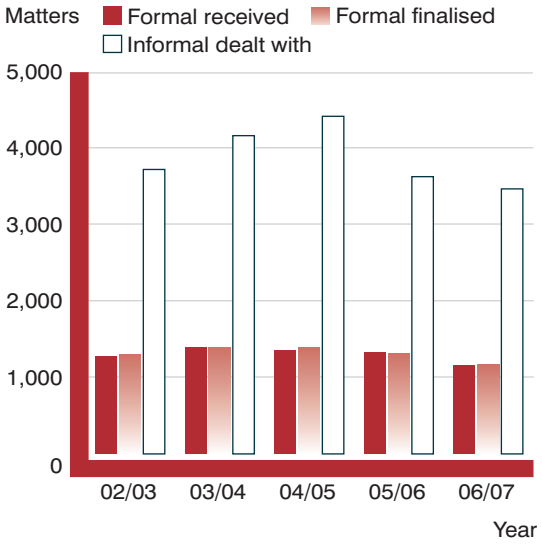
This figure does not include matters about public sector agencies that fall into the categories of police, community services, local government or corrections.

Category of agency	Total
Planning, property and housing	1,041
Business regulation and revenue	843
Law and justice	735
Transport and utilities	730
Education	601
Health	397
Environment and natural resources	189
Emergency services	20
Culture and recreation	32
Aboriginal Land Councils and services	35
Total 2006–07	**4,623**



Five year comparison of matters received and finalised — fig 32

Matters	02/03	03/04	04/05	05/06	06/07
Formal received	1,280	1,390	1,355	1,329	1,158
Formal finalised	1,304	1,390	1,386	1,317	1,167
Informal dealt with	3,719	4,161	4,414	3,625	3,465



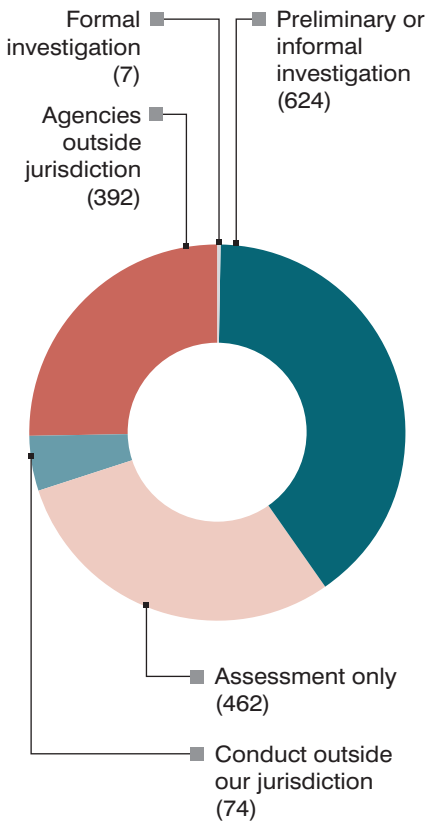
* This figure does not include complaints about public sector agencies that fall into the categories of police, community services, local government, corrections or FOI.

What people complained about — fig 33

This figure shows the complaints we received in 2006–07 about NSW public sector agencies other than those complaints concerning police, community services, councils, corrections and 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	Formal	Informal	Total
Customer service	177	668	845
Complaint-handling	200	524	724
Charges / fees	144	454	598
Object to decision	85	395	480
Approvals	109	233	342
Enforcement	122	192	314
Contractual issues	65	190	255
Issue outside our jurisdiction	62	191	253
Information	57	172	229
Other administrative issue	22	155	177
Policy / law	33	126	159
Management	27	75	102
Misconduct	36	51	87
Natural justice	6	30	36
Child protection	5	7	12
Child abuse related	8	2	10
Total 2006–07	**1,158**	**3,465**	**4,623**

Formal complaints finalised **fig 34**



Current investigations (at 30 June)	
Under preliminary or informal investigation	82
Under formal investigation	1
Total	**83**

Performance indicator

Time taken to assess complaints	
Target	**2006–07**
90% within 48 hours	92% within 48 hours

Performance indicator

Average time taken to finalise complaints	
Target	**2006–07**
Average: 7 weeks	Average: 6.5 weeks

Performance indicator

Complaints resolved through the provision of advice or constructive action by public sector agency	
Target	**2006-07**
65%	68%

Changes at the Office of the Protective Commissioner

The Protective Commissioner is an independent public official legally appointed to protect and administer the financial affairs and property of people with disabilities who are unable to do this for themselves.

The Office of the Protective Commissioner (OPC) is part of the NSW Attorney General's Department and underwent a significant restructure in August 2006. Previously, each client receiving financial management services was allocated an estate manager. As a result of the restructure, a team of front-line client liaison staff now handle all client requests. The staff are supported by specialist teams who deal with issues such as financial planning, budgets and disability services.

We became aware that the OPC was experiencing significant challenges adapting to the new structure. We met with the Protective Commissioner to discuss what action they were taking to address the problems identified. The OPC has been frank about the difficulties they are facing — these include delays in callers getting through to customer liaison staff, problems with new technology designed to support decision-making, the need for improved coordination between the new specialist units and the failure to achieve 'turn around' targets when making decisions. Some improvements have been made and the OPC has arranged for an independent review of the operation of the new structure. It seems further structural change may be necessary before service levels for a very vulnerable group are acceptable. We will continue to monitor the situation closely.

Case study 10

The OPC managed the finances of a young pregnant woman with a physical disability and an acquired brain injury. The woman reported that the OPC's restructure increased her difficulties in dealing with them. She said their decisions were delayed, they did not update her as promised and she had to repeatedly ask for and give information to the OPC. This situation distressed the complainant. We were also concerned about the disproportionate level of resources required to manage her estate.

We suggested the OPC take a more proactive approach and they have now:

- appointed an authorised medical visitor who — after interviewing the complainant — advised the OPC about how to prioritise her requests

- made decisions on all outstanding requests by the complainant and informed her of these decisions in writing
- allocated the complainant to the OPC's shop-front office where she can deal with the same specially trained staff member.

The OPC also made several changes to improve the transition to the new structure for all clients. They increased resources to the budgets area, began interviewing 20 clients a month to check customer satisfaction and started a more formal evaluation of the new structure.

Performance indicator

Percentage of our formal investigation reports recommending changes to law, policy or procedures	
Target	**2006-07**
90%	85%

Performance indicator

Percentage of recommendations made in investigation reports implemented by public authorities	
Target	**2006-07**
80%	89%

National certificates of competency

In September 2006, WorkCover issued new-style national certificates of competency — with photo identification, provision for the signature of the licence holder and tamper-proof security features. These certificates provide assurance that people operating complex machinery or undertaking high-risk work have a valid licence. Holders of the pre-1997 NSW certificates of competency had until 1 September 2006 to apply to convert their certificates to the new national system. The NSW certificates will not be acceptable after 31 August 2007. WorkCover received approximately 56,000 applications for conversion before 1 September 2006. We received a number of complaints about delays in processing applications and WorkCover's failure to communicate with applicants.

We asked WorkCover what preparations they had made in anticipation of the surge in applications, whether they had acknowledged receipt of the applications, if they had advised applicants of processing delays and what resources and staffing they had in place to deal with these delays. As a result of our inquiries, WorkCover scanned all the applications they had received into a database that recorded the details of each application. They also sent a letter to each applicant apologising for the delay and advising when they could expect to have their application processed. In addition, WorkCover increased the number of staff assigned to processing applications and updated their website to advise of the delay.

Delays at the Crown Lands Division

This year we received a number of complaints about the time taken by the Crown Lands Division of the Department of Lands to deal with applications and complaints. We made inquiries into each individual matter and also asked the department to explain the reason for the delays more generally. We met with senior managers of the Crown Lands Division and also visited a regional office. These meetings were informative and allowed us to better understand the problems faced by the division. Senior managers were candid about the problems — which appear to have arisen partly due to recent legislative reforms, as well as the breadth and complexity of work the division deals with.

We remain very concerned about the significant number of outstanding applications for things such as road closures, native title land claims and lease conversions. Based on their current resources, the division estimates it could take 10 years to clear the current backlog of road closure applications.

The division told us about a number of initiatives they have planned to address these problems. We believe the department is putting in place appropriate measures to attempt to both quantify and then start to address the situation. At this stage, the division is providing us with regular progress reports for a period of 12 months. At the end of that period we will review whether we need to take further action.

Case study 11

This year we concluded an investigation into the Department of Lands' intervention in the tender for Rawson Park tennis courts in Mosman. The courts are on Crown land and Mosman Municipal Council was manager of the reserve trust. At the time of the matters complained about, a reserve trust could grant a lease over the land it controlled with the consent of the Minister for Lands. The council conducted a tender process for the lease of the tennis courts and applied for permission to grant the lease to the successful tenderer.

After a group of local residents raised objections, the department decided to intervene in the tender. Following a review of

the tender process by an external consultant, the department directed that the tender be re-run. We received a protected disclosure raising concerns about the department's intervention, the conclusions they reached as a result of the consultant's review, and the advice they gave the Minister after considering the review.

The department made strong representations throughout our investigation about the correctness of their decisions and actions. However, we identified a number of matters of concern. In particular, it appeared the department had not taken into account all of the relevant factors surrounding the tender in reaching their decision to intervene. These included the actual level of risk identified by the review, the review's findings of no apparent evidence of bias, the significant disadvantage to the successful tenderer, and the potential a decision to re-run the tender process had to escalate the acrimonious divisions in the community.

The department accepted our recommendations that they make an ex-gratia payment to the original successful tenderer and develop a written procedure for dealing with complaints. We also recommended the department provide guidelines for reserve trust managers about their requirements for conducting tenders concerning Crown land.

Given the department considered the failings in the tender process adopted by the council in this case were so important that they warranted their intervention, we were surprised at the limited amount of information in their guidelines about tenders concerning Crown land. They contain no specific requirements in addition to those in the government's code of practice for procurement and the local government tendering guidelines produced by the NSW Department of Local Government. Although there is a general invitation for trust managers to contact their local Lands office if they need further guidance on handling tenders, we assume the department's advice to a local council trust manager would be in line with these already existing documents and — in particular — that the department has no additional requirements of their own. We will monitor the department's handling of this issue through our ongoing complaint-handling work.

Wheelchair accessible taxis

Wheelchair accessible taxis, known as WATs, are a vital form of transport for many people with physical disabilities. We were concerned to receive a complaint suggesting that some WATs did not comply with the *Commonwealth's Disability Standards for Accessible Public Transport 2002*. The complainant told us that he continued to come across WATs that could not accommodate his wheelchair, despite its dimensions falling within the standard. This complaint raised a concern that the Ministry of Transport was issuing licences for WATs that did not comply with the standard.

The Ministry of Transport will issue a licence for a WAT if the WAT owner provides a certificate that states the vehicle complies with the standard. Private engineering signatories provide certification and the Roads and Traffic Authority (RTA) administer the signatory scheme. The complaint suggested that although the vehicles may have been certified, they did not comply. This raised questions about whether private signatories were incorrectly certifying modified vehicles, whether the Ministry of Transport was issuing licences to WATs that were non-compliant on the basis of that certification, and what action the RTA could take if private engineering signatories were incorrectly certifying WATs.

We asked the Ministry of Transport about the specific WATs mentioned in the complaint and they provided copies of the certificates issued for them. These certificates stated that the WATs fully satisfied the Commonwealth Disability Standards for wheelchair accessible taxis, but did not detail how. Initially, neither the RTA nor the Ministry would take responsibility for dealing with the problem. Each told us that the other was responsible for making sure vehicles complied. However — as a result of our inquiries — the RTA agreed to inspect each vehicle mentioned in the complaint to verify whether or not it complied with the standards.

The Ministry of Transport also advised that if any taxi requiring compliance did not meet the standard, they would remove it from operation until it did. The RTA advised that if there was evidence that a private engineering signatory had incorrectly certified the WATs, they would bring this to the attention of the private engineering signatory so the situation could be rectified.

We understand there is a further issue with some WATs meeting the standard, but still not being suitable for some types of wheelchairs. We are continuing our inquiries about this and a number of other issues relating to the regulation of WATs.

Roads and Traffic Authority

The case study over the page highlights the need for the RTA to communicate effectively when alerting people to the potential impact that their proposals could have on them.

Case study 12

The proprietors of a Pacific Highway roadhouse complained that the RTA had failed to tell them about the effect that an upgrade of a section of the highway could have on their business when it was consulted on their development application (DA). After their DA was approved and building was well advanced, the preferred route for the upgrade was announced. The next day the RTA phoned the complainants to advise them that their roadhouse might be affected. The complainants claimed that the RTA subsequently told them the upgraded highway could be shifted slightly to avoid the effect on the roadhouse. The RTA denied this, but, on the basis of their understanding, the complainants opened their roadhouse for business.

It subsequently became clear that the highway upgrade would not be altered to accommodate the roadhouse. The complainants applied to the RTA for them to purchase the strip of their property along the highway containing the roadhouse and its parking area. After some months, the RTA indicated they would consider the purchase under their preferred option hardship policy. However, the terms offered were significantly less generous than those sought by the complainants.

After the complainants closed their business, the RTA made a more generous offer that we considered reasonable. The complainants reluctantly accepted this offer and an independent valuation was conducted to determine a settlement figure, in addition to costs the RTA had already agreed to meet.

We found that — although not legally required — it was unreasonable for the RTA not to have directly warned the complainants that their development might be affected by the highway upgrade. We suggested that the RTA amend their procedures to avoid a similar situation occurring in the future. We also recommended that they should apologise to the complainants for failing to warn them about the potential impact of the highway upgrade.

Lotteries and risk management

Through our regular monitoring of international developments, we became aware that a recent investigation by the Ontario Ombudsman revealed a woeful lack of robust systems in that jurisdiction's lotteries system. We took the opportunity to discuss with NSW Lotteries the fraud and anti-corruption measures in place here in NSW.

NSW Lotteries were aware of the Ontario investigation and had in fact carried out a number of internal and external reviews of their own processes and procedures in 2004 — and, as a result, introduced additional fraud prevention measures. They provided us with a detailed briefing and — although the operation of a lotteries system will always present a high risk — we were satisfied that they have processes in place to continually review these risks and identify areas for enhanced security.

Department of Housing

Many public housing tenants have complex and challenging health and socioeconomic circumstances. The Department of Housing is required to work with other government agencies to help ensure the tenancies of such clients are sustained. We were able to achieve a number of positive outcomes this year — ranging from individual remedies for complainants to changes in policies and procedures that will benefit all tenants.

Case study 13

In 2005, the Department of Housing terminated the lease of a long-term tenant for failing to pay his rent. The tenant received a disability support pension and the department was aware of his chronic mental illness. The tenant's rent was normally deducted from his pension by Centrelink and sent directly to the department. The tenant failed to pay his rent because his pension had been cut off.

A similar situation had arisen some years before when Centrelink stopped the tenant's pension after he failed to reply to their correspondence. On that occasion, the department took active steps to identify the problem. It was discovered that the tenant had stopped taking his medication which caused him to withdraw from all social contact and to not respond to letters and phone calls. The department acted to re-establish the tenant's contact with the local community mental health service and his situation stabilised.

When the problem arose a second time, a housing officer took action to terminate the tenancy after only two and a half weeks of unpaid rent. After obtaining the required approval, he went to the tenant's unit to carry out the termination. He believed that the premises might have been deserted so police were asked to accompany him. After drilling the lock, police became concerned for the safety of any tenant and entered the premises.

A struggle ensued and police officers used batons and capsicum spray against the tenant and called further officers to assist. As a result of the incident, the tenant suffered two fractured arms and was taken to hospital. He was transferred to a psychiatric facility where he received care for some months and was later charged with assaulting police.

We were particularly concerned at the apparent failure of the housing officer to follow departmental procedures for dealing with tenants who have a known mental health condition. We also had concerns about the lawfulness of the police entry into the unit and the reasonableness of the charges laid against the tenant. As a result we started a direct investigation.

We found that certain housing officers had failed to act in accordance with departmental procedures. In particular, they failed to give appropriate consideration to all relevant factors before seeking to terminate the tenant's lease — and provided incorrect information about the tenant to the Consumer, Trader and Tenancy Tribunal (CTTT) during the termination hearings. They also failed to record a number of their decisions and actions.

The department accepted our recommendations that the officers concerned be counselled and receive further training, and that improvements be made more generally to make sure housing staff are aware of and properly trained in implementing their policies and procedures. They have also arranged for all staff to receive training about decision-making and record-keeping, and are involved in developing a new electronic document record management system. Our recommendation that the department apologise to the tenant and provide an ex-gratia payment — as well as reimburse his rent for the period of his hospitalisation — was accepted.

Although the police had acted lawfully in entering the premises and restraining the tenant, we believe that better guidance should be given to police about taking a person's mental health condition into account before exercising their discretion to lay charges. We have asked the NSW Police Force to review the relevant Commissioner's direction and report back to us.

Reasons for decisions

We have suggested to the Department of Housing that reasons for their decisions should be expressed clearly and accurately and in plain English. Reasons should include the information relied upon in coming to the decision, relevant sections of policies and procedures and an explanation of how they apply in the given case and — if appropriate — an adequate statement of the evidence relied on or rejected.

Recent changes to legislation and the *Reshaping Public Housing Reforms* are likely to increase the importance and complexity of departmental decisions. This means it is even more important to make sure that reasons for decisions are adequately explained and documented.

We have provided advice to the department about their policy on appeals and reviews of decisions. We have suggested the policy be written in plain English and that the person conducting the review should not have been involved in the original decision. The department has agreed they should provide adequate reasons for their decisions and that this will be implemented in the next phase of their policy review. We will continue to monitor this issue.

Case study 14

A public housing tenant with a disability complained about a severe cockroach infestation at his unit. He had reported the problem to his client liaison officer five weeks earlier but no action had been taken. At our suggestion, he then contacted the department's client feedback line to make a formal complaint. He was told a fumigator would come to his unit within the next three weeks. The tenant phoned us a week later complaining that the infestation had become so severe that he could not cook or sleep at night. We made inquiries with the department and — as a result — they agreed to arrange for a fumigator to attend the premises within 24 hours.

Tenant repair costs

The *Residential Tenancies Act 1987* provides that tenants are only responsible for damage that they or their guests intentionally or negligently cause. They are not responsible for damage caused by fair wear and tear or for vandalism by a third party. The Act provides that the CTTT can determine liability if there is a dispute.

In 2003 a legal centre complained to us that the department unreasonably, and possibly unlawfully, billed tenants for repairs to property damage for which they were not responsible. We started an investigation into this issue, but this was discontinued after the department agreed that the process for determining liability might be unreasonable and that they would review their policies and procedures.

We provided feedback to the department on amendments to their policy.

Despite this, we continued to receive complaints about this issue. We conducted further extensive inquiries with the department — and they advised us that the changes to the policy and procedures were delayed because of the introduction of the *Reshaping Public Housing Reforms*.

The department has now changed their policy so that — at the end of a tenancy — they must advise a tenant in writing if they believe the tenant is responsible for damage. If the tenant does not respond in writing or disputes liability, the department will internally review their decision. If they uphold the original decision, they will seek an order for payment from the CTTT.

Case study 15

A mother living alone who had mental health issues left her home because of a domestic violence situation and vandalism of the property. She had police event numbers for the incidents she had reported. However, the department decided she was liable for damage to several properties and refused to place her on the waiting list for another property until she paid the debt. After our intervention, the department decided they did not have enough evidence to obtain an order from the CTTT and cancelled the debt.

Case study 16

The Office of Fair Trading (OFT) told a builder that he would have to apply for a new builders licence because his licence had expired some time ago. The builder followed this advice and re-applied for his licence. However, he was later notified by the OFT that his licence could have been renewed as he had been within the three-month renewal period. The complainant thought this was a significant mistake because his old licence number carried goodwill for his business. He wrote to the manager of the Home Building Services asking to use his old licence number on the new card, but received no reply.

After the builder complained to us, we made inquiries with the OFT. They acknowledged that — due to an administrative oversight — the builder's letter had not been answered and was now missing. However, as a result of our inquiries, the OFT approved the builder's request and refunded him the difference between the fee for a licence renewal and an application for a new licence.

Delays at the Department of Planning

Although the Department of Planning has reduced delays in processing development applications, many matters are still not being determined within the timeframes required by planning legislation. We made inquiries last year as a result of a complaint about coastal development applications. The complainant objected to what he believed was a lack of accountability on the part of the department. He argued that at a time when the department was seeking to expand their control over planning matters, they were not being subject to the same scrutiny as local councils — who have been severely criticised for delays. We wrote to the department and they acknowledged the need to improve 'turn around' times and told us about a number of changes they were making to achieve this. These changes included establishing a backlog program to deal with coastal development applications, setting performance targets for the completion of assessments and installing data management and reporting systems.

Recent information from the department shows that the backlog of coastal development applications has been cleared and performance targets are being achieved. However, these targets are not as strict as the statutory times for finalising complex development applications. The department has told us they expect that a higher percentage of applications will be processed within the legislative timeframes in the coming 12 months — and the benchmarks will be revised to reflect the new systems and staffing improvements.

We acknowledge the complexity of many of the development applications the department determines, but are concerned that processing delays are still occurring.

8. COMMUNITY SERVICES

Highlights

- Our 2006 Reviewable Disability and Child Deaths annual report was tabled in Parliament and included 62 recommendations for systemic and procedural change.
- We finalised 22 investigations into significant issues relating to the provision of community services and provided comprehensive reports and recommendations to relevant Ministers, government authorities and non-government funded agencies.
- We resolved and/or made recommendations for improvements to services in 54% of the 569 complaints finalised this year.
- We coordinated 3,164 visits to 1,230 services by Official Community Visitors.
- We provided information, education and training to a wide range of community service providers, consumers and other stakeholders including:
  - 31 speeches and presentations and
  - 27 training and education workshops.

Community services in NSW are provided by the Department of Community Services (DoCS), the Department of Ageing, Disability and Home Care (DADHC) and a large number of non-government agencies funded, licensed and authorised by government.

These services are for some of the most vulnerable people in the state and include:

- child protection and out-of-home care for children and young people
- accommodation, support and respite services for people with a disability
- accommodation and support services for the homeless
- support services for the aged.

Our role under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) is to encourage and promote improvements in the quality of services by:

- responding to, resolving and investigating complaints about services
- monitoring the delivery of services, making recommendations for improvement and checking their implementation
- reviewing the deaths of people with disabilities who are in care and of certain children and young people
- providing information, education and training to agencies and consumers about service standards and complaint-handling
- coordinating the Official Community Visitor scheme.

Complaints about community services

In 2006–07 we received 560 formal complaints about community service agencies, down from 595 in 2005–06 (see figure 35 and 36 over page). Over half of the formal complaints (57%) were about DoCS and 18% were about DADHC (see figure 35 over page). Twenty-three percent of formal complaints were about non-government services funded, licensed or authorised by DoCS or DADHC (2% of formal complaints were out of our jurisdiction).

The most frequent complaints were about child protection services, followed by out-of-home care services and accommodation and support services for people with disabilities. See figure 37 (over page).

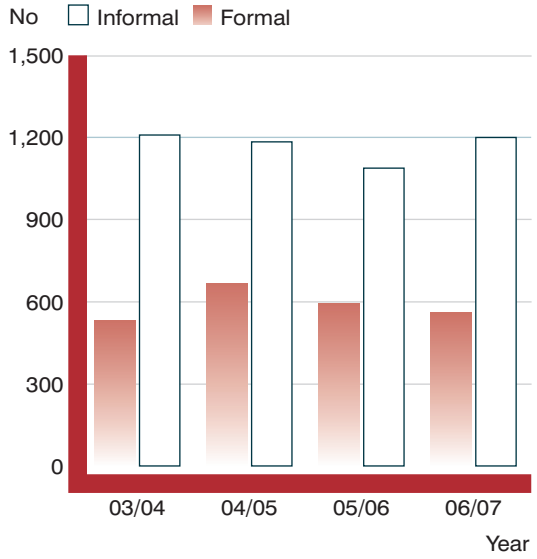
We resolved and/or made recommendations for improvements to services in 54% of the 569 complaints finalised this year. See figure 39 (page 81).

Formal and informal matters received — by agency fig 35

Agency category	Formal	Informal	Total	%
DoCS				
Child protection services	174	418	592	34%
Out-of-home care services	137	268	405	23%
Other (incl. requests for assistance, licensing)	9	25	34	2%
Adoption	1	5	6	0%
Sub-total	**321**	**716**	**1,037**	**59%**
DADHC				
Disability accommodation and support services	72	62	134	8%
Home care service	7	36	43	2%
Policy and strategic services	23	36	59	3%
Sub-total	**102**	**134**	**236**	**13%**
Non-government funded or licensed services				
Disability services	56	65	121	7%
Out-of-home care services	17	22	39	2%
Home and community care services	19	19	38	2%
Supported accommodation and assistance program services	12	22	34	2%
Children's services	5	7	12	1%
Boarding houses	5	19	24	1.5%
General community services	2	11	13	1%
Family support services	0	6	6	0.5%
Other	11	15	26	1%
Sub-total	**127**	**186**	**313**	**18%**
Other (general inquiries)	0	98	98	6%
Complaint outside our jurisdiction	10	66	76	4%
Total 2006–07	**560**	**1,200**	**1,760**	**100%**

Number of formal and informal matters received about agencies providing community services — four year comparison fig 36

	03/04	04/05	05/06	06/07
Formal	531	667	595	560
Informal	1,209	1,184	1,088	1,200
Total	**1,740**	**1,851**	**1,683**	**1,760**



Formal and informal matters received — by program area fig 37

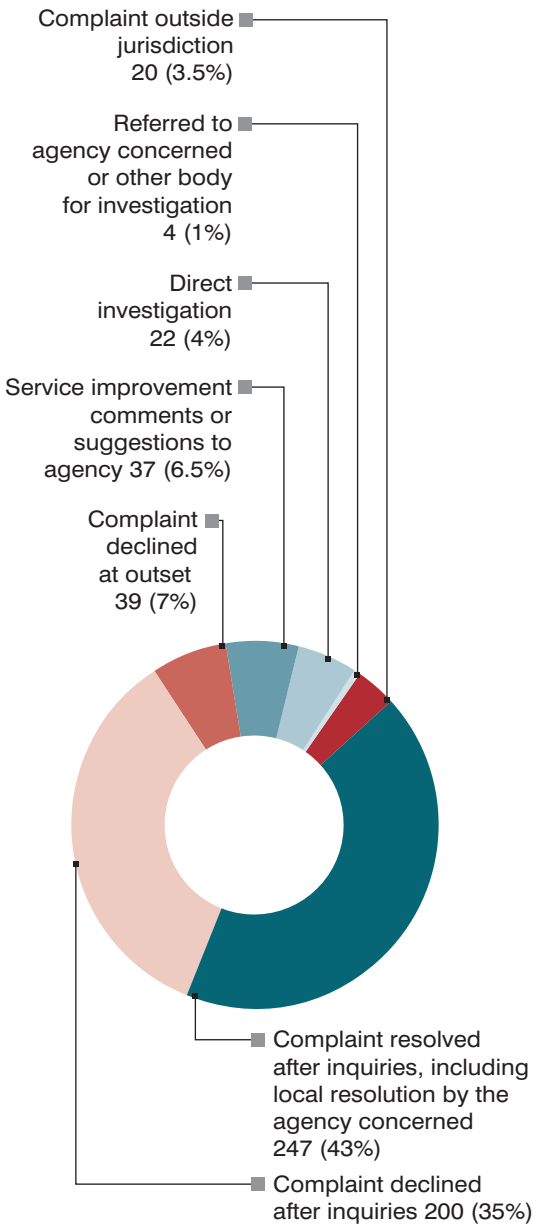
Program area	Formal	Informal	Total	%
Child protection services	185	426	611	34.7%
Out-of-home care services	156	293	449	25.5%
Disability accommodation services	119	138	257	14.6%
Disability support services	56	87	143	8.1%
Aged services	9	20	29	1.6%
Children's services	8	21	29	1.6%
Supported accommodation and assistance program services	12	23	35	2.0%
Adoption services	1	5	6	0.3%
General community services	3	13	16	0.9%
Family support services	1	10	11	0.6%
General inquiry	0	98	98	5.6%
Complaint outside jurisdiction	10	66	76	4.3%
Total complaints received	**560**	**1,200**	**1,760**	**100%**

What people complained about fig 38

This figure shows the issues that were complained about in 2006–07. Please note that each complaint we received may have been about more than one issue.

Issue	Formal	Informal	Total
Case management / decisions	192	321	513
Poor quality services	181	198	379
Case planning and casework	80	139	219
Individual needs not met	57	73	130
Complaint-handling by services	61	126	187
Contact with family, friends	52	51	103
Service provider management	32	56	88
Access to or exit from services	40	59	99
Clients not involved in decisions	16	46	62
Non-provision of information	16	45	61
Inadequate service policies	33	82	115
Professional conduct of staff	16	37	53
Funding of services or providers	12	13	25
Other issues	8	11	19
Total issues raised	**796**	**1,257**	**2,053**

Outcomes of formal complaints finalised in 2006–07 about agencies providing community services fig 39



Performance indicator

Average time taken to assess and determine complaints	
Target	2006–07
70% within 10 weeks	63% within 10 weeks

Performance indicator

Number and proportion of finalised complaints resolved and / or where services are improved	
Target	2006–07
50% or more	310 (54%)

Services for children and families

Community services for children and families in NSW are provided primarily by DoCS and non-government agencies funded by DoCS. They include child protection, services for children and young people in out-of-home care, family support and assistance, children's services and community development programs.

DoCS is in the fourth year of a five year, $1.2 billion reform program which includes employing more case workers, new early intervention services and out-of-home care service models, and improved support for front-line staff who respond to risk of harm reports. They will also be conducting a quality review of each of their community service centres (CSCs) over the next four years.

Complaints

In 2006–07, 31% of the formal complaints we received were about DoCS' child protection services and 28% were about out-of-home care services, either funded or provided by DoCS. A small number of formal complaints were about counselling, family support and children's services (see figure 35).

For child protection services, the most common complaints were about DoCS' response to risk of harm reports — either the lack of intervention or the type and adequacy of the intervention. Other issues complained about included:

- communication between DoCS and families whose children were the subject of risk of harm reports
- communication between DoCS and other agencies and/or reporters of risk of harm concerns
- the professional conduct of caseworkers
- DoCS' work in relation to Children's Court processes
- DoCS' own handling of complaints about their child protection activities.

For out-of-home care services, the most common complaints were about contact arrangements between children in care and their families. Other issues complained about included:

- the adequacy of support for maintaining placements, including foster placements
- the adequacy of placements for meeting children's needs, including the standard of the physical environment of residential placements
- communication with caseworkers about care arrangements
- moving children between care placements and the adequacy of transition planning
- decisions and administration issues about carer allowances and other payments
- complaint-handing about problems arising with care placements.

Complaints about family support services were generally about the adequacy and/or quality of services provided. Issues complained about in relation to children's services included a delay in building improvements and a pre-school's failure to implement their anaphylaxis policy. Case studies 17 and 18 show the types of complaints we deal with.

Case study 17

A 12 year old child under the parental responsibility of the Minister for Community Services and living in the care of a residential service rang us to complain that she had been told by her DoCS caseworker that she had to move to another placement in another town. She did not understand the reason for the decision and did not want to move because she had recently got a pet. She also complained that she found it difficult to contact her caseworker.

We approached the local DoCS manager who said they did plan to move the child as the current placement was temporary and not adequate for her needs. Although a placement in another area was being considered, no definite plans were yet in place. We were satisfied that the department's plans were in the child's interests and established that they had scheduled a meeting with her to talk about the plans. We therefore referred the complaint to DoCS to deal with directly and asked them to report back to us.

As a result, DoCS decided not to move the child to another area but to find a suitable local long-term placement. The caseworker also gave the child her mobile phone number so she could be more easily contacted when needed.

Case study 18

We received information about a youth Supported Accommodation Assistance Program (SAAP) service that raised serious concerns about the conduct of staff and the service's management of a range of issues — including alleged assaults between residents, illegal drugs on the premises, theft of residents' personal belongings, the poor quality of food and unhygienic premises.

We found that DoCS were aware of the allegations and intended to investigate in their capacity as the service funder. We were

satisfied that the department's plans would address the issues so we formally referred the matter to them to investigate and report back to us on the outcome.

Rather than investigate the individual complaint issues, DoCS appointed an independent consultant to complete a comprehensive review of the service. The review incorporated the allegations as well as the service's policy and practice obligations under the SAAP standards and its service agreement with DoCS.

The review found the service was in breach of its obligations in a number of areas — including lack of an adequate policy framework to guide staff, poor casework practices and problems with employment and management arrangements. The review made a range of recommendations for addressing these issues and DoCS advised us they intend to establish and monitor an improvement plan for the service.

Reviewing complaint-handling practices

Under our legislation, we are responsible for reviewing the complaint-handling systems of community service providers. In 2006–07, we created additional management and staffing positions to enable us to conduct proactive complaint-handling reviews of particular program areas. We benchmark complaint-handling systems and practices against the Australian Standard for Complaints Handling.

In January 2007 we began a complaint-handling review of the family support services sector. After consulting with the NSW Family Services Inc., the peak body for family support services, and DoCS — who fund non-government family support services via the Community Services Grants Program (CSGP) — we selected and visited 20 family support services across NSW. These included:

- large and small services
- metropolitan, regional and rural services across all DoCS regions
- services with a high proportion of Aboriginal and CALD clients
- services that are and are not members of NSW Family Services Inc.

We reviewed the complaint-handling systems of each service, gave them feedback about what they are doing well and made recommendations for improvements to:

- complaint-handling practices and procedures
- communication with their clients
- staff training.

Carolyn Campbell-McLean and Anne Ciliegi at the Association of Children's Welfare Agencies Conference, May 2007.

We will monitor the action they take in relation to our recommendations and report the outcomes to the Minister for Community Services.

In the second half of 2007, we will produce a summary report about the complaint-handling issues we identified during the review. The report will include suggestions for improving complaint-handling across the sector and will be distributed to all NSW family support services, NSW Family Services Inc. and DoCS. We will also provide complaint-handling training in Sydney, Armidale, Dubbo and Nowra — in partnership with NSW Family Services Inc. — to help family support agencies to improve the quality of their services.

Our child protection investigations

In 2006–07, we initiated 17 new investigations, finalised 19 investigations and monitored the implementation of recommendations arising from six investigations, completed in previous years, about various aspects of the care and protection system for children. Many of these investigations were initiated under our 'own motion' powers following our reviews of the deaths of children.

We have had an increase in investigations about how effectively health services identify and respond to children at risk of harm. These have shown the importance of effective communication within area health services, and the problems children face when health providers make assumptions about service provision by other agencies, particularly DoCS.

Our investigation findings highlight the need for all agencies to provide adequate training for staff and have appropriate systems in place to facilitate effective interagency responses to child protection concerns. We welcome the initiatives of the Human Services Chief Executive Officers' Forum and the Child Protection Senior Officers Group to evaluate the uptake and effectiveness of the *NSW Guidelines for Child Protection (2006).*

Last year we reported our concerns about DoCS not conducting comprehensive risk assessments for some children who live in circumstances where there is a high risk of harm. Some of our investigations this year indicate that this continues to be a concern (see case studies 19 and 20 over page).

Case study 19

The Children's Court issued long-term care orders for five siblings nine weeks before the birth of a sixth sibling. The five older children were placed with foster carers.

By the time the sixth child was two and a half years old, she had been the subject of 14 risk of harm reports to DoCS. However — even with the family's child protection history — she had not been the subject of a comprehensive risk assessment. This was despite reports to DoCS that suggested the child was neglected, small and possibly underweight for her age, may not have been fully immunised as a baby and toddler and was likely to be suffering generally from neglect.

We found that the DoCS file for the child had not been appropriately maintained, staff had failed to take account of the family's child protection history and it was unclear from the records on what basis decisions were made. The department had started risk assessments for the child, but had not completed them — and it was not clear why.

We recommended the department take steps to find the child and do a comprehensive risk assessment. We also recommended they find out if the deficiencies identified in our investigation would be addressed by current or proposed initiatives to improve child protection practice and procedures, and if any managerial or remedial action was required in relation to the conduct or decisions of any individual officers involved with the family.

DoCS located the child, undertook a risk assessment and initiated Children's Court action. They told us of the initiatives underway to improve their child protection practices, but did not consider there was a need for any remedial or managerial action in relation to any individual officer.

Case study 20

We received a complaint that two children known to DoCS and DADHC were at risk of harm because of ongoing neglect at home. Our inquiries established that the children had been repeatedly reported to DoCS over many years, and their development was probably being compromised because of neglect. DoCS told us that although they were concerned about the children's welfare and acknowledged the concerns about the children were serious, they could not complete a risk assessment because of competing priorities.

This advice concerned us, particularly given the department's long awaited release of their policy on neglect in July 2006. This policy clearly highlights the negative impact chronic neglect can have on children's health, development and welfare. We therefore decided to investigate the adequacy of DoCS' response to concerns about the children.

In response to our investigation notice, DoCS acknowledged that their initial response had been less than adequate. They told us they had now prioritised risk assessment for the children and were taking steps to improve their capacity to provide care and protection services in the region where the children lived.

After a risk assessment, DoCS placed the children in foster care and lodged care applications in the Children's Court.

Reviewing child protection legislation

In January 2007, we received a discussion paper from DoCS reviewing the *Children and Young Persons (Care and Protection) Act 1998* (CYPCP Act). The paper outlined a number of challenges for the child protection and out-of-home care systems in NSW. These included:

- the significant increase in child protection reports
- the large number of reports referred to local DoCS offices for action
- the over-representation of Aboriginal children in child protection reports
- the significant number of reports relating to very young children
- the high number of reports relating to substance use and domestic violence
- the increase in appeals against orders of the Children's Court
- the increase in the period of time children are spending in care
- the number of children experiencing multiple placements in care.

In response to these challenges, the discussion paper canvassed a number of options for reforming the system. One option explored was whether a tribunal should replace the Children's Court. Concerns have been raised about the adversarial nature of Children's Court proceedings, but we do not believe that replacing the court with a tribunal would resolve these concerns. Our suggestion is for 'an appropriate forum (involving key government and non-government agencies) to focus on achieving

a more consensus-based understanding about the expectations surrounding the conduct of child care proceedings'.

We believe that such a forum could also be used to drive critical discussions about the expanded use of alternative dispute resolution in care proceedings, including options such as family conferencing and — for care matters involving Indigenous children — circle sentencing. The child protection system could also be improved if the legal rights of agencies to exchange information about concerns for the safety, welfare and wellbeing of a child were expanded.

Another important issue concerns the lack of data and research about care proceedings. This makes it extremely difficult to determine whether the system is operating effectively.

A copy of our response to the discussion paper, which includes an earlier report we did on the Children's Court, is available on our website.

Reviewing out-of-home care

This year we have reviewed a number of programs and services for children and families, including the circumstances of young people in out-of-home care.

Very young children in out-of-home care

This year we started a review of a group of 50 children in statutory out-of-home care. All the children were under the age of five when the Children's Court issued final care orders, and have orders allocating all or aspects of parental responsibility to the Minister for Community Services. Each review involves examining the child's DoCS file as well as interviewing their DoCS caseworker, their carers and any other relevant service providers.

We want to find out whether:

- the individual needs of children are being adequately identified and responded to
- children's placement changes are being minimised
- children are being appropriately matched with carers
- carers are being provided with sufficient information about the children placed with them, and appropriately supported to meet their needs
- if the plan is to restore the child to parental care, adequate and appropriate support is being provided to the child, parent and carer
- there is timely and effective decision-making if problems are identified with the restoration process.

We are providing DoCS and other relevant service providers with a report on the results of each individual review. A report detailing systemic issues and observations from the individual reviews will be completed in 2007–08.

Support for Aboriginal foster carers and non-Indigenous carers of Aboriginal children

Since March 2007, we have been conducting a project to better understand the needs of Aboriginal foster carers and non-Indigenous carers of Aboriginal children throughout NSW. We are interviewing 100 foster carers to hear first-hand their views about the support provided to them by DoCS and funded out-of-home care services. In some locations we are also meeting with DoCS local managers, non-government organisations and Aboriginal service providers to discuss what systems and support mechanisms are in place. We have actively consulted with AbSec, the peak Aboriginal child and family agency in NSW, throughout the project.

The first stage of the project is examining issues such as:

- the information provided to foster carers before a placement is made
- the support provided to foster carers, their awareness of their rights and responsibilities and their involvement in the case planning process
- the application of Aboriginal placement principles and provision of relevant cultural support
- contact arrangements between children in care and their families.

Young people living in SAAP services who are in statutory care

Last year we began reviews of the circumstances of 15 young people under the parental responsibility of the Minister for Community Services who were living in services funded under the SAAP. These services are funded to provide transitional accommodation and support for people who are homeless, but there were concerns that they were being required to accommodate children and young people who should be supported within the statutory out-of-home care system.

We wanted to know why the children were living in SAAP services at the time, and what plans DoCS had to move them to more appropriate accommodation or help them to live independently.

The 15 children in the group were aged between 13 and 15 years and from five different DoCS regions. Just over half had been under the parental responsibility of the Minister for 12 months or less, four were subject to interim care orders for two months or less, four had been under the parental responsibility of the Minister for one to two years and three for eight years or more.

The reasons for the children being in SAAP services varied. Six children had — at least initially — been placed in a SAAP service when DoCS initiated

care proceedings following sudden or unexpected homelessness and/or breakdown in family relationships. The remaining nine children had been placed in a SAAP service after the breakdown of an existing out-of-home care placement arranged by DoCS. For a few, the SAAP service had been chosen by DoCS because of the programs provided. For others, it was clear that they were in SAAP because there was no other placement available.

The length of time the children had been in SAAP services varied from a few days to several months. One child had been there for two years. Many remained in SAAP for extended periods before moving to appropriate alternative accommodation.

We reviewed whether case planning for the children included locating placements with authorised carers and whether there was active casework to achieve this. We also considered whether responsibilities for the day-to-day care and decision-making and supervision of the child while in SAAP were clear.

For most of the children, DoCS' long-term case plans were to move the children to appropriate out-of-home care placements, and we found evidence of casework to achieve this. Five of the group moved to long-term foster placements and three to other alternatives during or following our reviews. Six of the group remained in SAAP as part of a long-term case plan.

Not all the children had a documented case plan at the time of our review, even though the casework to meet their immediate and short-term needs was generally responsive. We recognised that the unstable circumstances of some children at the time of their entry into care made it difficult to establish a long-term case plan. However, in those circumstances, it was difficult to identify if case planning was adequately promoting their longer-term stability and well-being.

Given the purpose and focus of SAAP, the use of these services for children in out-of-home care raises a number of policy questions. While the day-to-day care needs of the majority of children we reviewed were generally being adequately met, the lack of security of their circumstances was evident for many. For example, some of the children experienced periods of 'time out' from SAAP services. In some cases they had been 'exited' from services and, in most of these cases, it was unclear whether DoCS had been consulted about the placement changes. SAAP services are not required to be accredited by the Children's Guardian or to meet standards for out-of-home care services, so there is a question about their capacity to meet the long-term needs of children in statutory care.

A number of caseworkers told us that they chose the SAAP service because the programs they provided suited the children's needs. Several told us about difficulties finding suitable placement alternatives, especially if children did not have 'high and complex' needs and further foster placements were not considered appropriate.

Against a background of high levels of demand for SAAP services, the use of these services for children in out-of-home care is a significant issue that warrants careful consideration by DoCS, and the SAAP and out-of-home care sectors.

In March 2006, DoCS released a draft policy for consultation with relevant peak agencies — *Assisting unaccompanied children under 16 years in SAAP youth accommodation services*. We are monitoring the finalisation of this policy.

Services for people with a disability

A wide range of agencies provide services for people with a disability and older people in NSW, including DADHC and several thousand non-government organisations funded or licensed by DADHC. These include supported accommodation services — such as group homes, large residential centres, licensed boarding houses, in-home support and assistance — respite care services, day programs and services for school leavers, advocacy services, food services, home modifications and maintenance and community transport.

Complaints

This year 21% of the formal complaints we received were about disability accommodation services — either funded or provided by DADHC — and 10% were about other support services for people with a disability or older people funded or provided by DADHC (see figure 37 on page 80).

The most common complaints about agencies providing accommodation support services related to access to services — including delays in providing permanent accommodation, management of the process for offering a placement and filling vacancies, and the adequacy of the planning and transition process for moving residents into and between placements.

Other issues complained about included:

- the adequacy of behaviour management and related management of risk and safety issues
- the adequacy of supervision and support provided to residents
- decision-making processes and consent issues
- the adequacy of complaint-handling by agencies and alleged retribution for complaining
- the professional conduct of staff and the handling of staff misconduct allegations
- boarding house fees and charges.

The most common complaints about disability support services related to problems getting access to needed services — including delays and long waiting lists, lack of access to respite services due to beds being 'blocked' and in-home assistance not being delivered on time or in accordance with service agreements.

Other issues complained about included:

- service quality and adequacy of services for meeting client needs
- reductions or changes in service arrangements
- the professional conduct of staff
- the adequacy of complaint-handling
- the administration of funding packages
- DADHC's monitoring of service quality.

Case study 21

An official community visitor (OCV) complained that the transfer of a disability group home from one service provider to another had been poorly managed, resulting in a range of safety issues. There were a number of problems with the condition of the house, staff were not properly trained to meet the residents' needs and assaults between residents and on staff were becoming increasingly serious. The group home had been auspiced by three different providers over three years. The OCV was concerned that strategies developed by both DADHC and the service provider to address the problems were inadequate.

We asked DADHC and the service provider for information about the transfer of the home and the arrangements for supporting the residents through the transition. We also facilitated a meeting with DADHC, the service provider and the OCV. This provided an opportunity to discuss the historical issues, understand the context and possible causes of at least some of the current problems and explore ways to address the immediate issues affecting the residents. The meeting confirmed what was already in place to improve the condition of the house and support the residents' behavioural needs, and set up an action plan for addressing unresolved and longer-term issues.

Given the nature and history of the problems, we monitored progress over several months. Over that time, DADHC provided additional support through their regional behaviour support team, and the service developed systems for documenting and monitoring issues that arise in the house.

A new DADHC action plan was drafted to support the residents. The OCV also reported improvements at the group home.

Our investigations

This year we finalised three investigations about services for people with a disability. We also began two additional investigations that are continuing.

The three investigations we finalised this year were about:

- aspects of the care arrangements made by DADHC for two group home residents and their administration of policies, procedures and practices for the realignment of group homes in the metropolitan west region (see case study 22).
- DADHC's provision of services to a person with an intellectual disability and high support needs.
- DADHC's actions in assessing an agency as a 'preferred' or 'approved provider' of interim funded disability services (see case study 23 over page).

The investigations we started this year concern the adequacy of the response of DADHC and the Hunter New England Area Health Service to the critical health issues of two people living in supported accommodation, including the adequacy of the cooperative work between the agencies.

Case study 22

We began an investigation after an OCV complained about the transfer of residents to a group home. We were concerned about whether DADHC gave adequate consideration to the needs of all residents of the group home affected by the transfer. We also wanted to find out if requirements associated with a regional restructure of service provision had been addressed and if there were sufficient safeguards to ensure client transfers were consistent with the relevant laws and standards.

We found that the decision to move two residents from one group home to another did not comply with departmental guidelines. Significant compatibility issues between the two men were either not identified or not adequately considered in the decision-making process. In addition, not all stakeholders were consulted about the proposed move. Together, these failures meant that DADHC did not adequately consider the individual needs of the two people when deciding to move them. We found this was unreasonable and in breach of the disability service standards.

At the time of our investigation, the department was yet to settle on guidelines to support the regional restructure of service provision. We reviewed the draft guidelines and found that — if implemented — they would minimise similar problems arising in the future. The guidelines contained clear requirements to ensure clients' best interests are being served by the recommended move.

In 2003, we began an investigation into DADHC's administration of their children's policy. As part of that investigation, we considered the adequacy of DADHC's purchasing and monitoring arrangements for interim funded services for children and young people with a disability. DADHC undertook to require all providers of interim funded services — not recurrently funded by the department — to demonstrate that they met the disability service standards, as well as certain other requirements. These services would be referred to as approved providers.

Case study 23

In 2006 we received a complaint from the parent of a young person. At the time of the matters complained about, she was in the care of an interim funded service. Although the young person had epilepsy and was required to wear a safety vest when swimming, the service allowed her to swim alone and without a vest. After she became immersed in water, she suffered uncontrolled epileptic seizures, lapsed into a coma and was hospitalised for a month. We identified concerns about the adequacy of the service's policies for handling critical incidents. As the service was an approved provider, we decided to investigate DADHC's assessment of the service.

We found the assessment was not thorough. In response to this finding, DADHC told us that they would review their pre-qualification process. They also reviewed the service, developed a service improvement action plan — which included systems for minimising and better responding to critical incidents and staff training — and undertook to monitor the service's implementation of that plan.

During the course of the investigation and DADHC's review, the service ceased to operate as an approved provider of children's services and the other children at the service were moved to appropriate placements. The department's action plan and continuing monitoring of the service is relevant to the service's care of adults with a disability.

Reviewing and monitoring the delivery of disability services

Last year the NSW Government released *Stronger Together*, a ten year plan for increasing the capacity and quality of the service system for people with a disability and their families. Major initiatives under the plan include improving access to services and providing services based on assessed need, increasing services to help people with a disability to remain living at home and increasing the range of specialist accommodation services.

This year we have monitored the progress of a number of DADHC initiatives, including those associated with *Stronger Together* commitments.

New models of disability accommodation

Stronger Together makes a number of commitments in relation to supported accommodation services. These include the closure over time of large institutions, the redevelopment of some of those properties and the development of new models of accommodation services. The plan states that services will be consistent with contemporary accommodation and care standards and will comply with the Disability Services Act.

A number of concerns have been raised with us about DADHC's plans. These include their plans for large institutions — against the background of previous commitments to close them — as well as plans for new accommodation models. Questions have been raised about how the proposed models will enable residents to participate in the community, and how existing residents of large institutions will be given the opportunity to live in the community.

We have asked DADHC for detailed information about their plans for accommodation services, and in the coming year we will be obtaining legal advice to inform our continued monitoring of these issues.

Standards of care and services in boarding houses

Last year we reported on our investigation into DADHC's monitoring of licensed boarding houses against the requirements of the *Youth and Community Services Act 1973*. We found serious problems with the way boarding houses in NSW are licensed and monitored by DADHC — including problems with regional compliance with the department's monitoring policy, limitations in the monitoring system because of questions about the legal enforceability of some standards under the Act and inadequate safeguards for protecting people with a disability who live in unlicensed boarding houses.

This year we have monitored DADHC's progress with addressing the issues we identified. These include:

- a review of record-keeping in licensed boarding houses and plans to address issues identified by that review
- drafting an updated policy manual for monitoring boarding houses, including complaint-handling procedures
- establishing regional workplans for monitoring licensed boarding houses to be reviewed quarterly
- recruiting and training additional DADHC monitoring and casework staff.

DADHC have also initiated a clinical review of the health of residents in licensed boarding houses in one metropolitan region.

We note that legislative problems continue to impact on DADHC's capacity to effectively monitor standards in boarding houses, and this has implications for resident welfare. DADHC have told us that they have provided advice to their Minister on options for new legislation in this area and have been working with other government agencies to identify legislative gaps and ways to address them. However, the timeframe for any legislative changes remains unclear.

Support services for people with high and complex needs

We investigated a complaint about DADHC's provision of services to a person with complex support needs who was also in frequent contact with the criminal justice system. We were concerned about the circumstances in which the person, who had been a client of the department for many years, had been exited from DADHC accommodation services. We were also concerned about the considerable delay in providing him with alternative accommodation and the adequacy of interim support.

The investigation highlighted some of the current challenges for meeting the needs of people with an intellectual disability who have complex support needs associated with their behaviour and/or mental health.

We found that DADHC had failed to meet their responsibilities in exiting their client, including not referring him to other support services. We also found that they had failed to properly deal with subsequent requests for support for the client. Although a funding package to provide support services was available, DADHC had difficulty locating a suitable service provider. They did not take adequate steps to review their strategy in the context of these difficulties, and did not assess whether the person's needs were adequately met in the interim. As a result, the person was without an adequate support service for more than 15 months.

At the time of our investigation, DADHC told us that the current disability accommodation services exit policy would be re-issued with the department's vacancy management policy for the sector — scheduled for completion in July 2007. We recommended that the department review the exit policy to ensure it provided adequate guidance to staff, and take steps to ensure staff awareness of the current policy in the meantime. DADHC has since advised us that the vacancy management policy review, including the exit policy, is now due for completion in November 2007.

We also recommended that DADHC review their procedures for allocating support services, including those provided through a tender process, to make sure that — if the provision of support is delayed — there are adequate arrangements to meet client support needs in the interim.

In response, DADHC have advised us of a number of strategies they have adopted for improving support for clients with challenging behaviour. They are also planning to reform their emergency response program for providing assistance to clients in crisis, and review policy guidelines for prioritising and allocating services as part of improvements to case management and services provided by their community support teams.

Services for people from culturally diverse communities

In December 2005, DADHC launched a strategy to improve services for people from culturally and linguistically diverse (CALD) communities. The strategy aimed to increase the use of programs and services by CALD communities, and to improve how services respond to their needs and circumstances.

This year, representatives from the CALD peak agencies raised concerns with us that DADHC's implementation of this strategy had stalled and people with disabilities from CALD communities would be adversely affected as a result.

We have contacted DADHC to find out what progress has been made and will decide on any further action once we have received their response.

Services for Aboriginal communities

In 2005, DADHC released an *Aboriginal Policy Framework* that outlined strategies to increase consultation with Aboriginal communities and develop culturally appropriate services that are more accessible to Aboriginal people.

This year, we received feedback from Aboriginal communities that raised questions about whether the framework had been implemented across all regions and how consultation with local Aboriginal communities is informing the planning and delivery of community services.

We have asked DADHC for advice about their implementation of the framework, their consultation with Aboriginal communities and how they are ensuring the framework is implemented consistently across all regions of the state.

In June 2007, our Aboriginal Unit met with the Board of the Aboriginal Disability Network. This meeting was arranged in the context of our Aboriginal Unit holding discussions with members of the Aboriginal community about their awareness of DADHC's plans to improve Aboriginal people's access to disability services across the state. The Disability and Community Services Commissioner has arranged to meet with the Board again to report on DADHC's response to our questions about the implementation of the *Aboriginal Policy Framework*.

For further details about this work see Chapter 3: Our relationships.

People with an intellectual disability and the criminal justice system

Two years ago we reported on our investigation into DADHC's role as lead agency for a cross-government Senior Officers' Group (SOG), responsible for improving the interagency coordination of support for people with an intellectual disability who are in contact with the criminal justice system. We found that DADHC had failed in their leadership role and, as a result, the SOG had failed to implement its terms of reference.

Last year we reported that the SOG had developed a new strategic plan which focused on implementing projects such as the development of supported accommodation options for people leaving corrective services. This represented a shift in direction as the initiatives targeted specific DADHC services for certain individuals, rather than the development of a whole-of-government approach. We raised concerns about the capacity of the current approach to achieve the government's commitments in this area.

This year, in response to our concerns, DADHC drafted *People with an Intellectual Disability and Criminal Justice Service Principles and Protocols* — a set of overarching cross agency principles to guide the individual and collaborative work of the nine participating government agencies. The SOG will consider the draft document this year.

A number of other key developments include:

- the creation of an Office of the Senior Practitioner within DADHC, responsible for oversighting the department's work with people who have an intellectual disability in contact with the criminal justice system
- a review by the SOG of the NSW Government's progress against the recommendations of *The Framework Report 2001*
- the roll out of *Stronger Together* — which includes implementation of DADHC's criminal justice program, and commitments to develop 200 specialist accommodation places over five years.

DADHC have also reported that they are developing a policy framework for community support services for people with an intellectual disability who are in contact with the criminal justice system, and revising the criminal justice resource manual for caseworkers and behaviour support practitioners.

Much of the work in this area is still in the initial stages so we will continue to maintain an active monitoring role.

Respite care

Respite care for people with disabilities or people who are aged and their carers is a critical component of the community services system. *Stronger Together* includes commitments to create 750 additional flexible respite places in 2006–07. Our work this year has identified some concerns about access to, and the allocation and provision of, respite care in NSW.

From February 2006 to June 2007, we received 11 complaints about beds in respite centres being 'blocked' across three regions. Accommodation of people with disabilities in respite centres is typically for short periods of time, to provide a break for both the person and their carers. Beds in respite centres become blocked when they are used to house someone for long periods of time, usually because the person does not have alternative accommodation. For the complaints we received, the beds had been blocked for between two months and eight years.

In addition to concerns about the duration of stay, the complaints raised significant issues such as:

- the adequacy of care provided to residents living in blocked respite beds — including individual planning, health care planning and behaviour management
- the adequacy of plans to move some residents into permanent accommodation
- the assessment of risk and management of incidents for residents in respite services
- a lack of respite for other families due to blocked beds.

Peak agencies for respite care also raised concerns with us about the current provision of respite in NSW. These concerns included the allocation and prioritisation of respite places, planning to address unmet need and the restrictive guidelines for providing respite under the Home and Community Care (HACC) program.

We have raised our concerns with DADHC and will plan our future work once we have their response.

Services for people who are homeless

The Supported Accommodation Assistance Program (SAAP) is a jointly funded Commonwealth/State program that provides accommodation and support services to people who are homeless. In NSW, SAAP is administered by DoCS and delivered through non-government, community-based organisations with some local government involvement. The program funds more than 380 services in NSW that assist some 25,000 individuals each year.

Monitoring access to SAAP services

Our 2004 special report to Parliament, *Assisting homeless people — the need to improve their access to accommodation and support services*, found that certain groups of homeless people faced a high possibility of being excluded from SAAP services. In some cases, exclusions appeared to be unreasonable and possibly in contravention of anti-discrimination and SAAP legislation as well as SAAP standards.

We made a range of recommendations to DoCS and SAAP service providers aimed at ensuring the program maintained non-discriminatory and fair approaches to client eligibility, access and exiting. There has since been significant change within the SAAP system and notable progress in implementing measures that reflect our recommendations.

This year, DoCS provided a further progress report on their implementation of our recommendations. We are continuing our discussions with DoCS about their work with the Department of Housing to improve access to SAAP by people with physical disabilities, but we are satisfied that DoCS has met — or has strategies to meet — the recommendations they accepted.

In March 2007, we appointed an independent consultant to assess SAAP agency responses to our six recommendations for service providers. A written survey was distributed to all SAAP providers in NSW — which elicited a 40% return — and the consultants interviewed service providers, peak agencies and agencies that refer clients to SAAP. The findings were that:

- SAAP providers had acknowledged and moved to address issues of access and exiting
- the client risk assessment tool developed by peak agencies is being used by the majority of service providers, although a minority have not yet introduced any form of risk assessment
- some services had adjusted policies and procedures
- a small number of services had worked to improve links with other services to support them in working with people with complex needs.

Interviews with referral agencies elicited a mix of views about whether access to services had improved. The use of 'time outs' and temporary bans from services as a punitive response to clients who contravene agency policies also appears to be an ongoing issue. We will discuss these findings with DoCS and SAAP peak agencies.

There are a range of complex circumstances — other than unmet demand — that may lead to clients not being accepted at entry or exited early from SAAP services. In most cases, an individual risk assessment process is used to make decisions about acceptance or exclusion and SAAP agencies ensure that clients are not left without any accommodation as a result of decisions about acceptance (see case study 24).

Case study 24

A woman in custody with undiagnosed mental health issues was referred by prison staff for a placement at a SAAP service. A case manager from the service visited the woman in prison to assess whether the service would accept her as a resident. The service's assessment process sought information about potential residents' psychiatric histories. During the assessment, the woman acknowledged that she had been psychiatrically assessed — but she had not been diagnosed with a mental health disorder and was not on medication.

However, during the assessment, the SAAP case manager observed that the woman was exhibiting some extreme behaviour and was disordered in her thinking as to time and space. This concerned the worker, and she discussed the concerns with the prison welfare worker. The (prison) worker confirmed that there was no diagnosis, but acknowledged — off the record — that the woman's behaviour was quite disturbed and not well managed. The (prison) worker said that the woman had physically threatened prison staff when she was in a delusional state.

The SAAP service decided that they were unable to accept the woman into the service, but referred her to a service that takes women on remand who have existing mental health and drug and alcohol issues.

Reviewing deaths

Since December 2002 we have had responsibility under Part 6 of CS-CRAMA for reviewing the deaths of:

- children and the siblings of children reported to DoCS as being at risk of harm at any time in the three years before they died

- children whose deaths were a result of abuse or neglect, or occurred in suspicious circumstances
- children in care
- children in detention
- people with disabilities living in care
- people living in licensed boarding houses.

Our aim is to identify shortcomings in agency systems or practice that may have directly or indirectly contributed to a person's death, and make recommendations to prevent and reduce the risk of deaths in the future.

When reviewing deaths, we seek information and assistance from a range of government and non-government agencies. These include the NSW Registry of Births, Deaths and Marriages, the State Coroner, DoCS, DADHC, the NSW Police Force, NSW Health and various other government and non-government agencies that provide services to children and to people with a disability. CS-CRAMA gives us full and unrestricted access to records that we reasonably require to fulfill our reviewable death function.

Two expert advisory committees help us to perform our reviewable deaths functions. In 2006–07, the Reviewable Child Death Advisory Committee and the Reviewable Disability Death Advisory Committee each met on three occasions. They provide us with valuable advice on complex child and disability death matters, policy issues and health practice issues. There is a full list of committee members in Appendix J.

Our annual report

Each year we table a report to Parliament about our work and activities in reviewing deaths during the previous calendar year. In December 2006 we released our third annual report about our work in relation to reviewable deaths, *Report of Reviewable Deaths in 2005,* which is available on our website.

This report differed from previous years in that we decided to release the report in two volumes — *Volume 1: Deaths of people with disabilities in care*, and *Volume 2 : Child deaths* — to recognise the unique yet diverse issues, challenges and priorities of the disability and child protection sectors, and the specialised work we do in each area.

Between 1 January and 31 December 2005, we reviewed the deaths of 117 children and 68 people with a disability. We made a total of 62 recommendations that were directed to DADHC, DoCS, NSW Health, the NSW Police Force, and the Human Services' Chief Executive Officer's Group. We have received responses from agencies to our recommendations and will continue to monitor the implementation of these recommendations.

The Reviewable Disability Deaths volumes reported on some of the issues raised in consultations undertaken across the state about the interaction of people with disabilities in care with the health system. These issues included the following:

- barriers for people with disabilities accessing health risk screening and allied health services — including a lack of capacity or willingness by GPs to undertake comprehensive health assessments, and long waiting lists for public services or prohibitive costs for private services
- cases of inadequate identification of risk for people with disabilities leading to ineffective management of those risks, particularly nutrition and swallowing risks
- the importance of planning to meet individual health needs and gaps where it was not clear that staff were being provided with adequate information about the health and other needs of people in their care
- concerns about responses to critical incidents in disability services and licensed boarding houses, such as first aid not being administered in a timely or effective way
- concerns about the number of cases in which people, very recently discharged from hospital, were readmitted to hospital
- inaccurate record-keeping and inadequate documentation to support end of life decision-making.

A key focus of the review of child deaths that occurred in 2005 was the impact of parental substance abuse and the challenges this presents for agencies. We found:

- a number of instances where agencies did not report or did not adequately report risk of harm to a child's safety to DoCS
- when reports were made to DoCS, a high number of cases were closed without assessment — including those that indicated a significant child protection history
- concerns about the quality of secondary assessments and the need for holistic assessment and greater expertise by DoCS staff in the area of parental substance abuse.

The deaths we reviewed in 2006

This year, we reviewed the deaths of 221 people who died in 2006. This included 82 people with a disability who died in residential care, 16 people living in licensed boarding houses at the time of their death, and 123 children (in one case, a child died in residential care). In 114 of the child deaths reviewed, a risk-of-harm report had been made to DoCS in the three years before the child died, or they were a sibling of a child so reported.

Figures 40 and 41 provide details about the deaths reviewed in 2006 and show comparative figures for 2003 to 2005.

We have a responsibility to respond to concerns raised in our reviews of individual deaths. We may

undertake detailed analysis of an individual death or report back to service providers about our concerns. We may also make 'own motion' inquiries under the Ombudsman Act and, if appropriate, investigate the conduct of agencies with statutory responsibilities towards the person who died.

We took action in relation to concerns we identified in the reviews of 38 deaths that occurred in 2006. In eight cases, this involved making preliminary inquiries of agencies. At the time of writing, five of these matters had been resolved without progressing to investigation and five were pending. Following our review of a further nine deaths, we started and/or finalised 13 investigations under section 16 of our Act.

Deaths of children **fig 40**

	2003*	2004**	2005	2006
Registered child deaths	605	540	598	623
Deaths in jurisdiction	161	104	117	123
Jurisdiction not yet determined due to insufficient information	20	28	68	84
Child known to DoCS — reports made about the child and/or their sibling	121 of 161 (78%)	96 of 104 (99%)	109 of 117 (93%)	114 of 123 (93%)

* 2003 data includes the month of December 2002 (13 months total).

** These figures are correct as at the time of writing but may not be identical to the figures reported in our reviewable deaths annual report for 2006, which will incorporate information that becomes available later in 2007.

Deaths of people with a disability **fig 41**

	2003*	2004**	2005	2006
Deaths notified to our office	114	98	70	105
Deaths in jurisdiction	110	93	68	98
Deaths in residential care (*Disability Services Act*)	89 (81%)	69 (74%)	55 (81%)	82 (84%)
Deaths in licensed boarding houses	21 (19%)	24 (26%)	13 (19%)	16 (16%)

* 2003 data includes the month of December 2002 (13 months total).

** These figures are correct as at the time of writing but may not be identical to the figures reported in our reviewable deaths annual report for 2006, which will incorporate information that becomes available later in 2007.

Under section 43(3) of CS-CRAMA, we can also report to service providers or other appropriate people on matters related to a reviewable death, or arising from a review. We issued 29 such reports in relation to the deaths of 26 individuals who died in 2006. We also issued one report relating to a possible systemic issue identified in our reviews of 18 child deaths.

We notify the Coroner of reviewable deaths if those deaths have not already been reported to that office. We also notify DoCS and the Coroner if we identify previous deaths of other children in a family.

Our fourth annual report — tabled and publicly available later in 2007 — will examine reviewable deaths that occurred between 1 January and 31 December 2006. It will also report on systemic issues such as the deaths of people with dementia and the need for risk management to minimise the risk of people falling and injuring themselves, and the outcomes of the medical and service review of people who died from respiratory illness in 2005. It will also cover key challenges in the child protection system — such as the adequacy of risk assessments — and agency strategies for managing parental substance abuse.

Causes of death

In March 2007, we engaged the National Centre for Classification in Health at the Queensland University of Technology to analyse the underlying causes of death for the children whose deaths we reviewed between 2003 and 2006. We were particularly interested in identifying any notable differences in the cause of death for children whose deaths were reviewable, in comparison to all child deaths in NSW.

The work was completed in June, and the findings will be more fully reported in our *Report of Reviewable Deaths in 2006*. Some key findings were that:

- over 40% of children whose deaths were reviewable died as a result of natural causes, 18% died as a result of sudden or unexpected causes (SIDS, SUDI), 26% died as a result of unintentional causes of death (accidental) and almost 14% died as a result of intentional causes (assault or self harm)
- children under one year old represented the largest age group of reviewable deaths. However, as a proportion of the total population girls, aged 10 to 12 years and boys aged five to nine years represented the highest number of reviewable deaths
- a higher proportion of Indigenous child deaths were reviewable than non-Indigenous child deaths (42% compared to 19%). A greater percentage of Indigenous deaths were the result of sudden or unexpected causes than non-Indigenous deaths, while more non-Indigenous child deaths were the result of intentional causes (assault or self harm)

- although it was a small sample group, certain natural cause deaths were more prevalent among children whose deaths were reviewable — children in this population were more likely to die as a result of meningococcal disease, epilepsy and pneumonia than children in the general population.

Community information, education and training

We provide information, education and training to community service agencies, people receiving community services and other community services stakeholders about complaints and complaint-handling, service standards and our work in the community services sector. These activities play a valuable role in encouraging and influencing improvements in the quality of community services in NSW and promoting the rights of people receiving services.

Information and awareness activities

We aim to ensure that both people receiving services and service providers know who we are, what we do and how to contact us.

In 2006–07 we developed and implemented a new community services information strategy aimed at increasing awareness of our role in community services, the issues we identify in our work and the action we take to promote service improvements. Some of our activities this year include:

- information and awareness forums for community service providers in the Riverina and Illawarra regions
- articles about our work in regional print and electronic media and in the newsletters of over 20 peak bodies and advocacy groups — including the Association of Children's Welfare Agencies (ACWA), the NSW Council of Social Services (NCOSS) and People with Disabilities (PWD)
- thirty-one presentations at conferences and forums — such as the National Disability Services conference, the Professional Association of Nurses in Developmental Disability Areas (PANDDA) 17th annual conference and The Right to the Right Health Care conference
- distribution of NSW Ombudsman publications to relevant information outlets.

Our staff were also involved in more than 80 other community information and consultation activities in 2006–07.

Our child and family services education project reached over 600 community services employees throughout the state during the year. Activities included training workshops, information stalls at the DoCS Aboriginal staff conference and the ACWA conference, and presentations to DoCS caseworkers, disability advocates, health professionals, child sexual assault workers, foster carers, foster carer support groups and children's services peak bodies.

Education and training

Our flagship complaint management and handling training and our consumer rights workshops continue to be in high demand. In 2006–07 we conducted 27 workshops and provided training to over 450 service managers, staff and people receiving community services.

Feedback from participants continues to be extremely positive, with 95% telling us that our workshops were of a consistently high standard and will assist them to handle complaints more effectively.

Case study 25

During 2006–07 we reviewed the complaints handling systems and practices of 20 DoCS funded non-government family support services. One service we reviewed had a particularly well-developed and responsive system for handling complaints.

We found that the service had a comprehensive complaints policy that addressed all the essential elements of a good complaints handling system and complied with the Australian Standard for Complaint Handling. The policy demonstrated a positive attitude, coupled with respect for — and promotion of — the rights of consumers. The service's complaint system was accessible to, and accessed by, staff. The service's clients included a high proportion of people from culturally and linguistically diverse backgrounds and many people with low literacy. They had readily accessible information in plain English — which had been translated into several community languages — about their rights to make a complaint about any service problems and how complaints would be handled.

Our staff had previously run a comprehensive complaint-handling training program for all the service's managers and staff. The service management clearly supported and endorsed the training when we provided it.

It was pleasing to see this agency embracing and implementing the knowledge and skills gained from our training and providing an excellent example of a complaint-handling system that works well for staff, managers and the clients of the service.

Boarding house program

Our program targeting licensed boarding houses, *Solving problems — Right at Home,* has continued to be very effective. Conducted in partnership with OCVs, the program provides training for proprietors and staff of boarding houses as well as small group awareness and skills based training for residents, focusing on consumer rights. We also provide information to employees from allied services working with boarding house residents, such as health and home and community care staff.

Participants have told us that bringing together residents, staff and allied workers has helped build trust, and has empowered residents to discuss and resolve problems directly with the staff at boarding houses.

We conducted four boarding house programs this year for over 90 people and have another four training programs planned for 2007–08.

***Solving problems — Right at Home*. Carolyn Campbell-McLean, Community Education Officer (front middle) with boarding house residents during a training workshop.**

Official community visitors

Official community visitors (OCVs) are statutory appointees who provide an independent mechanism for the Parliament to ensure that children and people with disabilities living in residential services in NSW receive the highest standard of service possible. The Minister for Community Services and the Minister for Ageing and Disability Services appoint OCVs for up to six years.

OCVs visit residents in accommodation services, provided and funded by DADHC or DoCS, including:

- children and young people in out-of-home care
- children and young people with a disability in out-of-home care
- adults with a disability
- adults living in licensed boarding houses.

The role of OCVs is to inform the relevant Ministers about matters affecting the conditions of people in care, promote the legal and human rights of residents, consider matters raised by residents, provide information and assistance on advocacy and help resolve the grievances and concerns of residents. They provide an independent 'window' into the quality of services provided to children and young people, people with a disability and people living in licensed boarding houses.

Visitors do this by:

- making regular visits to eligible services
- enquiring about the adequacy of the care and services provided to residents
- acting on issues raised by residents, staff and others having a genuine concern for the welfare and conditions of residents — such as family, advocates and guardians
- resolving or progressing complaints with service management
- reporting on systemic problems and promoting and encouraging good practice
- providing information to residents and services to promote the rights of residents in care.

We administer the OCV scheme, setting priorities for visiting and providing support to OCVs in their day-to-day work. We recruit, induct and support OCVs, provide training programs on service practice issues and coordinate an annual OCV conference, regular OCV regional and consultation meetings, and meetings with sector specific groups.

In 2006–07, 31 OCVs visited 1,230 services, making 3,164 visits to 6,582 residents. They provided 9,507 hours of service to residents, which is a significant increase on the 7,581 hours in 2005–06. Three new OCVs started during the year.

Generally, OCVs work alone — sometimes in very challenging circumstances. Over the last 12 months, we have increased our support of OCVs and provided them with more opportunities for professional development. We have held a number of workshops highlighting practice issues and sector changes and developed new reporting mechanisms to enhance the information OCVs provide. This will enable us to better monitor and report service provision trends and patterns — as well as identify and resolve issues in individual services.

Issues raised by OCVs

During 2006–07, OCVs identified 2,898 issues of which 1,643 were finalised (57%). Of the finalised issues, 74% were resolved. Visitors continue to monitor the action taken by services about the remaining 43% of current issues (see figures 42 and 43 over page).

Some of the most common issues raised with OCVs include the:

- development, implementation and review of plans to meet the needs of residents — 463 issues

- inadequate condition of premises and facilities — 325 issues
- the development, implementation and review of plans for managing the behaviour of residents — 250 issues
- inadequate management of nutrition, health and hygiene issues for residents — 246 issues.

Official Community Visitors attending a workshop on dispute resolution at the 2007 Official Community Visitor conference

Number of visits made by official community visitors in 2006–07 fig 42

Target group of services	No. of services	No. of residents	No. of activity hours	No. of visits	
				05/06	06/07
Children and young people	107	213	1,040	414	370
Children and young people with a disability	41	133	481	134	142
Children, young people and adults with a disability	18	71	180	109	54
Adults with a disability in residential care, including boarding houses	1,064	6,165	7,806	1,912	2,598
Total	**1,230**	**6,582**	**9,507**	**2,569**	**3,164**

Outcome of issues identified by OCVs finalised in 2006–07 fig 43

Target group of services	No. of visitable services	No. of issues identified	Percentage of issues finalised	Percentage of issues finalised* (resolved issues)	Percentage of issues finalised** (unresolved issues)	Percentage of issues finalised*** (closed issues)
Children and young people	107	377	60%	58.50%	29.50%	12%
Children and young people with a disability	41	106	40%	48%	33%	19%
Children, young people and adults with a disability	18	115	58%	79%	21%	0
Adults with a disability including residents of boarding houses	1,064	2,300	57%	78%	10%	12%
Total	**1,230**	**2,898**	**57%**	**74%**	**14%**	**12%**

* where services take action to remedy the issue, resulting in improved services for residents.

** where services are unable or unwilling to resolve issues. For example, issues that are beyond the capacity of services to resolve as they are affected by systemic budgetary, policy or other factors. OCVs may report such issues to the NSW Ombudsman with a view to complaint or other action.

*** where issues are no longer relevant. For example, because a service closes or a resident of a visitable service about whom an issue has been identified relocates to another service.

Review of the merger of the Community Services Commission into the Office of the Ombudsman

In October 2006, the Parliamentary Joint Committee tabled a report on a stakeholder review of the merger of the Community Services Commission into our office. The review was a precursor to the committee's review of CS-CRAMA to be undertaken in 2007.

The aim of the review was to find out the views of peak agencies in the community services sector in NSW about the services provided by the Ombudsman.

The committee concluded that our special investigative powers and capacity to make a special report to Parliament appear to have been appreciated by stakeholder groups and to have been of benefit to the community services sector. They identified the following matters as warranting further assessment and evaluation during the statutory review:

- the extent of the implementation of the Ombudsman's recommendations made in reports to Parliament and arising from investigations
- the percentage of formal complaints that are resolved
- the level of complainants' satisfaction with the handling of their complaints
- the level of public recognition of the role of the Ombudsman in relation to community services.

The committee expressed concern about the extent to which the Ombudsman is able, under CS-CRAMA, to:

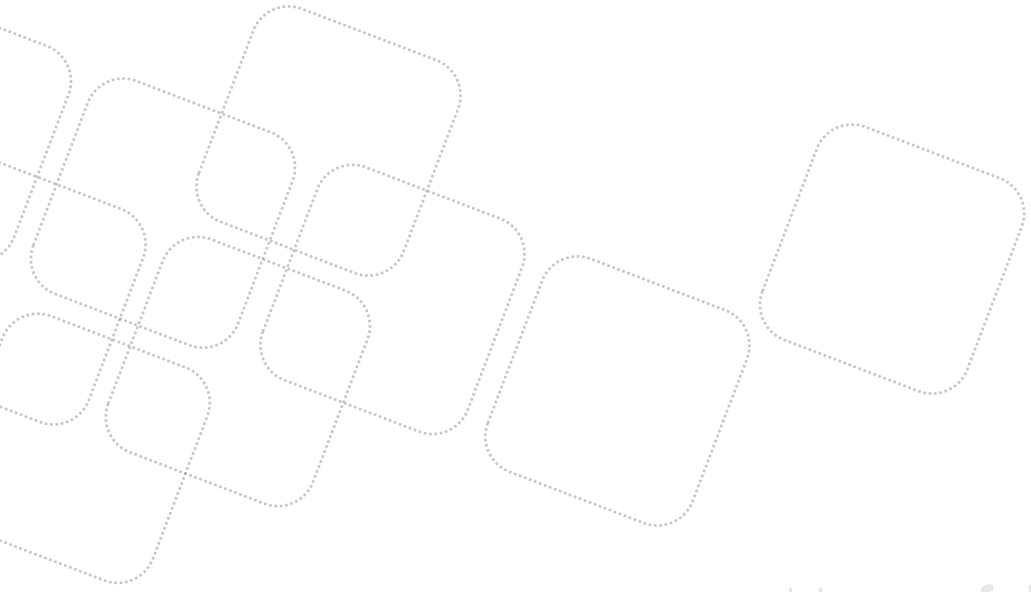
- promote access to advocacy support for people receiving, or eligible to receive, community services to ensure adequate participation in decision-making about services they receive
- facilitate immediate responses to emergency situations not adequately dealt with by DoCS or other service providers.

They noted that the integrity of the overall system within which we carry out our community services functions is central to any assessment of these issues.

We acknowledge the importance of the committee's findings and, in response, we have:

- strengthened our complaints work by creating additional management positions in the complaints section
- expanded our community profile, particularly through information and education strategies targeted to rural areas
- continued to build relationships with peak agencies in the sector to assist us to better deliver our services
- started a significant project examining the support provided to foster carers of Aboriginal children.

In addition, we commissioned an independent consultant to measure the views of stakeholders about our work. Overall, the findings were very positive.



we want to see **fair accountable** and **responsive** administrative practice and service delivery in NSW in our own organisation and those we oversight we work to **promote good conduct fair**

Highlights

- We achieved 636 positive actions involving local councils from the 539 complaints we investigated. Some complaints resulted in multiple positive outcomes. The provision of further information, reasons for decisions and the review of cases featured highly in these. Other remedies achieved included correction of errors, apologies, changed decisions and the mitigation of consequences of decisions that could not be undone, staff training and disciplinary action, payment of compensation and changes to council policy and procedures.

- After years of inaction, Sutherland Shire Council finally disclosed critical information about public safety risks to residents living next to the Kurnell Oil Refinery. Council also compensated our complainants for the financial detriment they suffered after they relied on inaccurate information provided by council and purchased two residential building blocks that were effectively sterilised for development.

- Liverpool Council stopped their rangers from issuing infringement notices for a traffic offence they did not have the power to police.

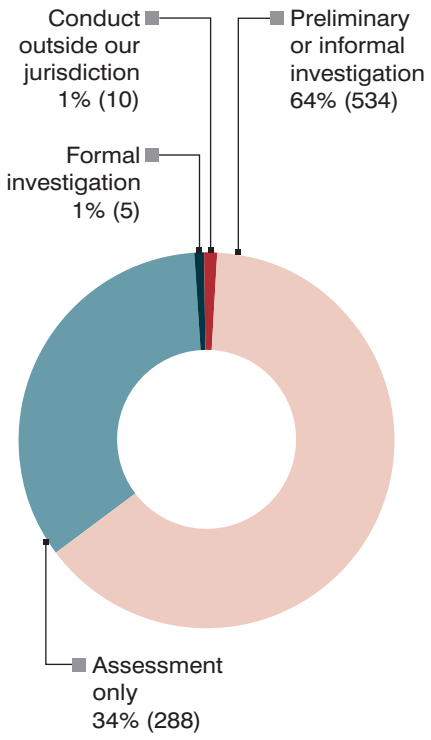
Complaint trends and outcomes

Formal complaints about local government authorities jumped 13% this year and there was also an increase in informal complaints made to the office by telephone or in person (see figure 46 over page). Basic administrative issues were mostly about corporate and customer service. The way councils handled resident complaints continued to be the major area of complaint, followed by problems related to building and development and enforcement issues. Figure 45 (over page) gives a breakdown of the nature of the local government complaints received and Appendix E details how we dealt with the specific complaints made against individual councils.

A greater percentage of complaints this year warranted inquiries so we almost doubled the number of preliminary investigations we conducted compared to the previous year. We achieved a broad range of outcomes from these investigations. Of the 539 preliminary or formal investigations we conducted, we registered 636 positive outcomes for the complainants involved or the wider community through changes to policies and procedures (see figure 44 over page). Over a third of these involved the provision of further information to the complainant about the rationale and the legal and policy context of the decisions that aggrieved them, which assisted in resolving their concerns or helping them understand the reasons for the actions taken. Other remedies achieved included payments of compensation, changed decisions, admission of and correction of errors, reviews of cases, apologies, the mitigation of the consequences of decisions that could not be undone, changes to internal processes and council policies, and the implementation of staff training. The following case studies provide a sample of the many cases we dealt with during the year.

Formal complaints finalised fig 44

Current investigations (at 30 June)	
Under preliminary or informal investigation	61
Under formal investigation	3
Total	**64**



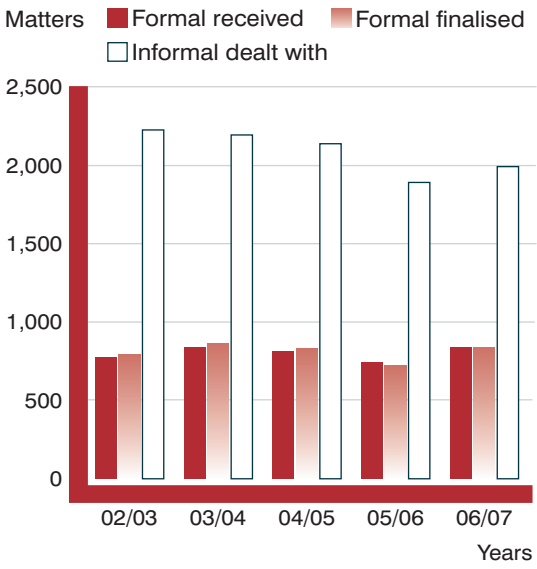
What people complained about fig 45

This figure shows the complaints we received in 2006–07 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	Formal	Informal	Total
Corporate / customer service	418	419	837
Development	102	440	542
Enforcement	102	196	298
Rates charges and fees	36	198	234
Environmental services	31	187	218
Engineering services	35	150	185
Object to decision	33	151	184
Misconduct	47	69	116
Uncategorised	1	71	72
Community services	16	31	47
Issue outside our jurisdiction	8	27	35
Strategic planning	6	28	34
Management	6	24	30
Child abuse related	0	1	1
Total 2006–07	**841**	**1,992**	**2,833**

Five year comparison of matters received and finalised fig 46

Matters	02/03	03/04	04/05	05/06	06/07
Formal received	774	840	814	744	841
Formal finalised	791	865	833	720	837
Informal dealt with	2,226	2,194	2,138	1,891	1,992



Enforcement issues

We regularly receive complaints about the conduct of rangers in relation to companion animals, parking tickets, noisy trail bike riders or abandoned vehicles. Given the increasing public scrutiny of councils' revenue-raising activities, it was disappointing to receive a complaint this year about rangers issuing infringement notices for a traffic offence that police are actually responsible for enforcing.

Case study 26

At the direction of a crossing supervisor, a truck driver stopped at a children's crossing just past the stop line marked on the road — but before the actual crossing. A ranger from Liverpool Council issued the driver with a penalty notice for disobeying Rule 171 of the *Australian Road Rules* (ARR). The complainant alleged the ranger was misusing the rule to issue penalty notices for an offence rangers were not authorised to enforce.

We sought the views of the RTA, the police and the Australian Road Rules Maintenance Group.

They all agreed it was a traffic offence, not a parking offence.

We found the description of the events surrounding the alleged offence met the elements of Rule 80 and not Rule 171. Only police are authorised to issue infringement notices for traffic offences like Rule 80. In response, council withdrew the penalty notice and issued an instruction to rangers and parking services not to apply Rule 171 to situations where the vehicle is in the process of moving or coming to a halt.

Councils are not obliged to take enforcement action in response to every complaint about unauthorised activity or development. However — when deciding whether or not to take enforcement action — they are obliged to act without unreasonable delay, be consistent and consider relevant matters.

Unfortunately, decisions about enforcement action are not always made on the basis of proper investigation and consideration — and people often have to contact us to get action.

Case study 27

A couple complained about Sutherland Shire Council's failure to act on complaints about asbestos-contaminated soil that had been stockpiled against a fence along the boundary line of their property. After our inquiries, council admitted they had not taken action and issued a clean-up notice to the owners of the property. The owners then provided council with documentation from a qualified consultant about a clean-up management plan — including a date for the work to be finalised — and council undertook to monitor the clean-up operation to ensure compliance.

Case study 28

A resident complained about Muswellbrook Council's inadequate response to his numerous complaints about the hours of operation of an earthmoving business on a neighbouring property in a residential zone — and associated problems with noise and pollution. The owner of the business claimed it had been established at the site before planning controls were introduced.

Our investigation found that council had accepted the owner's claims of existing use rights, even though there were no consents in council records and the development exceeded any approvals or existing use rights that might have existed.

When existing use rights are contested, the property owner must establish the history of an operation on the site. Council did not provide any guidance on the type of information it required the business owner to provide, and did not consider evidence of several long-time residents who contradicted the business owner's claims. In determining that existing use rights did apply to the site, council relied on reports that did not include any details or analysis of the relevant law, planning instruments and zoning requirements. They did not have copies of all the planning instruments that historically applied to the site and their general record-keeping practices were poor.

Council responded positively to the deficiencies we identified. They developed guidelines and provided training to planning staff — and resolved to apply the guidelines to recent decisions, including those relating to the site in question. They are also developing an enforcement and prosecutions policy to assist staff to act promptly, consistently and effectively on allegations of unlawful activity. Relevant record-keeping practices have been reviewed and updated and a process for registering and tracking complaints is being developed. Council are also in the process of documenting local planning history.

In 2006–07 we received a number of complaints about councils issuing orders inconsistently. When we made inquiries about these complaints, councils investigated the allegations about discriminatory treatment. In some cases, there was no central or coordinated method for recording and monitoring the investigation and resolution of complaints. Often, different sections of a council were responsible for different aspects of their regulatory responsibilities and used different procedures and records.

Case study 29

Eurobodalla Shire Council required a property owner to remove shrubs he had planted on the nature strip at the front of his house. The owner complained the council had discriminated against him because they had ignored a neighbour's illegal structures and several cars, boats and caravans parked on the nature strip

in his street. Council had further exacerbated the situation by providing inaccurate information in response to the owner's complaints.

Following our inquiries, council issued warnings to all owners of cars, boats and caravans to move their vehicles off the nature strip and confirmed that a contractor would undertake the work to remove the illegal structures. They also improved access for all road users.

We found that a poor understanding by different sections of council's operations of their responsibilities to inform compliance and enforcement officers of illegal activities resulted in inaccurate advice being provided to the complainant. At our suggestion, council adopted a compliance and enforcement policy to guide their decisions and actions when dealing with unlawful activity — and provided training to staff in the use of this policy.

In all cases involving enforcement issues, we encourage councils to establish effective systems for recording and acting on complaints. We also encourage them to develop appropriate enforcement and prosecution policies that detail the factors that should be considered when deciding what enforcement and prosecution action, if any, will be taken.

Information and transparency

An important duty of all public authorities, including councils, is to be complete and accurate when providing information that they have a legal or moral obligation to disclose. Incorrect or incomplete planning control information in disclosures made by staff or in section 149 planning certificates can have serious consequences — see case study 30. Making sure key information is accessible is also important — see case study 31.

Case study 30

As a result of a series of public and confidential reports received since 1986, Sutherland Shire Council had been aware that heat radiation effects from potential tank, pool or jet fires at the Kurnell oil refinery could extend into nearby residential areas. Despite being aware of the risk, council did not inform all their planning staff about it — or develop a strategy for dealing with development applications. This led to inconsistent decision-making. For example, council approved one residential subdivision despite knowing that at least part of it fell within the affected area — but later used the same information to refuse development applications to build on some of the lots.

Council also showed little regard for the public interest in their failure to inform people about all the restrictions and risks applying to development on the Kurnell Peninsula, particularly in the 'buffer' zone for residential development. Despite repeated warnings from the refinery and the recommendations of their own risk assessment manager, council only took action to alert the public of the risk after our complainants began legal action.

The complainants had made inquiries with council about two residential building blocks at Kurnell before purchasing them. They were provided with inaccurate information — to the effect that they were entitled to erect a dwelling on each allotment. To the complainants' significant financial detriment, council later refused their application to build on the lots — based on the safety risk detailed in the reports they had failed to disclose. We recommended that the complainants be fully compensated.

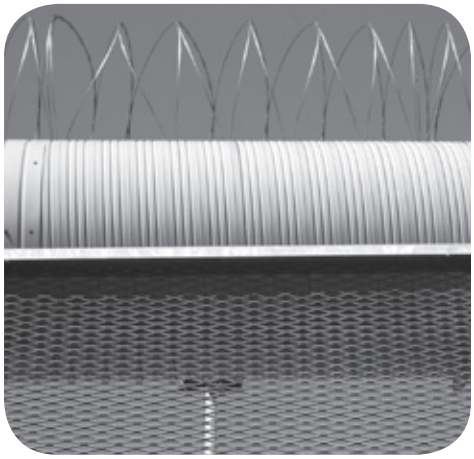
After prolonged negotiations, council reached a settlement with the complainants. They have also resolved to prohibit further residential subdivision in the area because of the ongoing safety risks.

Case study 31

A woman wrote to us to complain about Woollahra Council's response to her advice that the development next to her property was not complying with the conditions of development consent. The woman's property had suffered from vibrations caused by an excavation for the building.

We discovered that a private certifier had been appointed for the development, but council had not made it clear to the complainant or the developer who was responsible for pursuing the complaint. We also found that council did not have a policy or procedures for dealing with complaints about developments when a private certifier has been appointed as the principal certifying authority.

We suggested that council implement a policy clearly setting out the respective responsibilities of the council and private certifiers, and describing what action council will take when a complaint is received about a development involving a private certifier. We also suggested the policy be made available on council's website and information about it provided to objectors when notifying them of the outcome of development applications, as well as to private certifiers when council is notified they have been appointed as the principal certifying authority.



Highlights

- We spent 175 person days visiting correctional centres. We visited all but three centres at least once and met with many staff and inmates to discuss both concerns and achievements. Our staff learnt a lot about the running of the correctional system through these visits, which helped us to respond quickly to inquiries when we were back in our office.
- One inmate was released on bail after we pursued inquiries with both correctional and administrative staff at his centre. The centre found that some documents had not been provided to them by the court advising of his "bail granted" status.
- As a result of inquiries we made, the Department of Corrective Services introduced a new policy to provide guidance to inmates and staff about inmates conducting business activities while they are in gaol.
- In a number of centres, access to basic amenities and inmate needs were improved due to our intervention, including getting haircuts, having a shower while a shower block was being painted and being provided with prescribed medication that had run out.
- In response to suggestions we made, a Commissioner's Instruction was issued detailing new administrative arrangements for the reporting and investigations of unauthorised releases of information.

Introduction

In a society in which the government is responsible for the imprisonment of its citizens, good public administration includes a fair and humane correctional system. When the first NSW Ombudsman was appointed in 1975, there were approximately 3,300 inmates in NSW gaols. This year it is anticipated the inmate population in NSW may reach 10,000, with approximately 18,000 more offenders under community supervision. For 32 years the Ombudsman has dealt with complaints about the correctional system — primarily from inmates, but also from their families and other members of the community. While there are a number of other watchdog agencies dealing with matters relating to corrections, the issues raised with the Ombudsman cover the broadest range of topics.

The existence of a specialist corrections unit in the Ombudsman's office does not mean the Department of Corrective Services (DCS) is under greater scrutiny than other public agencies. It just means we have specialist staff who have detailed knowledge of the operating rules and practices of the correctional system — and this enables them to better respond to the issues that inmates contact us about, without necessarily needing to make inquiries with departmental staff.

We recognise the practical difficulties inmates may have in bringing their concerns to us, and we have adopted policies and procedures to alleviate these where we can. For example, it is no longer essential for a complaint to be made to us in writing — we can now accept oral complaints. We routinely visit correctional centres to talk to those who are concerned about speaking with us in the somewhat public areas where inmate phones are located. Mail to and from our office also attracts professional privilege to give an assurance of confidentiality.

Whether it is a phone call to a general manager or another officer in a centre, or a letter to the Commissioner containing our questions and concerns, we also recognise that responding to the inquiries we make with the department takes time out of busy days — and our queries must be responded to along with those made by others. However — making inquiries and checking on allegations raised with us ensures there is the level of transparency and accountability we expect from our correctional system. As a society, we acknowledge that the denial of a person's liberty in being sent to gaol is their punishment, and the administration of that punishment should be fair and reasonable. The Ombudsman's oversight of the correctional system —

through the complaint process — is one mechanism that Parliament has established to ensure this.

Our relationship with DCS is generally positive and cooperative. We try to resolve the majority of concerns brought to us quickly and at the local level, so this professional relationship is important. Staff working in centres and throughout the department generally provide us with information and respond to our questions in a timely manner. They will continue to do so as long as the most senior staff in their department encourage them to respond to us in this way and lead by example.

Complaint trends and outcomes

Most complaints we receive involve issues about daily routines — such as placement within a centre, lack of amenities, telephone access, lack of activities or programs and time out of cells. Many of these issues, such as access to phones, can often be quickly resolved at a local level. A call to the centre complained about will often show that access is not always an issue, but was problematic on a particular day — due perhaps to lack of staff, a variation to the usual structure of the day, or technical faults with the phones. However — a complaint we identify as 'access to telephones' may also be evidence of a bigger problem, such as at Cessnock where the communications company seems unable to provide an adequate and continuous service to the phones in one of the wings. This is despite ongoing and repeated efforts by staff and management at the centre to address the problem. Case studies 32 and 33 illustrate some of the basic amenities issues we have resolved in the past year.

Case study 32

Each cell in a correctional centre contains a few basic fixtures — a bed, some shelving or a cupboard, a sink, a toilet and sometimes a shower. A Goulburn inmate complained that his toilet had been broken for the past month and in the last two weeks conditions in his cell had deteriorated. He and his cellmate felt that it was very unhygienic. They had put in an inmate request form and contacted the department's Corrective Services Support Line (CSSL), but nothing had happened. They had also spoken to their area manager and been told that the plumber was away and the toilet would be fixed when he returned from holidays. We contacted the general manager's office and received a phone call from the security manager advising that the toilet was 'being fixed as we spoke'.

Case study 33

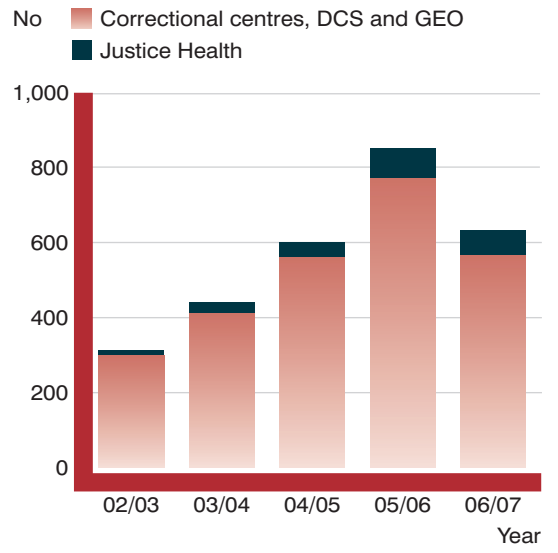
Simple activities such as getting a haircut can become problematic in gaol. In male centres an inmate is usually trained in the use of electronic hair clippers and their proper care and maintenance. They then become the 'barber' — the only person authorised to cut other inmates' hair, and they are paid for doing so. One inmate at the Metropolitan Special Programs Centre wrote to us that inmates had been without proper hair clippers for three months, allegedly due to some dispute about which part of the department should pay for them. We called the general manager at the centre and he immediately gave us an undertaking that an officer would arrange for the clippers in the unit to be replaced.

Following a significant upsurge in complaints the previous year which paralleled the increase in inmate numbers, complaints about correctional administration in centres operated by the Department of Corrective Services and GEO Australia (Junee Correctional Centre) fell by almost a quarter this year. This is a welcome change. We consistently encourage inmates to use internal systems, including the Corrective Services Support Line which is now available in all centres, as the first point of call for their grievances. The reduction in complaint numbers is a likely indication that the internal systems are being used by inmates and working more effectively. Contrary to this general trend, complaints about Justice Health increased by 12% (see figure 47).

Formal and informal matters received about correctional centres and Justice Health — five year comparison fig 47

	02/03	03/04	04/05	05/06	06/07
Formal					
Correctional centres, DCS and GEO	299	412	561	772	566
Justice Health*	15	30	41	80	69
Sub-total	314	442	602	852	635
Informal					
Correctional centres, DCS and GEO	2,585	2,773	2,852	3,242	3,010
Justice Health*	292	327	283	218	266
Sub-total	2,877	3,100	3,135	3,460	3,276
Total	**3,191**	**3,542**	**3,737**	**4,312**	**3,911**

* Justice Health provides services in both Correctional Centres and Juvenile Justice centres. For simplicity, all Justice Health matters are reported in this table.



A breakdown of the complaints received against each correctional centre can be found in Appendix F. The subject matter of the complaints is detailed in figure 48. As in previous years, the main areas of complaint concerned administrative matters affecting the daily lives of inmates — time out of cells, basic hygiene and amenities, access to telephones and mail, lost property, problems with visits and transfers, buy ups, access to medical services and allegations of unfair discipline and officer misconduct. In the reduced circumstances in which most inmates live, and the hothouse atmosphere of prisons generally, these issues can easily fuel distress and anger unless they are dealt with quickly and sensibly. Access to our corrections unit continues to provide an important safety valve for inmates in the NSW correctional system. Through our assessment and investigation of complaints and regular visits to centres, we continue to provide an important service that assists in ensuring the transparency and accountability of these agencies, as well as ensuring the legal and human rights of inmates are respected.

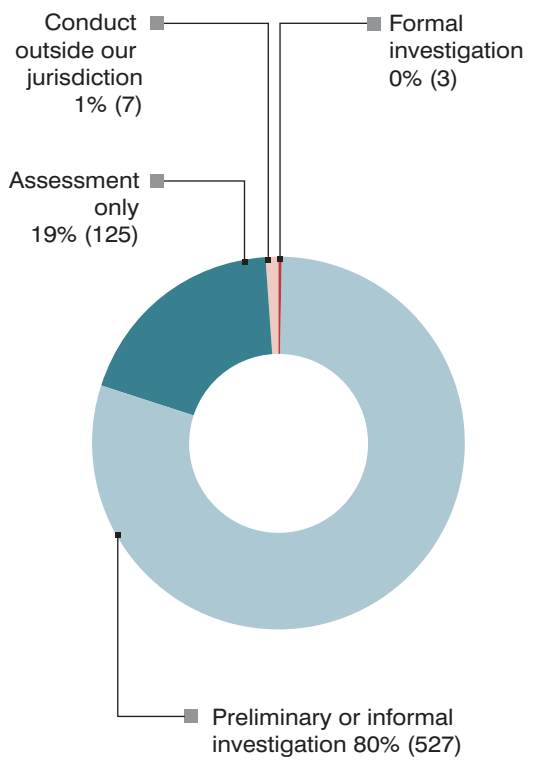
What people complained about fig 48

This figure shows the complaints we received in 2006–07 about correctional centre concerns, 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	Formal	Informal	Total
Daily routine	86	481	567
Property	61	300	361
Visits	37	221	258
Transfers	43	189	232
Medical	25	201	226
Officer misconduct	54	155	209
Classification	20	186	206
Other administrative issue	15	154	169
Records / administration	42	121	163
Buy ups	23	137	160
Case management	24	121	145
Probation / parole	17	111	128
Unfair discipline	14	99	113
Work and education	13	82	95
Segregation	19	74	93
Mail	12	76	88
Food and diet	9	61	70
Security	11	53	64
Information	18	45	63
Legal problems	6	51	57
Issue outside our jurisdiction	7	29	36
Day / other leave / works release	4	30	34
Fail to ensure safety	4	21	25
Court cells	2	6	8
Periodic / home detention	0	3	3
Child abuse related	0	2	2
Community programs	0	1	1
Total 2006–07	**566**	**3,010**	**3,576**

This year we finalised 527 preliminary and three formal investigations. (See figure 49). From these we achieved 385 positive outcomes for the complainants. Given that in approximately 40% of these cases we found there to be no or insufficient evidence of any wrong conduct on the part of the agency involved, this is a pleasing result. Even in cases where we find the actions taken by correctional officers to be legal and reasonable in the circumstances, an important part of our work involves providing detailed explanations to the complaining inmate, including information about the applicable legal rules and policies where possible. Often inmates are more prepared to accept explanations from our staff than they are from correctional staff because they see us as independent arbitrators.

Formal complaints finalised **fig 49**



Current cases (at 30 June)	
Under preliminary or informal investigation	56

The following case studies provide a sample of the wide range of matters we dealt with during the year.

There are some issues that arise consistently each year, such as those relating to segregation. Segregation removes an inmate from the general gaol population, usually for reasons of good order and security. It is not a punishment, but to most inmates that is simply a technical consideration. Segregation limits an inmate's time out of their cell, their ability to associate with other inmates and their access to programs and activities — so the legislation allowing it includes certain protections and rights of review. Even so, segregation is a frequent area of complaint to our office. Case study 34 discusses just one of the issues surrounding segregation that we dealt with in 2006–07.

Case study 34

An inmate had been on a segregation order for almost three months at Parklea Correctional Centre when he was transferred to Mid North Coast Correctional Centre for court matters. When he arrived at the Mid North Coast, he was put on a new segregation order.

There are legislative provisions enabling a segregated inmate to appeal to the Serious Offenders Review Council (SORC) against any segregation order still in effect after 14 days — and again at three months and six months if they remain segregated. The inmate was concerned that, by receiving a fresh segregation order, his ability to lodge an appeal application would be delayed by another two weeks. Segregation orders continue to be in force until the general manager revokes them, even when the inmate is transferred to another centre. The general manager at the centre receiving a segregated inmate must decide within 72 hours if the segregation order will be revoked, continued or amended. A new segregation order can only be started for the same inmate — within 14 days of the end of their last segregation — with the approval of the regional assistant commissioner.

We contacted Mid North Coast and found that Parklea had not sent the inmate's segregation paperwork with him. Mid North Coast made further inquiries and found that the Parklea segregation order remained in force — so the general manager decided the original order should continue. This enabled the inmate to lodge his appeal to SORC at the three month mark.

Our focus on resolving complaints informally where possible means we only need to use our coercive investigation powers — such as requiring officers to attend a hearing and give evidence on oath — infrequently. During 2006-07 we finalised one complaint that we managed in this way. The department accepted our recommendations in the matter, but it was disappointing that they also chose to express the view that our investigation was a waste of their resources, and that overlooking some procedural matters was an unfortunate by-product of responding promptly to an untested allegation. The details of the case are in case study 35.

Case study 35

An inmate at the Metropolitan Special Programs Centre (MSPC) complained about being removed from his work position in the centre because of an allegation that he had breached security by sending an email outside of the gaol to his child victim. He was concerned that the allegation was made maliciously. After several months he had still not heard whether the department had completed an investigation into the allegations. Our inquiries found that there was no evidence to support the allegations against the inmate. However, we were concerned about the way the department handled the investigation, so we began a formal investigation.

We found there was no wrong conduct in the immediate reaction of assessing and eliminating the potential for possible security breaches by removing the inmate from his work position where he had access to a networked computer. However — given that the allegations had the potential to be highly damaging to the department — we were critical of the way the actual investigation of the alleged security breach was investigated. There was no proper forensic examination of the suspect computer, and an inadequate risk assessment of the potential for any other inmate to misuse computers in the work environment.

There was also inadequate recording of the information collected and the steps taken in response to this information. The security manager did not keep a clear and detailed contemporaneous note of the allegations and the steps he took to investigate them. He also did not report the matter to the intelligence officer at the MSPC or file an intelligence report. In fact, the security manager gave evidence that he did not know how to complete an intelligence report or who would be responsible for recording and reporting investigations into serious allegations in the absence of an intelligence officer.

Finally, we found that the records of the allegations that subsequently found their way to the inmate's case files were misleading and inaccurate, and had the potential to be prejudicial to the inmate.

We recommended the department set the record straight about the allegations and the fact that no evidence was found to support them — by telling the inmate and annotating his files. We also recommended that:

- all security managers are trained in investigation and intelligence reporting and analysis
- the department's policies about recording and reporting allegations are made clearer.

Visits to correctional centres

Our visits to correctional centres provide a window into the correctional system. They provide our staff with the opportunity to understand first hand the closed environment of a gaol and to gain knowledge about routines, programs, departmental policies and procedures. Other people and agencies such as official visitors also regularly visit correctional centres. However, the Ombudsman is the only agency that reports publicly on an annual basis about what we see and experience during our visits.

During 2006–07 we spent the equivalent of 175 person days visiting centres. The only centres we did not visit in the past 12 months were Broken Hill, Ivanhoe and Yetta Dhinnakal. As we receive relatively few complaints from or about these centres — and because of their distance from Sydney — we only schedule visits there every two years or so. However, we have visited many other centres twice or more depending on the number of inmates, the amount of contact we receive by phone and letter from the centre, and whether any inquiries into a specific complaint have highlighted a potential need for a visit by our staff.

Our corrections unit staff undertake all visits to correctional centres. Sometimes other specialist staff — including those from our Aboriginal unit or our inquiries team — accompany them. Having a core group of staff responsible for visits means we have developed some excellent working relationships with correctional staff and managers in the centres. This has ongoing benefits for resolving complaints by phone or email when we return to the office.

We find that visits often help identify issues that are concerning a number of inmates. For example, at Berrima Correctional Centre the inmate development

committee met with us to discuss the lack of hairdressing facilities for women at the centre. The women are not allowed to have scissors and there were no haircutting facilities available. Before we left the centre, we raised this issue with the general manager. She had been unaware of the situation and took immediate action. Within a fortnight we were told she had identified a room to be used for haircutting and the women would be able to book haircuts once a week.

Visits give us unique access to — and understanding of — the conditions in which many inmates live in NSW gaols. There are extensive redevelopment plans for Cessnock Correctional Centre, but the current accommodation facilities for maximum security inmates are very poor. Many of the cells have multiple hanging points and are dark and dank, and the bathroom windows in some wings have been boarded up with ill-fitting pieces of wood for many months.

In Grafton's minimum security area, the units contain dormitory style accommodation in what appears to have previously been a communal living area. The men who sleep there are separated only by curtains and have little or no privacy.

Since the opening of Area 5 at Parklea Correctional Centre, we have continuously received complaints about the heat in the cells during the summer months. Our inquiries showed that poor design is at fault. The airflow system cools common areas, and then a secondary process cools the cells — leaving the cells 5°C cooler than the outside temperature. When temperatures reach 45°C at Parklea (as they have done on a few summer days in recent years) the in-cell temperature is 40°C. We received the same complaint from some inmates at Mid North Coast Correctional Centre, which is built using a similar design. We wrote to the Commissioner suggesting that the same system not be used for new centres to be built at Wellington and on the South Coast.

During our visits in 2006–07, we have seen some improvements in facilities such as:

- the new Mental Health Assessment Unit at the Metropolitan Remand and Reception Centre (MRRC)
- the new clinic, gate and Mental Health Assessment Unit at Silverwater Women's Correctional Centre
- work to fix drainage problems in 10 yard at the MSPC after many years of complaint.

We have also been able to see some of the positive things happening in correctional centres. These include:

- the Pups in Prison program at Kirkconnell and Junee Correctional Centres in which inmates and staff raise and train assistance dogs
- a program at John Morony Correctional Centre where inmates grow specific plants to provide a 'browse' for koalas and elephants at Taronga Zoo
- inmates growing seedlings at Glen Innes Correctional Centre that are then donated to charities to sell as part of their fundraising
- inmates throughout the correctional system having access to art supplies, teachers and encouragement to express themselves, to create works of art, and sometimes to sell them at the Boomgate Gallery at Long Bay.

We have also used our visits this year to observe the ongoing response of juvenile inmates to the department's operation of Kariong Juvenile Correctional Centre. The young men we've spoken with during our visits confirm that the low level of contact we receive from them is generally because there have been few areas of complaint.

International education has been a part of our visits this year. In May 2007, the Commissioner agreed to allow two officers from the National Ombudsman Commission of Indonesia to accompany our staff on one of our regular visits to the MSPC. The Indonesian officers were observing the role that visits to correctional centres play in complaint-handling and found the experience very worthwhile.

We also visit cell complexes in courts and police stations that are operated by the DCS. During these visits we meet with staff, assess the facilities provided and talk with any offenders who may be in the cells at the time. We provide the department with feedback on these visits as part of our ongoing liaison with DCS head office.

Policies and procedures

When new policies and procedures are introduced, we often receive complaints because people do not know how they should be implemented, the procedures are not sufficiently clear or there are unforeseen implications of the policy. Case studies 36 and 37 show how this occurred when the Commissioner introduced a new policy requiring all inmates at C1 classification and above to wear ankle cuffs when they were escorted outside their centre.

Case study 36

When an inmate with a lower classification than C1 from the Silverwater complex was taken to Westmead Hospital, he was made to wear both hand and ankle cuffs — despite protesting he was not required to do so. The situation deteriorated when he arrived at the hospital and the escorting officer had to park the vehicle some distance from the entrance, forcing the inmate to walk cuffed through a public car park. This caused him distress and injury to his ankles and was no

doubt concerning to members of the public. We assessed two issues — that a minimum security inmate was ankle-cuffed contrary to the relevant instruction, and the distance the vehicle was parked from the hospital entrance. The Commissioner acknowledged the inmate had been inappropriately ankle-cuffed due to a misinterpretation of his instruction. He also advised us that a local policy had been devised for the inmate's centre so that, in future, escorting officers will call ahead to hospital security to secure an appropriate short-term parking spot.

Case study 37

An inmate who fitted the criteria for ankle-cuffing on hospital escort complained to us that not only was this humiliating — but the cuffs had cut into his leg, causing him to bleed. He was concerned there was a risk of cross infection if this happened to other inmates and either party had open wounds on their ankles. As they are responsible for the majority of inmate escorts, we contacted the court escort and security unit about this issue. They told us that if any blood is detected on cuffs they are placed in a bucket of kerosene. However, a major hospital's central sterilising unit advised us that kerosene has no antibacterial or antiviral qualities — unless it is set on fire! Meanwhile the security manager at another correctional centre told us staff normally wipe the cuffs with disinfectant if blood is detected. Given the lack of consistent and appropriate procedures for sterilising cuffs, we asked the Commissioner to consider issuing suitable instructions. The Commissioner agreed not only to seek advice on the best method for sterilising the cuffs, but has also called for an insert to be developed for the cuffs to prevent them injuring inmates.

Legal and family-related business matters remain high priorities for most inmates when they are sent to gaol. Often, however, they face practical difficulties in gaining access to relevant information and sharing that information with appropriate parties — such as lawyers and their families. It is also challenging for inmates to retain confidentiality of documents about their legal and family matters once these documents become part of their in-cell property. Case studies 38, 39 and 40 outline some of the problems that were brought to us this year.

Case study 38

A high-profile inmate claimed he was being discriminated against because he had been told that, unlike other inmates, he could not give his wife financial advice — and if he did so he would be punished. As a result of his offences, he had been disqualified from managing a corporation under the *Corporations Act 2001*. Over 12 months the department referred two matters to the Australian Securities and Investment Commission (ASIC) to determine whether the inmate was breaching his disqualification. On both occasions ASIC reported that he had not breached the Act. The department remained concerned about the inmate engaging in any level of business activity.

Although they do not make up the majority of the inmate population, the department does need to manage some 'white collar' criminals. It therefore needs to be able to determine what does or does not constitute managing a corporation or running a business — as opposed to providing family financial advice on what can be complex and sophisticated financial arrangements. We asked the department to develop some guidelines to help both staff and inmates to understand what type of business activity may be conducted while in custody. The Commissioner has now authorised a change to the department's operations procedures manual to incorporate a section providing such guidelines.

Case study 39

In 2005, an inmate at Parklea Correctional Centre asked an offender services and programs officer to fax some documents to his legal representative. The worker faxed the documents to the NSW Police Force by mistake. Our inquiries supported the department's view that the worker had made a genuine mistake. However, we also learned that — because faxes are not placed in an envelope — they do not attract the same legal privilege as letters and parcels. We believe expediency sometimes requires inmates to send or receive documents to or from their legal representatives by fax. In October 2006 the department told us that a proposal to amend the regulation — supporting the recognition of faxes as legal documents — would be submitted to the Minister.

Case study 40

During a cell search at Goulburn Correctional Centre an inmate had a large amount of paperwork removed from his cell. He complained to us because the paperwork included legal documents that were to be used in a Supreme Court appeal and they had not been returned. Goulburn staff told us that some of the confiscated items had been destroyed. We were shown video footage of the search from which it was apparent the coloured folder described by the inmate was taken by staff. However, as no inventory had been kept of what was confiscated — and the general manager's approval had not been sought before the items were destroyed — there was no record of what happened to the folder. While we were unable to locate the inmate's legal documents, the staff who conducted the search were reminded of their obligations in relation to inmate property, the accurate recording of all confiscated items and their destruction.

Many of the complaints we handle would not arise if there was better communication between corrections staff and inmates. Often, when we contact a centre, we find action is being taken to help the inmate but no one has told them this. Other times, a positive outcome results because we have asked staff to look a little more closely at a situation.

Case study 41

With two weeks left until his release date, an inmate at Cessnock Correctional Centre was worried that his post-release plans would not eventuate because he hadn't seen a welfare officer. He told us the welfare officer had left and not been replaced. When we contacted the centre we were told that — although there were staffing issues — there was at least one welfare officer who could see the inmate. The inmate called back that afternoon to say the welfare officer had seen him and his plans were back on track.

Case study 42

In late November 2006, an inmate at the MSPC contacted us because he was convinced he should have been released from custody the day before. He had spoken to his wing officer who told him he was on remand, yet the inmate was sure his charges had been dropped. We spoke with a senior officer at the centre who confirmed the wing officer's advice. As the inmate was quite adamant about his facts, we then contacted the centre's records staff. Initially they had the same view as the officers, but after looking again at the inmate's file they saw something that made them seek clarification from the court. They then found that the original 'bail refused' warrant had been cancelled. The Attorney General's Department issued the centre with formal advice about the cancellation of the warrant and the inmate was released on bail that evening.

Case study 43

After an inmate was assaulted, he was told that — after serving his punishment of seven days cellular confinement — his assailant would be moved from their unit for inmates with identified intellectual disabilities to another area. The assaulted inmate called us in a distressed state because he had now been told his assailant would return to the unit where the assault had occurred and he was very fearful of what would happen. We spoke with the area manager who was surprised to hear the inmate had been given that advice. The assailant was definitely being moved to another unit and the department's computer system had been annotated to make sure they would never be located in the same accommodation unit. The manager undertook to speak to our complainant and ease his concerns.

Case study 44

In some correctional centres, such as Berrima, only communal showers are available to the inmates. An inmate at Berrima called us after the women there were told their showers would not be available for three days while they were being painted. The women had spoken to their wing officer who told them the only other shower was out of order. We spoke to the area manager who told us that the original plan for the women to have access to the special management cell shower had been scrapped by the security manager. As we considered it inappropriate for the women to be asked to go for three days without a shower, we spoke to the general manager who is based at another centre. She immediately agreed that the women should have daily access to a shower and undertook to make appropriate arrangements that day.

Case study 45

In order to use the telephones in correctional centres, inmates must have money placed into their phone account. This usually occurs once a week when inmates complete a form nominating an amount to be taken from their main account. Administrative staff then make the relevant account adjustments.

An Emu Plains inmate called us on a Friday to complain that phone accounts had not been updated. When the inmates asked correctional staff, they were told it would probably not happen until the following Monday. The women were upset because for many of them this would mean they couldn't speak with their families during the weekend — which is often their only opportunity if partners are at work and children are at school during the week. When we called the centre, the area manager explained that the accounts officer was in fact acting in another position but all phone accounts would be updated after 2pm that day.

Junee Correctional Centre

Last year we reported that we received significantly more complaints about Junee Correctional Centre than any other centre. This trend has continued over the past 12 months. Senior management of the GEO Australia were very concerned about this trend and have met with us in an effort to identify any significant issues or areas where internal complaint-handling performance could be improved. Despite also meeting with management at the centre and making a close analysis of the complaints received about Junee, we have not been able to point to any specific cause or reason, apart from reinforcing the importance of good communication between staff and inmates. The internal complaints and grievance system at Junee largely replicates that in other correctional centres, and Junee inmates have access to the CSSL like all other inmates. We visited the centre on three occasions during the year — but the number of inmates wanting to speak with us was no greater than in previous years and we did not see any immediate reasons to account for the high levels of complaints. GEO has also told us they are reviewing activities and programs available to inmates at Junee in an effort to reduce some potential causes of complaint. Case studies 46 and 47 outline two of the matters we dealt with about Junee this year.

Case study 46

Inmate discipline is a common cause of complaint. The *Crimes (Administration of Sentences) Act 1999* (CAS Act) specifies the punishments that can be given to an inmate who is found guilty of a correctional centre offence or returns a positive urinalysis test.

An inmate from Junee called us when he returned his first positive urinalysis test in over six years and was punished with seven days confinement in his cell. He also had his privileges removed for 42 days, including having his television taken from him. The inmate claimed he had asked to see the official visitor but an officer had refused to organise this. We called Junee and found them initially reluctant to accept our view that the general manager did not have the authority to impose the combination of punishments the inmate received. We referred them to the CAS Act — which states that a general manager or visiting magistrate may order the withdrawal of privileges for up to six months for a positive drug test. An inmate may be punished for correctional centre offences with seven days confinement to cells or by the withdrawal of privileges for a certain time, but not both. Junee agreed to withdraw the seven-day cellular confinement.

Case study 47

When officers at Junee Correctional Centre entered an inmate's cell and removed his paperwork — including documents relating to his case — he was not told why and became upset. He tried to make inquiries with his area manager and was told the officer would 'get back to him'. We found out that the officers had taken the paperwork from his cell so they could fax the police a copy of their own brief. The police had lost the brief and had contacted the centre, asking for a copy from the inmate. Junee staff agreed with us that the actions of the officers were inappropriate and told us that all paperwork had been returned to the inmate, along with an explanation about what had happened and why.

Update on a challenge to our jurisdiction

The CAS Act makes it a criminal offence for anyone to disclose information obtained in the course of the administration of the correctional system, except in very limited circumstances. We reported last year on an investigation we had started as a result of a number of articles published in the press. The articles appeared to be sourced from — and sometimes quoted — departmental information, including intelligence reports and other security-related information. We were concerned that confidential information might be being inappropriately 'leaked' to the press by departmental staff.

The Commissioner challenged our jurisdiction to investigate on the basis that our inquiry related to an alleged violation of privacy — which is excluded from our jurisdiction by Schedule 1 of the Ombudsman Act. We did not agree with this view. Our investigation concerned the adequacy of the department's policies and procedures about the disclosure of information and the investigation of unauthorised releases — and the action taken by the department to investigate the particular disclosures. To resolve the dispute about our jurisdiction, we agreed to jointly seek binding advice from the Solicitor General. As a result of this process we clarified the terms of our investigation, making it clear we were investigating actions taken by the department to investigate possible breaches of the disclosure provisions of the CAS Act.

We interviewed departmental staff and examined a number of matters that had been considered by the department's professional conduct management committee (PCMC) concerning allegations of the unauthorised release of information. Our conclusion was that if local managers report allegations about the unauthorised release of information to the department's employment and administrative law branch, the PCMC appropriately assesses and deals with them. However, we identified a number of areas in need of improvement and made suggestions to remedy these deficiencies. For example, we suggested that:

- the department should include an explicit reference to the provisions of the CAS Act in their policies and procedures
- the director of the department's media unit should be required to notify the employment and administrative law branch immediately if the unit becomes aware of a possible unauthorised release of information. The PCMC should then assess and investigate these notifications in accordance with their usual procedures.

Since the conclusion of our investigation, a new Commissioner's Instruction has been issued which addresses these suggestions. Hopefully this will reinforce the important obligations upon all departmental officers, with respect to the confidentiality of official information and its responsible use.

Justice Health

Justice Health provides all medical services to the NSW correctional system, both within centres and the community. Their services include projects to assist with continuity of care after release and diversionary programs, especially in the areas of mental health and drug dependence. Although the Ombudsman does not examine clinical or professional matters, we do receive complaints from inmates about the health services they receive. We manage these complaints by either contacting the clinic at the correctional centre — especially if we are visiting the centre — or by emailing Justice Health if we need more detailed information. Occasionally we also meet with senior Justice Health staff to address more complex or systemic matters.

A major source of complaints concerns schedules for inmates' daily routines clashing with Justice Health clinics, resulting in insufficient time for inmates to receive their medication or a clinical assessment. When we have inquired with both Justice Health and the department about these matters, we have usually found they are working to resolve access problems. Sometimes, however, this doesn't change the fact that some inmates miss their medication. This is an example of something most of us take for granted — but which can cause problems for people in gaol. Inmates with quite serious medical conditions rely on their medication being provided by Justice Health — and when this doesn't happen they often contact us for assistance.

Access to dental services is another issue that we receive many complaints about. In some areas, it is

difficult for Justice Health to find a dentist to provide those services. In other cases, it is the length of time an inmate must wait to be seen that is the problem. When an inmate needs dental treatment they call a central number and describe their needs and level of pain. They are then 'triaged' and given an appropriate place on the dentist's waiting list at their centre. If they are in immediate and extreme pain, they can also seek pain relief from the centre clinic. As a result of the redevelopment of the clinic at Silverwater Women's Correctional Centre, there was no dentist chair available for six months. Although this has now been fixed, it meant many of the women had to wait a long time to receive even basic dental services. Justice Health aims to provide a dental service equivalent to that provided in community-based dental facilities — however, currently in NSW there are many thousands waiting to access community dental services.

We have also been contacted by a number of inmates/patients about their movement into and out of the forensic hospital at Long Bay — and their movement between wards while in that facility. This is a slightly more difficult area for us, as it often also involves the Mental Health Review Tribunal and the Minister for Health — neither of which are in our jurisdiction. However, we have worked with all relevant parties to provide some assistance where we can to the inmates/patients who contact us.

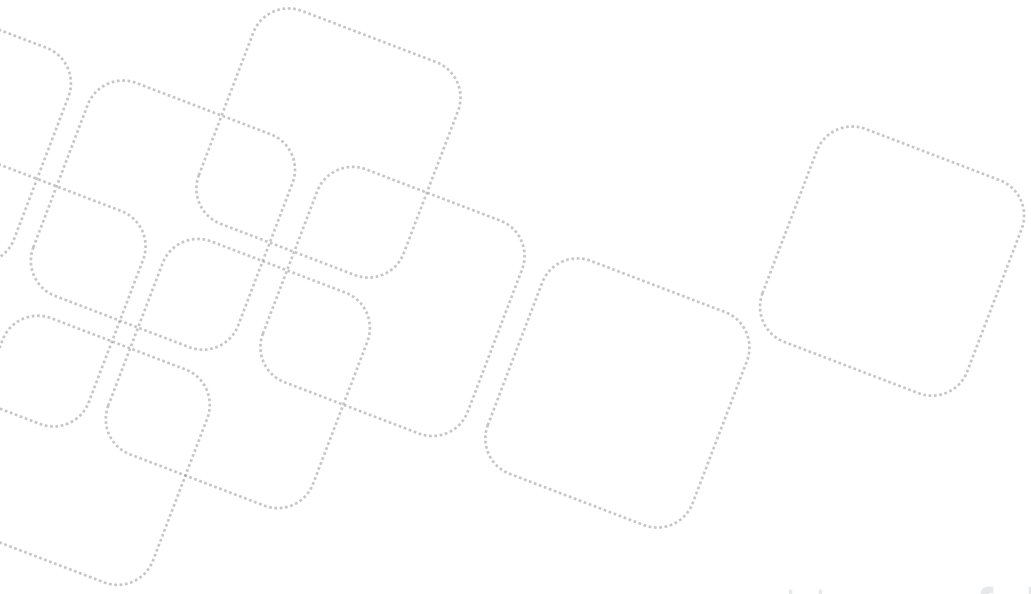
Case studies 48 and 49 cover some of the issues about Justice Health that were brought to us this year.

Case study 48

An inmate from Dillwynia Correctional Centre complained to us that — for the second time in a month — she had not been given the medication she needs for her brain tumour. This time she had been without the medication for two days. We made immediate inquiries with the clinic and were told they had not been able to give the inmate her medication because of a breakdown in administrative practices — this meant the medication had not been ordered when existing supplies began to run low. The nursing unit manager took immediate action to make sure the woman received her medication the following day and to reinforce ordering practices with staff.

Case study 49

After three weeks in custody, an inmate at the MRRC was told that he could not have access to asthma medication. He told us that — although he had received it when he first came into custody — the clinic told him there was nothing on his file indicating he should have asthma medication. We contacted the nursing unit manager who checked the inmate's file and found the public health nurse had written a note some weeks earlier that read 'History of asthma — Ventolin'. They were unsure, however, whether the inmate should still be receiving the medication. As a result of our call, the clinic arranged for the nurse to see him again for an assessment of his asthma and any appropriate medication.



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11. JUVENILE JUSTICE

Introduction

Detainees in juvenile justice centres complain to us about a range of issues that affect them. They can contact us by phone, by letter or during our visits to centres. There are eight full-time centres in NSW and we visited each centre twice during the year. During our visits we meet with centre staff, take complaints from detainees and inspect facilities and records. This year — at the invitation of managers — we also addressed staff meetings at a number of centres to explain our role and how we do our work.

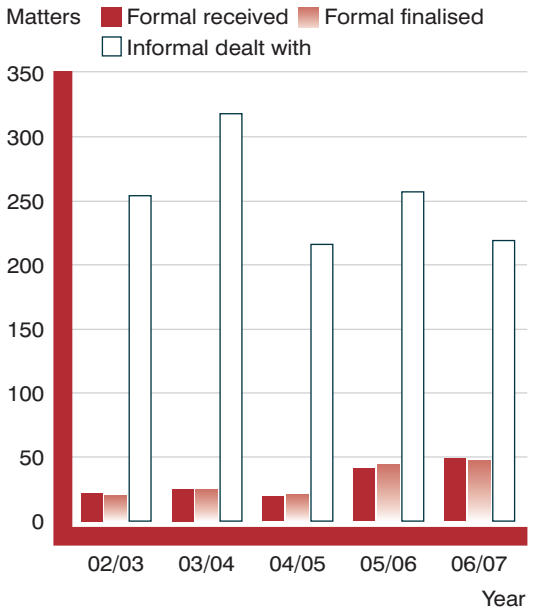
When we visit centres, we also talk to staff about their role in handling complaints. We generally encourage detainees to raise any problems they have with centre staff first, before they contact us. It is therefore important that staff understand their responsibility to take complaints seriously, look into what has happened and tell the young person the outcome.

Complaint trends and outcomes

Formal complaints about juvenile justice centres increased slightly this year, although there was a drop in informal telephone complaints and complaints made to our officers during visits to the centres. (See figure 50). Figure 51 (over page) gives a breakdown of the issues that were the subject of complaints and figure 67 (in Appendix F) provides a breakdown of complaints received by each centre. A quarter of the complaints were about issues associated with the daily routine of detainees in centres, with allegations about staff misconduct comprising the next largest specific area of complaint. The vast majority of complaints made by juvenile detainees are received on visits or over the phone. These complaints are dealt with on the spot where at all possible by making on-site inquiries with centre staff and through the provision of information and advice in premature matters. Only in the more complex matters where detailed inquiries are needed are detainees invited to make written complaints with assistance if needed. We conducted 43 preliminary investigations during the year as a result of formal complaints received.

Five year comparison of matters received and finalised **fig 50**

Matters	02/03	03/04	04/05	05/06	06/07
Formal received	22	25	19	41	49
Formal finalised	20	25	21	44	47
Informal dealt with	254	318	216	257	219



Numbers in custody

In last year's annual report we noted that there had been an increase in the number of young people in custody at certain times. This increase has been sustained in 2006–07. Although it is the court that decides a young person should be placed in custody, the Department of Juvenile Justice (DJJ) is responsible for accommodating them. Both staff and detainees have talked to us throughout the year about the practical problems associated with managing increasing numbers of young people sentenced to a period in detention.

What people complained about **fig 51**

Issue	Formal	Informal	Total
Daily routine	8	57	65
Officer misconduct	10	19	29
Other administrative issue	1	26	27
Food and diet	1	25	26
Unfair discipline	4	16	20
Visits	5	10	15
Medical	2	11	13
Property	2	11	13
Transfers	1	11	12
Work and education	2	8	10
Security	1	6	7
Case management	2	4	6
Issue outside our jurisdiction	2	3	5
Day / other leave / works release	2	2	4
Classification	2	2	4
Fail to ensure safety	0	2	2
Mail	1	1	2
Legal problems	0	2	2
Segregation	2	0	2
Community programs	0	1	1
Complaint-handling	0	1	1
Buy ups	0	1	1
Records / administration	1	0	1
Information	0	0	0
Total 2006–07	**49**	**219**	**268**

Each juvenile justice centre is designed to accommodate a particular number of detainees. When there is more than this number, young people have to sleep on mattresses on the floors of other detainees' rooms or in holding rooms that are not intended to serve as bedrooms. Some centres have identified an increase in minor misbehaviour — partly attributable to tempers becoming frayed as detainees and staff try to cope with extra numbers. The lack of vacant beds in centres across the state means it can be difficult for young people to be held in custody near their families. It also makes movements to court more complicated.

We have been impressed by the efforts that centre staff — as well as Department of Education and Training teachers in centre schools — have made to maintain services in the face of increased numbers. However, it is clear that physical resources are stretched and, if the increase in numbers continues, permanent solutions will be needed.

Transfers to Kariong Juvenile Correctional Centre

Young men over the age of 16 who are given the maximum classification under the DJJ's objective classification system are transferred to Kariong Juvenile Correctional Centre. As the Department of Corrective Services manages Kariong, both the Director General of Juvenile Justice and the Commissioner of Corrective Services must approve the transfer. Both departments have assured us they have processes in place to complete the necessary paperwork as quickly as possible. However, we have been concerned on a number of occasions during the year by the time taken for approval to be given.

A detainee is usually given a maximum classification because of significant bad behaviour — for example, they have seriously assaulted another detainee or staff member. While waiting to be transferred, these young men are frequently kept in segregation because of the risk posed to themselves or others if they were allowed to mix. It is therefore important that transfers take place as soon as possible so that detainees can be inducted into the more secure environment at Kariong and begin to participate in normal routines.

An efficient process is needed to ensure the timely transfer of detainees between the two departments, including effective communication mechanisms at an operational level to ensure any problems are resolved promptly.

Case study 50

We received a complaint on behalf of a young man who had appealed to DJJ against his reclassification to Kariong. In his letter of appeal, the detainee said he was frightened of going to Kariong. The appeal was unsuccessful and the transfer went ahead. The classification paperwork, including the detainee's letter, was sent to Kariong in his paper file. However, the detainee's comment was not included as an alert in DJJ's electronic records system that is also shared with Corrective Services.

There is often direct telephone contact between staff of the two departments about a detainee being transferred, and transfers to Kariong are usually done when nursing staff and Kariong's psychologist are available to see the detainee. However, it is important that all information about the detainee's state of mind and any particular concerns about their welfare are made immediately available. We suggested to Juvenile Justice that staff who deal with

classification matters be required to enter all relevant information in the alerts section of the department's electronic records system — as well as including it on the paper file. The department agreed with our suggestion.

Complaints and notifications

As well as dealing with general complaints about juvenile justice, we also oversee the department's investigations into allegations that their employees have behaved in ways that could be abusive to young people. Many juvenile justice staff appreciate the importance of the complaints process. However, we have noticed that some front-line staff have become so anxious about the possibility they may be the subject of allegations about child protection matters that they have developed a negative attitude towards young people making complaints in general.

We have tried to address these concerns by talking to staff during visits to centres about our various roles and responsibilities, emphasising the importance of complaints and how they can benefit an organisation, and reiterating that we are 'an honest broker'— not advocates for any party — when handling complaints.

Inappropriate language

During a visit to a centre this year, detainees complained to us that staff swore at them and used other inappropriate language. We appreciate that staff often have to deal with verbal abuse from some of the young people in their care, particularly when detainees are misbehaving or upset. However, this does not justify staff using similar language in return. Centre management reacted immediately to these complaints. They raised the issue at staff meetings and sent out a strongly worded memo to staff directing that inappropriate language should not be used. Staff were also reminded that they are expected to provide an appropriate role model for detainees and must act in a professional way at all times.

Community programs

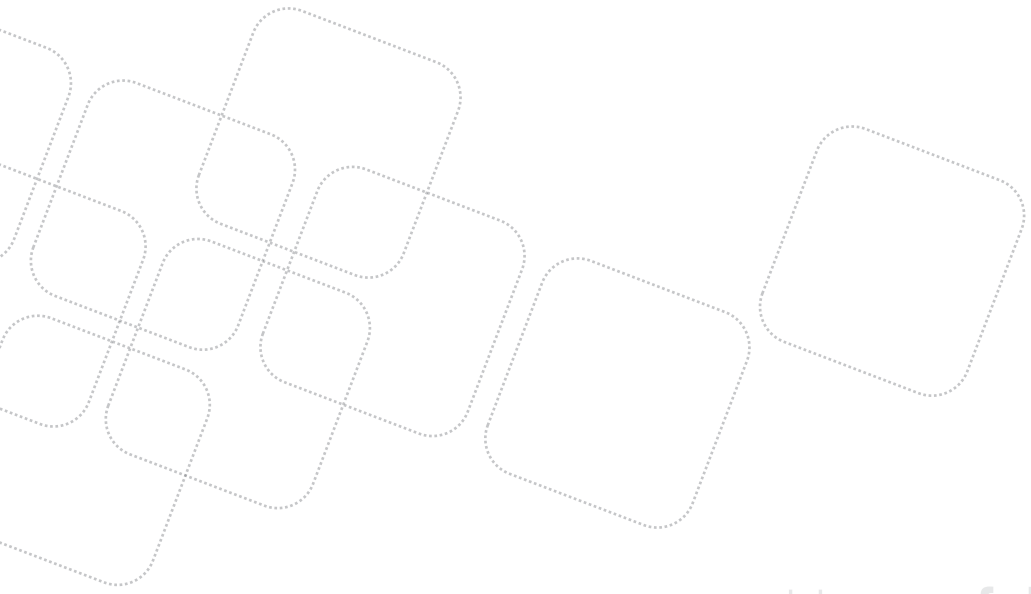
Although most of the complaints and inquiries we receive come from young people in detention, they sometimes raise issues about the department's provision of community-based services. When this happens, we make inquiries with the relevant juvenile justice office. The department has 35 community offices and two intensive programs units across the state. They provide community-based intervention for young people.

Case study 51

A detainee complained to us that her juvenile justice officer had refused to lodge a bail application for her and did not return her phone calls. We spoke to the officer who told us that bail applications are usually organised by another staff member and he had passed on the detainee's messages to that person. The officer said he did not make a note of the young woman's phone calls. We agreed with the detainee that it would be frustrating not to have phone calls returned, especially when they are about such an important matter. By the time we received the complaint, a bail application had been organised and the young person was no longer in custody. However, we suggested the department remind staff about the record-keeping requirements of its casework policy. The department subsequently issued a comprehensive memo to all staff about individual record-keeping responsibilities.

Case study 52

During a visit to a centre, a detainee told us that he wanted to change his juvenile justice officer in the community. He said the officer did not follow through on actions in his case plan, such as getting him into particular programs. We made inquiries with the manager of the community service office and the detainee was allocated a new juvenile justice officer. The manager said he had only just taken over responsibility for supervising community casework and was aware there were some issues that needed to be addressed.



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12. FREEDOM OF INFORMATION

Highlights

- As a result of our investigation, the Office of State Revenue published information on their website about the factors they consider when people apply for their fine to be waived.
- In 67% of the FOI reviews we did, the agency agreed to release documents that the applicant had a right to access, provided the applicant with useful information, agreed to refund fees or took some other action that satisfactorily resolved the complaint.

Introduction

Every day, public sector agencies make decisions and carry out activities that affect people's lives. It is critical that these decisions are made transparently. This helps the public to understand why a particular decision was made or a particular action was taken — and also improves the quality of the decision-making process.

We encourage agencies to actively communicate information to the public in a way that demonstrates their commitment to accountability. This is in line with the NSW Government State Plan, released in November 2006, that promotes 'customer friendly services' and lists as a key goal 'increased customer satisfaction with government services'.

The *Freedom of Information Act 1989* (FOI Act) gives every member of the public the right to have access to documents held by the public sector, subject to certain conditions and limitations. It also requires agencies to facilitate and encourage the disclosure of information.

Agencies can grant or deny access to documents. If they decide to deny access — or advise that no relevant documents are held — the applicant can make a complaint to our office or apply to the Administrative Decisions Tribunal (ADT) for a review of the decision. This review is called a 'determination' under the FOI Act.

When handling FOI complaints, we try to achieve outcomes that are consistent with the letter and the spirit of the Act. Some public officials have indicated a belief that we push agencies to disclose information that should not be revealed and try to impose our view of how the Act should operate — as opposed to how it works in practice. This is not the case. We use a straightforward interpretation of the Act, and form our views on each matter based on that interpretation. It is the Act itself — recording the intention of Parliament — which states that the discretions available to agencies under the Act should be, as far as possible, exercised to facilitate and encourage the disclosure of information.

Why agencies should provide information to the public

Public sector agencies are accountable for the activities they perform and the decisions they make, and Parliament requires them to publish certain kinds of information as a matter of course. For example, under a recent amendment to the FOI Act, agencies must publish details of any contracts they have with private sector entities to

undertake a project, provide goods or services, or transfer land. The rationale is that arrangements of this kind involve significant amounts of public money and any member of the public should therefore be able to know — without having to specifically ask — what those arrangements are.

We sometimes come across information we think an agency should routinely publish if they are to communicate effectively with the public about the work they do and the reasons they make decisions. This year, we investigated a complaint about the criteria used by the Office of State Revenue (OSR) to make a decision when a person claims they should not have to pay a fine. We argued this kind of information should be in the public domain as a matter of good practice. As a result of our investigation, the OSR have published the criteria on their website.

Case study 53

We received a complaint from a member of the public about the determination of his FOI application by the Office of State Revenue (OSR).

The application requested access to documents that the applicant believed would help him to prove that he had not committed a speeding offence. Among other things, he asked for a copy of the guidelines used by the State Debt Recovery Office (SDRO), the fine division of the OSR, to review representations from members of the public who claim that they deserve to have their fines reconsidered.

The OSR exempted the guidelines under a clause of the FOI Act dealing with documents relating to business affairs. However, they did not specify why the clause applied in this matter. When we informed the SDRO of our preliminary view that the guidelines were not exempt under the clause they specified, the OSR said that they were exempt under another clause. They also said that if the guidelines were released there would be 'an increase of representations and frivolous or unlawful claims could be strengthened because they had been tailored to the requirements of the guidelines'.

We began a formal investigation into the OSR's claim that the SDRO would be unable to effectively review representations from members of the public if the guidelines were released. In our view, if the SDRO tested each representation and required robust evidence to support each claim, frivolous claims would be detected in the normal course of reviewing representations.

We also felt that there was a strong public interest in the information being released. The SDRO informs people if their representations have been successful or not. If they are unsuccessful, no specific reasons are generally given for the decision. As the guidelines are not publicly available, the person has no way of knowing if the SDRO has reached their decision by appropriate means. In addition, the release of the guidelines would make available to the public the specific criteria that must be fulfilled for representations to succeed. This would promote the making of correctly focused and evidence-based representations — rather than incomplete and misdirected submissions.

As a result of our investigation, the OSR published the guidelines on their website.

Sometimes we deal with an FOI complaint that fosters public debate about a wider issue and whether information about that issue should be made publicly available. This year a journalist complained to us about a council's refusal to provide access to a document listing local food businesses that had been fined in the preceding 12 months for breaching food hygiene standards. Although we agreed with the council's decision to refuse access to this particular document in the circumstances that applied, we also agreed with the journalist's view that the public should be told whether or not restaurants and food outlets are complying with food hygiene standards. However, the decision to make this kind of information automatically public is a policy decision for the government.

Case study 54

A newspaper journalist asked the City of Sydney Council for documents containing details of fines imposed on food businesses found in breach of health regulations. Council initially said they did not have any such document. They later found that they did — and released it to the journalist with the restaurant names and street numbers blanked-out. Council said that releasing the blanked-out information would result in a breach of privacy under the *Privacy and Personal Information Protection Act 1998* (PPIP Act). They also said the information was subject to the exemption under the FOI Act for commercial and business affairs, as it could reasonably be expected that releasing the information would have an unreasonable adverse effect on commercial and business affairs.

The journalist asked us to review this determination. His web 'blog' had generated substantial interest in the subject — and referred to other jurisdictions in which restaurants are publicly rated according to hygiene standards.

We pointed out to council that the PPIP Act does not apply to FOI matters, and they accepted this. However, we agreed that releasing the names and addresses of the food businesses was likely to have an unreasonable adverse affect on those businesses — given that breaches were more than 12 months old and had been fixed, and the council had assured us there were no ongoing health issues with the businesses.

In our view, there are good reasons for introducing a system that alerts the public to current health and hygiene issues in all food businesses. Such a system would mean that all restaurants would be subject to the same scrutiny, not just those that happen to be the subject of a particular FOI application. We think this is an important issue for policy-makers to consider.

Attempts to uncover information of a potentially embarrassing or politically damaging nature to the government intensified as the March 2007 state election drew near. This year, we handled 43 complaints from journalists and opposition Members of Parliament (MPs) who had been unsuccessful in gaining access to documents about issues including:

- the incentives system used as part of managing the behaviour of serious criminals in high security correctional centres
- costings of Opposition election promises
- the assessment of a proposal for a V8 supercar race to be held at Homebush Bay
- the way traffic in the Sydney CBD was managed at the time the Cross City Tunnel was opened
- the project to untangle existing railway tracks to improve the system's efficiency
- the age of public buses being used to transport passengers around Sydney.

Agencies are often wary of releasing this kind of information on the basis that it will be misrepresented by the media. It is indeed possible that this can occur and that the agency — and by implication the government — can be embarrassed as a result. However, the FOI Act specifically provides that potential embarrassment to the government is not in itself a legitimate reason to deny access to a document. Access should only be denied if an exemption under the Act legitimately applies. This recognises that it may be in the public interest for a critical news story to be written about a particular issue. The criticism of the agency or the government may be fair and any embarrassment deserved.

Even if the potential criticism is not fair, we think it is better for agencies to take an open rather than a closed approach. If no legitimate exemption applies, the agency should release the information. If further information or explanation is required to give the matter context or to help the applicant better understand the agency's point of view, this should be given to the applicant at the same time.

Our experience has been that if an agency refuses to release documents without justification to avoid embarrassment, this can result in a news story critical of that very decision. Over the past 12 months there have been a number of articles characterising agencies as being secretive, 'covering up', and keeping things from the public. One newspaper even runs a weekly column about FOI, entitled 'What they won't tell you'.

The decisions agencies make on FOI applications

This year we conducted our 10th annual review of the FOI statistics reported by over 100 NSW agencies in their annual reports. Since we started these reviews, the number of FOI applications reported to have been made to these audited agencies has almost doubled — from 8,328 in 1995–96 to 15,958 in 2004–05. However, the number reported by audited agencies for 2005–06 decreased by 1,922 to 14,036. This decrease is almost solely due to 1,842 less applications being made to the NSW Police Force compared to 2004–05, because of the increased use of CrimTrac — as an alternative to FOI — by people seeking details about their criminal record.

If the overall figures for 2004-05 and 2005-06 are compared, less all police FOI applications, there is little difference in the number of FOI applications made to the remaining agencies — down by only 80 — or to the *numbers* of applications granted in full or in part.

The significant and disturbing downward trend in the *percentage* of determinations where all documents requested were released in full has continued — from 81% of determinations in 1995–96 to 52% in 2005–06. Over the same period, the number of applications refused in part has more than tripled from 12% to 40.5% of determinations. The number of matters refused in full has remained largely the same at around 7.5% of determinations.

In our last annual report we noted the marked increase in the number of FOI applications reported to have been refused on the basis that advance deposits were not paid — from 36 in 1995–96 to 172 in 2004–05. This figure leapt by a further 72% in 2005–06 to 296. This issue continues to be a significant concern. We assume the increase is primarily due to either an increase in the number of agencies charging advance deposits or to the amount charged by agencies as advance deposits. We actively encourage agencies to work with applicants to find a practical way to provide access to documents without expending an unreasonable amount of resources. In the coming year we intend to look very closely at all complaints to us about the amount agencies charge as advance deposits. Please see our website for a full report on this year's audit.

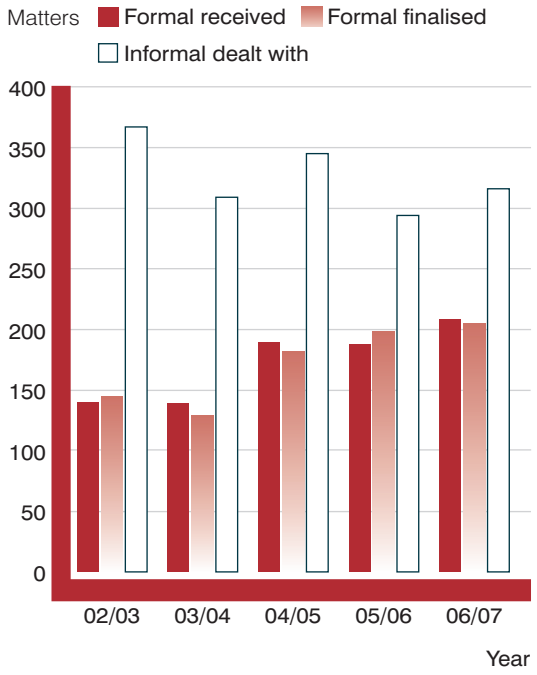
FOI complaints

This year we handled over 200 formal complaints about FOI applications (see figure 52). The majority of people complained about an agency's decision to refuse access to the documents (see figure 53). In some of these cases, the agency had not actually made a determination to refuse access — instead, they had failed to make a determination at all. The FOI Act provides that the applicant can proceed in these cases as if the agency had written to them denying access. The next step is a complaint to our office or a review application to the ADT.

In 2006–07, we finalised 205 complaints about FOI applications. Over half of these were resolved by persuading the agency to take some steps to address the complainant's concerns or because we found no evidence of wrong conduct. Please see Appendix G for a full list of the actions we took for each complaint finalised this year, and figure 54 for some of the actions that — as a result of our involvement — agencies took to resolve these complaints.

Five year comparison of matters received and finalised — fig 52

Matters	02/03	03/04	04/05	05/06	06/07
Formal received	140	139	189	188	208
Formal finalised	145	129	182	198	205
Informal dealt with	367	309	345	294	316



What people complained about — fig 53

This figure shows the complaints we received in 2006–07 about freedom of information, broken down by primary issues 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	Formal	Informal	Total
Access refused	99	62	161
Wrong procedure	73	20	93
Agency enquiry	0	65	65
General FOI enquiry	0	63	63
Pre-internal review enquiry	0	40	40
Pre-application enquiry	0	36	36
Charges	12	9	21
Documents not held	11	8	19
Third party objection	5	7	12
Documents concealed	3	2	5
Amendments	3	2	5
Documents lost	2	1	3
Issue outside our jurisdiction	0	1	1
Documents destroyed	0	0	0
Total 2006–07	**208**	**316**	**524**

Significant outcomes achieved in relation to complaints about freedom of information finalised in 2006–07 **fig 54**

Outcome	No.
Further information provided	67
Authority provided reasons	19
Authority admitted and corrected errors	3
Authority mitigated consequences	6
Authority reviewed case	15
Policy / procedure change	4
Authority reviewed and changed decision	17
Agreement reached through informal means	3
FOI documents released	39
FOI refund / remission of fees	6
FOI search made and documents found	4
Other remedy	4
Total	**187**

Delays

As we reported last year, we deal with a number of complaints about delayed determinations of FOI applications. The FOI Act states that an agency has 21 days to determine an application, and 14 days to determine an application for an internal review of the original decision.

Some cases we have handled this year involved delays of more than four months — and we have sometimes recommended that agencies consider refunding application fees.

In July 2006 we received complaints about extensive delays by the NSW Police Force in determining 13 FOI applications. At the time of the complaints, police were still processing 12 of the applications — many of which were three to four months old. None had been finalised within the requisite 21 days. We recognised that the police were still implementing a number of recommendations from our October 2005 investigation report into their processing of FOI applications, including increasing the number of staff in their FOI unit. The police advised that by August 2006 they had increased the number of staff in the FOI unit by six and, as a result, would be better able to comply with timeframes in the future. We advised the complainant that we would continue to monitor this issue.

By failing to meet statutory timeframes, agencies breach their legal requirements and may create an impression that they are deliberately delaying releasing the information. Applicants have a reasonable expectation that agencies will meet statutory timeframes and that — if there is a delay — they will provide an explanation or at least contact the applicant to apologise. By doing these things, agencies can avoid more time-consuming work — such as dealing with applications for internal review, communicating with irate applicants, or responding to Ombudsman inquiries if the applicant complains to us.

This year it came to our attention that the NSW Police Force was not acknowledging the receipt of applications. Generally, we would not consider this to be unreasonable. If all applications were responded to within 21 days, an extra acknowledgement letter would usually be unnecessary. However, there continues to be severe delays in the processing of applications by police, resulting in a number of applicants complaining to our office. Some people were unsure if the police had lost or forgotten about their application, or were deliberately delaying the process. We have reported our concerns about delays by the police in this area in our last two annual reports and are continuing to monitor this issue.

Case study 55

A newspaper journalist had been trying since June 2005 to obtain documents from RailCorp containing information about the risk of structures over Sydney rail lines collapsing on passenger trains. It took RailCorp eight months to make a determination — and then they refused access to most documents. After they failed to conduct an internal review of the determination, the journalist complained to our office in June 2006. Although RailCorp then completed an internal review and released some information to the journalist, we believed further information should be released. We communicated this view and it appeared RailCorp's FOI officer largely agreed and was in the process of redetermining the application. However, on 5 March 2007 we received a letter from RailCorp stating that they did not intend to release any further documents. No reasons for this were given. We began a formal investigation and asked RailCorp to provide a detailed statement of reasons for their decision to withhold the documents. Three days before the state election in March, the newspaper concerned reported that RailCorp was refusing to release documents. We are continuing our investigation.

Giving reasons for refusing access to documents

An important part of our work involves scrutinising agency decisions to refuse access to documents on the basis of exemption clauses set out in the FOI Act. The policy behind these exemptions is

that sometimes it may be in the public interest to refuse access to certain types of documents. These documents include those that, if disclosed, could reasonably be expected to:

- endanger the life or physical safety of a person
- help a person escape from lawful custody
- help someone commit a terrorist act.

The FOI Act specifically requires agencies to give applicants their reasons for refusing access to documents. It is not sufficient for them merely to claim that an exemption applies — they must explain why this is the case. We continue to see too many instances in which the agency simply states that access has been denied and quotes an exemption clause.

This year we dealt with a complaint about an agency which claimed that release of a document could reasonably be expected to endanger the life or physical safety of staff at one of the agency's public offices. They failed to provide reasons for this decision. Communicating to an applicant in these terms not only breaches the FOI Act but can be hurtful and inflammatory (see case studies 56 and 57).

Case study 56

We were contacted by a man who had been refused access to a copy of a complaint written about him by RTA registry staff. The RTA had decided that the document was exempt because it contained matter that, if disclosed, could reasonably be expected to endanger the life or physical safety of any person. The staff member who had written the complaint said they did not want their name released to the applicant. In deciding not to release the document, the RTA relied upon the views of the staff member and on a reference in the complaint to a police report about the applicant. However, the police report itself was not considered — or even looked at — in making the FOI decision.

We consider that agencies must provide clear evidence to determine there is a reasonable likelihood that harm or damage may result if a document is released. Although the views of a person who claims their life or physical safety may be endangered should be sought and considered, such views alone do not constitute clear evidence. An objective test needs to be applied.

Following our inquiries, the RTA decided to release the document with the name of the staff member withheld — as the applicant indicated he was interested only in the substance of the complaint, not the identity of the person who made it.

Case study 57

An assistant surveyor was working on an EnergyAustralia worksite when he and a colleague were involved in an incident with a resident in which angry words were spoken. The resident immediately contacted EnergyAustralia to complain. He alleged that threats had been made and he would be calling the police. EnergyAustralia's community relations manager immediately sent an email apologising to the resident. A series of emails were then exchanged between various managers at EnergyAustralia and the head subcontractor responsible for the work of the surveyors, requesting that the matter be dealt with. The assistant surveyor was subsequently told that his services were no longer needed and was directed to leave the worksite.

The following day he lodged an FOI application seeking access to the complaint and all documents relating to the incident. EnergyAustralia refused access to all the documents — including emails between the different managers responsible for dealing with the resident's complaint, and two emails from the resident. They did not provide descriptions of the documents or reasons for their decision. They just cited several exemption clauses, including one that related to the resident's alleged concerns for his personal safety.

After reviewing the file, we determined that EnergyAustralia should release all of the documents, as none of the exemptions applied. In particular, the exemption relating to personal safety requires evidence that the disclosure of the document could reasonably be expected to endanger someone's physical safety. Even if the surveyors had behaved in a threatening manner (which the assistant surveyor denied), any actual threat to the resident's physical safety would exist because of the incident itself — not because of the disclosure of the document containing the resident's complaint.

EnergyAustralia accepted our suggestion to redetermine the matter and released the documents.

Legal professional privilege

We have consistently reported our concerns about agencies that deny access to documents on the basis of legal professional privilege when no such privilege applies. In particular, we have repeatedly raised our concerns about Department of Education

and Training (DET) claims that all reports relating to accidents in schools are subject to this privilege — and for that reason would never be released to an FOI applicant. Our view is that this is the wrong approach. Whether or not the privilege applies will depend on the circumstances of each case. Routinely denying parents access to this kind of information prevents them from knowing what has happened to their child and, in some cases, how they came to be hurt.

We have continued our efforts to persuade DET to change their views and their formal policy on this issue. This year we sought the advice of the Solicitor General of NSW. He was of the view that any policy claiming the privilege over all reports about accidents in schools would be inconsistent with the law, and that whether or not the privilege applied would depend on an assessment of the facts and circumstances surrounding the creation of each document. This advice is consistent both with our views and advice provided to the department in 2001 by the Crown Solicitor's office.

In May 2007 we wrote to DET enclosing the Solicitor General's advice and asking them to consider redrafting their policy on the disclosure of school accident reports. We await their response.

Case study 58

In March 2007 we began an investigation relating to an FOI application by a newspaper for access to RailCorp's plan to advertise tenders for the construction and delivery of about 500 new millennium train carriages. RailCorp released some documents to the paper but determined numerous documents as exempt, claiming that release would damage their business affairs and prejudice the tender process. The reasons RailCorp provided to support the exemptions were not particularly thorough and did not consider the Premier's memo that sets out guidelines for the release of tender-related information and documents. RailCorp also determined three documents as subject to legal professional privilege. We could find no evidence to support this, particularly as one document consisted of an agenda for a meeting.

Despite various meetings, letters and telephone conversations with RailCorp, they refused to reconsider their determination. When the government awarded the tender for the construction of the carriages in 2006, we again approached RailCorp to reconsider their determination. After some time, RailCorp advised us that they would release some documents to the newspaper — but continued to claim various documents as exempt, including the three subject to legal professional privilege. RailCorp gave no reasons to support their view that the remaining documents should be exempt.

As part of our investigation, we have asked RailCorp for reasons why the remaining documents should be exempt. This investigation is continuing.

Understanding agencies' decisions

People commonly seek access to documents under the FOI Act to understand a decision made — or action taken — by an agency that directly affects them. Two types of situations we have come across this year are those where:

- the applicant is or was an employee of an agency and the agency has made a decision about their employment
- an agency has taken action against the applicant detrimental to interests for example, taken the applicants' enforcement action against them or cancelled their licence.

It would be ideal if agencies always provided comprehensive reasons for these kinds of actions so that people would not have to resort to the FOI Act.

During 2006–07, we dealt with complaints from employees of agencies who have either lodged grievances with the agency about an aspect of their employment or have made a protected disclosure to the agency under the *Protected Disclosures Act 1994*. We dealt with complaints from people seeking to understand why they had been sacked, transferred (see case study 59), not permitted to rejoin the NSW Police Force, or had disciplinary action taken against them. We also had a case involving an academic who sought access to a report compiled following a review of the division in which the academic lectured (see case study 60).

In some cases where an agency takes action detrimental to a person's interests, the documents relating to that action will include a letter of complaint about the person. Sometimes agencies deny access to these complaints on the grounds that they contain the personal affairs of the complainants. We take the view that procedural fairness generally requires that the person complained about should have the opportunity to answer the substance of the complaint made about them. We encourage agencies to communicate this to people who complain to them.

However, we acknowledge that in the case of complaints made to law enforcement agencies alleging unlawful behaviour, it is in the public interest that informants, such as police officers, can be confident their allegations will remain confidential.

Case study 59

An employee of RailCorp applied for documents under the FOI Act after she was transferred back to a division she had worked in before. She had previously requested a transfer out of this division on compassionate grounds and had believed that it was permanent. The employee hoped that the documents would help her to prove that she should not have been transferred back to the original division.

RailCorp provided her with some of the documents requested in her FOI application, but exempted others in part or full — claiming their release would have a substantial adverse effect on RailCorp's management and assessment of their personnel. They claimed that if managers were aware that their communications about an employee might be released under the FOI Act, they would stop making candid comments about employees and would not put their views in writing.

We believe that public sector staff who make professional assessments in the course of their duties should be willing to stand by those assessments and have them subjected to public scrutiny. RailCorp agreed with our suggestion that they revisit their determination and released further documents to the applicant.

Case study 60

We received a complaint from an academic at Macquarie University who applied under FOI for access to all documents relating to a report compiled after a review of the division in which the academic lectured. A final report about the review was tabled by the university and became a public document. However, the FOI application sought access to a draft of the report and all submissions made by current and former students and academic staff during the review.

The university gave the lecturer access to some documents, but determined all submissions and the draft report as exempt under certain clauses of the FOI Act. We agreed with the university's determination, particularly as the authors of the report needed the cooperation of staff, students and members of the public in making submissions because they had no power to compel people to provide information. Many of the submissions were made in confidence and — if they were released without the consent of those making the submission — similar inquiries in the future would be unlikely to attract cooperation.

The draft report contained information that enabled people who made submissions to be identified. However, we suggested to the university that they release to the applicant those parts of the draft report that were different to the final report — as long as individuals could not be identified. We also asked the university to consider releasing any submissions, provided that the person who made the submission did not object to its release. This could certainly be done with some of the submissions.

In our 2003–04 annual report, we reported on a complaint we had handled about documents relating to the closure of Beacon Hill High School in late 2002. As a result of a series of events over the next four years, it became clear that DET had failed to identify and release certain documents in response to both the original FOI application and an order for production by the Legislative Council. In late 2006, DET commissioned an independent investigation into their failure to release those documents. Given our concerns about how they had handled a number of FOI applications over recent years, we persuaded DET to broaden the inquiry to include an investigation of their practices, policies and procedures for dealing with FOI applications generally.

We met with the investigator a number of times to provide information about specific difficulties that we had encountered in handling complaints about the department. The final report was provided to DET in May 2007 and included recommendations to change policies and procedures, provide further training and hold regular liaison meetings with our office. We will continue to monitor the department's performance in the coming year.

Charging fees for access

There is a standard $30 application fee for lodging an FOI application, but the Act allows an agency to charge a $30 hourly rate if handling the application is likely to take more than an hour. Applicants seeking documents relating to their personal affairs need not pay for the first 20 hours of processing. The hourly rate is intended to cover all costs associated with administration, searching for and retrieving

documents — other than time spent in searching for a document that was lost or misplaced — and having discussions with the applicant to clarify what is sought.

If an additional fee is charged, we expect the agency to consider and offer public interest discounts if the documents relate to the integrity or accountability of the public service, the performance of public official functions, the expenditure of public money or the allocation or disposal of public resources. This year we sent an email to FOI coordinators in all public sector agencies stating our position on this issue.

Case study 61

A ratepayer applied under the FOI Act to Manly Council for information about a development that was adversely affecting her property. When she complained to us about council's determination, we noticed she had been charged $89 for processing a simple application that should not have taken more than an hour. The standard fee for a FOI application requesting non-personal information is $30 an hour.

When we contacted council, they told us they had had to retrieve a file from their archives (costing $59) to process the application and had passed this fee on to our complainant.

We wrote to council and explained that the *Freedom of Information (Fees and Charges) Order 1989* sets out the processing fees an agency is entitled to charge an FOI applicant. The initial application fee is intended to cover all costs associated with receiving and starting to deal with an application — including file registration costs, retrieval costs and initial discussions with applicants to clarify the application. There is no separate charge in the order that allows council to pass the cost of retrieving the file from archives on to the applicant.

Council refunded the additional $59 and advised us that their policy for charging for retrieval of files under the FOI Act had been amended so that future applicants would not be charged the additional fee.

Case study 62

A politician's adviser applied to Fairfield City Council for documents about land in the Fairfield area that had been the subject of media interest and scrutiny. The adviser asked council to reduce the fees for processing his FOI application on the basis that the release of the documents was in the public interest. The *Freedom of Information (Fees and Charges) Order 1989* states that the fees and charges for an FOI application may be reduced by half if an application relates to information that it is in the public interest to make available.

Council wrote back to the adviser and stated that he had not been successful in obtaining the public interest reduction as he had not demonstrated financial hardship or that the FOI application was in the public interest.

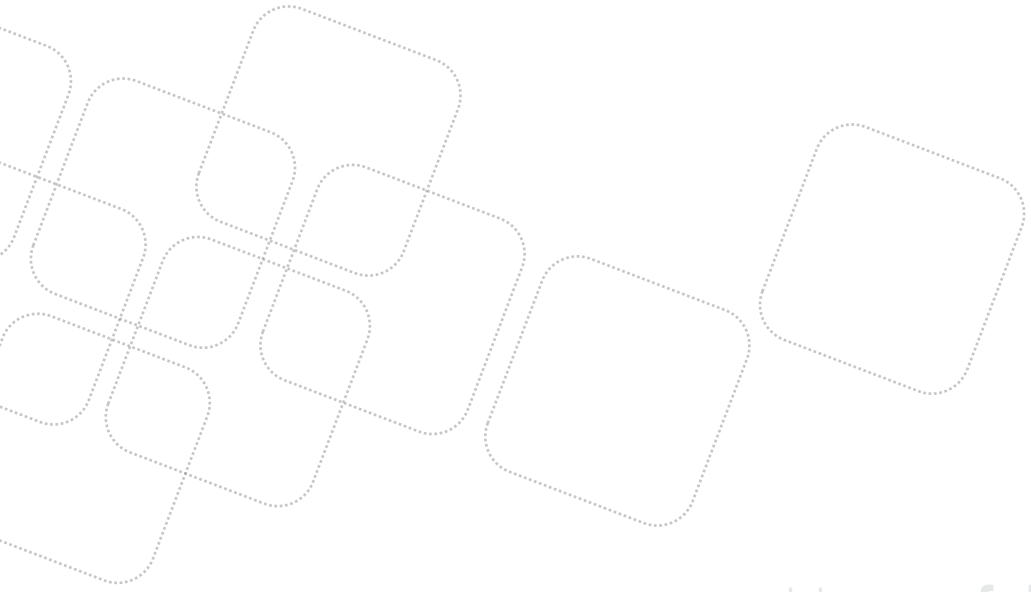
We wrote to council advising that an FOI applicant only had to satisfy one of the criteria to qualify for the rebate and that, in our view, the adviser was eligible for the reduction in fees. Council told us they would refund 50% of the fees that the adviser had paid.

Repeat applications

A person can apply under the FOI Act for documents as many times as they want. Although there are certain groups of people — such as journalists and MPs — who use the FOI Act as a tool to legitimately obtain information to help them with their work, agencies do have difficulties with individuals who make unreasonable and repeat applications under the Act and become a drain on public resources.

The FOI Act is intended to provide transparency in government, and agencies need to be appropriately resourced to fulfil this objective. However, there is no public interest served in agencies using considerable resources to deal with a small number of persistent individuals seeking documents — some of which are legitimately exempt — over and over again.

This year, as part of our project about unreasonable complainant conduct, we have been analysing some strategies to deal with repeat applications, and will continue to look into this issue next year.



we want to see **fair accountable** and **responsive** administrative practice and service delivery in NSW in our own organisation and those we oversight we work to **promote good conduct fair**

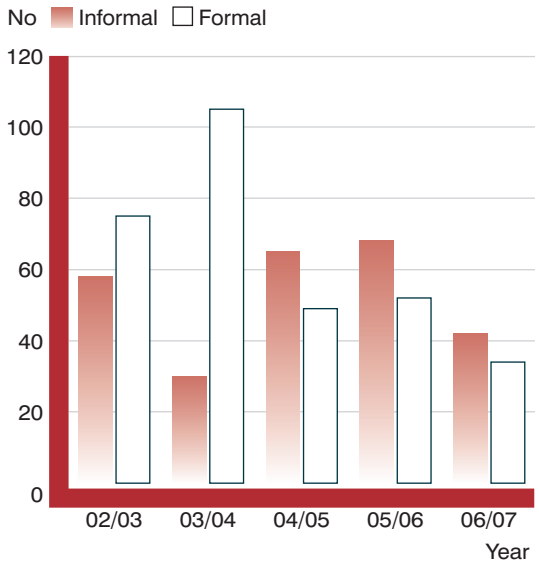
13. PROTECTED DISCLOSURES

Highlights

- The latest Parliamentary review of the *Protected Disclosures Act 1994* has been completed. The review has made a range of recommendations, including the establishment of a specialised protected disclosures unit in the Ombudsman's office.
- We continued our involvement in the *Whistling While They Work Project*. So far, a number of large-scale surveys about internal witnesses, workplace experiences and relationships, integrity agencies' practices and procedures, and the managing of disclosures by public employees have been conducted.
- We issued our *Complaint Handling at Universities: Best Practice Guidelines* based on our survey of all NSW public university practices and the lessons learnt from our UNSW and other university investigations.

Protected disclosures received **fig 55**

	02/03	03/04	04/05	05/06	06/07
Informal	58	30	65	68	42
Formal	75	105	49	52	34
Total	133	135	114	120	76



The number of protected disclosures we received this year has decreased in comparison to previous years; however, we are not aware of the reasons for this decrease.

The Parliamentary review of the Act

The Parliamentary Joint Committee (PJC) on the Independent Commission Against Corruption tabled its report on the review of the *Protected Disclosures Act 1994* (the PD Act) in Parliament in November last year. This was the third review of the Act, with the previous two conducted by the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission (PJC). In line with the previous reports, the Committee recommended that a protected disclosures unit be established in our office to perform a range of monitoring and advisory functions, including:

- providing advice to people making protected disclosures and to public authorities about issues such as the development or improvement of internal reporting systems

- auditing the internal reporting policies and procedures and monitoring the operational response to the Act by public authorities
- coordinating the collection, collation and public reporting annually of statistics on protected disclosures and any systemic issues or other problems with the operation of the Act
- coordinating education and training programs and publishing guidelines on the Act
- developing proposals for reforming the Act in consultation with investigating authorities and the Protected Disclosures Act Implementation Steering Committee
- providing executive and administrative support to the Protected Disclosures Act Implementation Steering Committee.

The Committee found there was a lack of clarity in the requirements for the investigation of disclosures due to the lack of provisions that impose obligations on authorities, especially investigating authorities, to investigate disclosures. The obligation on investigating authorities to deal with disclosures is contained in other legislation, for example the *Ombudsman Act 1974*, rather than in the PD Act. However, the linkages between the PD Act and the Acts for investigating authorities are unclear. The Committee found that this led to a situation where the Ombudsman could only investigate a disclosure if it could have been made and dealt with under the Ombudsman Act. The same situation applies to the Independent Commission Against Corruption, because the PD Act also requires disclosures to that investigating authority to be made in accordance with its Act. For this reason, the Committee recommended an amendment to the PD Act to impose an explicit requirement on each public authority and investigating authority to adequately assess and properly deal with a protected disclosure. This requirement would bring New South Wales into line with other Australian states who, with the exception of South Australia, already have a similar provision.

The Committee recommended the Act's name be changed to the *Public Interest Disclosures Act 1994* to emphasise the public interest objectives of the Act. The Committee also recommended that further obligations be placed on agencies to adequately assess and properly deal with protected disclosures. We support the recommendations of the Committee, which we believe to be reasonable and appropriate.

Whistling While They Work project

We have previously reported on our involvement in a significant three-year collaborative national research project into the management and protection of internal witnesses, including whistleblowers, in the Australian public sector. The project team includes five Ombudsman offices, three corruption-fighting bodies, six universities and a number of public sector employment commissioners or equivalents.

As part of the project's empirical research program, a total of seven surveys will be conducted nationally across 2005–07. Data analysis is currently being undertaken on the results of the first survey, conducted in 2005, of agency practices and procedures.

Over 23,000 employees from 130 public sector agencies received surveys in July 2006 about workplace experiences and relationships. The main aim of this survey is to gauge employee experiences working in the public sector, including their experiences of wrongdoing in the workplace, awareness of policies and procedures for reporting wrongdoing, and experiences of reporting misconduct.

A series of three surveys of internal witnesses, case handlers and managers in a number of case study agencies was conducted from November 2006 to July 2007.

Two surveys will be conducted of approximately 50 integrity agencies in mid 2007 to obtain information on the complaint-handling and investigative processes used by integrity agencies in the management of complaints about public sector wrongdoing and reprisal. We hope to include information about the major results of the surveys in next year's annual report.

A comprehensive issues paper, *Public Interest Disclosure Legislation in Australia — Towards the Next Generation*, has been prepared by the Project Leader, Dr AJ Brown and published by the Commonwealth Ombudsman, Queensland Ombudsman and this office. The paper analyses the current public interest disclosure legislation by asking a series of ten fundamental questions that any such legislation needs to address. Dr Brown's call for a national and coherent approach, in our opinion, deserves special attention. The period for submissions and comments on the paper closed in March 2007. It is intended that a report tentatively entitled *First National Report — Whistleblowing in the Australian Public Sector, Facts, Issues and Options* will be published at the end of the research project.

Managing workplace conflict resulting from an internal disclosure

As illustrated by case studies 63 and 64, an internal disclosure can sometimes lead to workplace conflict, particularly where the identity of the whistleblower is known or can reasonably be assumed. On occasion, such conflicts have led to a total and irreparable breakdown in relationships between whistleblowers

and their co-workers. When this occurs there are limited management options available. They include:

- reorganising the workplace to change seating arrangements and/or reporting supervisory arrangements
- relocating the whistleblower, the person or persons the subject of the disclosure, or co-workers
- offering voluntary redundancies
- suspension or dismissal of officers found to have engaged in serious misconduct.

In considering how to address workplace conflicts, agencies need to be mindful that any action taken in relation to a person who has made a protected disclosure cannot constitute detrimental or favourable action as defined by the Act.

Difficulties present when the investigation into an allegation has not been completed and there are no grounds justifying suspension or re-location of any person, who is the subject of the allegations. In such circumstances, the primary options available to the agency are likely to be:

- reorganising the workplace or reporting/ supervisory arrangements to separate the relevant persons
- facilitating a voluntary re-location of the whistleblower, or any person the subject of the disclosure, to another position or location acceptable to the relevant person
- requiring re-location of the whistleblower — or, possibly in special circumstances, any person the subject of a disclosure — to another position within the organisation, provided the new position is on the same pay and conditions, including at least equal seniority, responsibilities, prospects for advancement and accessibility between their home and place of work, or
- negotiating a voluntary redundancy package with the whistleblower — subject to the appropriateness of the necessary restructure or abolition of the position if the offer is accepted.

The disruption caused by exercising any of the first three options during the currency of an investigation points to the need for fully resourced investigations to ensure they can be finalised as quickly as possible and are consistent with procedural fairness requirements.

It is important to note that if it is necessary for a person to be moved, there can be no presumption that this should be the whistleblower or any person the subject of their disclosure. The decision will depend on the circumstances of each case.

Occasionally agencies require whistleblowers to sign confidential deeds of release as part of a settlement. Under such deeds, the whistleblowers undertake to refrain from making — or to withdraw any existing — complaints or disclosures they have made. Case study 63 is an example of such a case.

From a public policy perspective it is clearly not appropriate or acceptable for agencies or officials to insist that whistleblowers enter into any undertakings that effectively enable an agency or public officials to avoid appropriate public scrutiny and proper accountability. If a matter warrants investigation in the public interest, the fact that the whistleblower may not want to take the matter any further is, in our view, of little importance. Disclosures about corrupt conduct, maladministration and serious and substantial waste are in the public interest and the fact that the whistleblower and the agency have reached a private agreement does not make the matter any the less in the public interest. The public interest component remains despite any settlement and, if necessary, would in our view over-ride a settlement. It should be noted that any agreement to settle the matter is not binding on any investigating authority to which the matter may have been referred and nor should it be.

Case study 63

In last year's annual report, we discussed a protected disclosure which led to the apparently irreparable breakdown of a working relationship. The whistleblower in question had made a complaint alleging a more senior colleague may have acted corruptly. The authority told us the person about whom this allegation had been made was unlikely to be able to cope with the stress of working with a person who had made such a complaint about her conduct. It seemed that only a transfer, of one or other of the parties involved, could resolve the situation. Unfortunately, there were problems with finding a suitable transfer for either party. In addition, it appeared the authority was determined to transfer the whistleblower. We pointed out that the Act makes it an offence to take detrimental action against a person for having made a disclosure, and a directed transfer — against a whistleblower's will — seemed to fall into this category.

We suggested the authority take all reasonable steps to resolve the matter. The authority offered the whistleblower a voluntary redundancy, and she decided it would be in her best interest to accept this offer. However, the offer of a voluntary redundancy and was conditional on her agreeing to withdraw her complaint from the Ombudsman and signing a deed of release.

In accordance with the public policy considerations discussed above, we communicated to the authority in strong terms that we thought their conduct was inappropriate. The matter was eventually resolved to the satisfaction of this office and that of the whistleblower.

Case study 64

After a secret submission to management by other employees, a whistleblower employed by a TAFE institute was removed from his workplace through an involuntary directed transfer. Only as a result of our inquiries was the man able to learn of, and eventually see, the allegations that had been made against him. We have received an undertaking from the institute that the man will be able to return to work at his original workplace, and the employees who made the submission will be counselled to avoid further problems. We will continue to monitor this situation.

Case study 65

On occasion, the making of a protected disclosure can lead to 'payback' allegations being made against a whistleblower. We recently dealt with a case where complainants had become tired of defending themselves against attacks they saw as vexatious. When we intervened the public authority in question acknowledged that there appeared to be a problem. It agreed to remind its employees that frivolous and vexatious complaints do not meet the threshold of being protected disclosures within the meaning of the Act, and that the making of vexatious allegations could have consequences under the authority's code of conduct.

University of NSW investigations

Last year we reported on our continuing investigations of how UNSW had handled three cases of protected disclosures and its treatment of the whistleblowers involved.

A key theme that emerged from these three cases and several previous matters was problems with the university's complaint-handling procedures. We identified substantial deficiencies in these procedures and in the way UNSW treated whistleblowers.

During our investigations, UNSW has implemented changes to the policies and procedures relating to complaints and importantly, who is responsible for handling them. Since the first of the protected disclosures in question was made, UNSW has had four Vice-Chancellors. Many of the staff that featured prominently in our investigations — either as complainants and witnesses or persons of interest — no longer work with UNSW or hold positions with responsibility for handling complaints, in particular protected disclosures. None of the current management team were involved in the initial complaints nor were they the subject of our investigation.

On the basis of a number of factors including these changes and the commitment demonstrated by the new management team in implementing them, we discontinued our investigations in December 2006. At the same time we issued our *Complaint Handling at Universities: Best Practice Guidelines* based on our survey of all NSW public university practices and the lessons learnt from our UNSW and other university investigations.

Last year we also reported that one of the persons who was the subject of our UNSW investigation had commenced Supreme Court proceedings against our office, challenging our jurisdiction to investigate. These proceedings were discontinued in February 2007.

Referring protected disclosures to other bodies for investigation

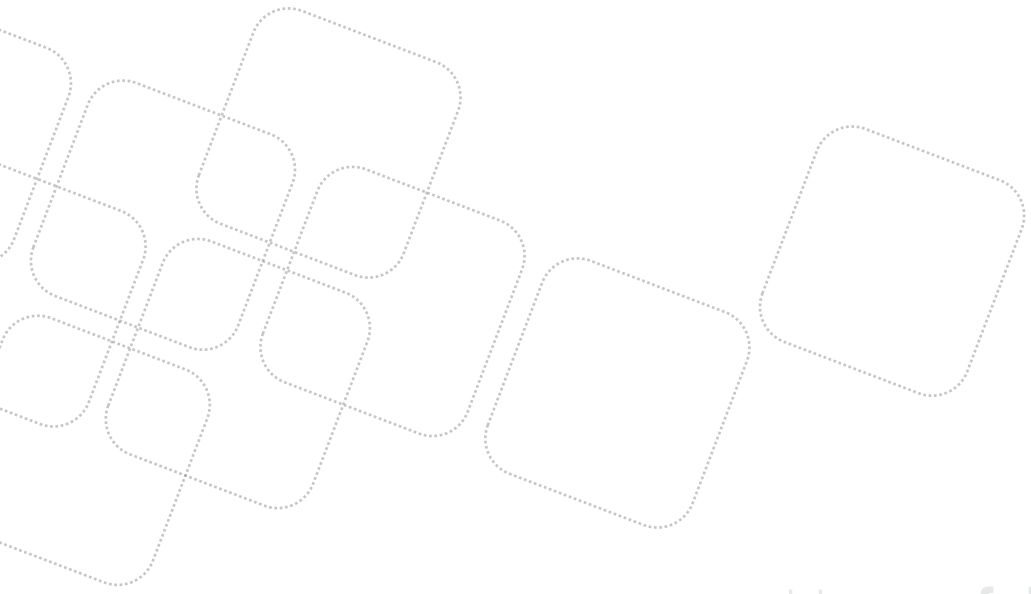
In March 2006 we received a protected disclosure making a range of allegations about the Health Care Complaints Commission (HCCC). An assessment of the allegations indicated that while some could be the subject of an investigation by this office, others were either outside our jurisdiction or not matters that we would normally exercise our discretion to investigate.

We decided that a body able to deal with all aspects of the complaint would be best placed to deal with the allegations. This would enable the allegations and their implications to be dealt with in their full context. In our view, the organisation that had the ability to review most, if not all, the matters raised was the Joint Parliamentary Committee for the Health Care Complaints Commission. One of the functions of that Committee is to monitor and review the exercise of the HCCC's functions under the *Health Care Complaints Act 1993*. We therefore referred the disclosure to the Committee under section 25 of the Protected Disclosures Act.

In early August the Chair of the Parliamentary Committee advised us that Parliament had obtained advice from the Crown Solicitor as to whether the Committee was an appropriate body to deal with a protected disclosure under the Act. The advice stated that a Parliamentary committee does not constitute an investigating authority, public official or public authority within the meaning of the Protected Disclosures Act and, accordingly, protected disclosures cannot be referred to it. The Committee handed the matter back to us for further consideration, indicating that some systemic issues raised in the complaint had been noted and that some would be examined as part of the review of the HCCC's 2005/06 Annual Report.

In light of this advice and our continued view that the matter be referred to a body with jurisdiction to fully consider all the matters raised, in August last year we referred the disclosure to the Minister for Health on the basis that it would be within his discretion to deal with the issue pursuant to his powers under section 81 of the Health Care Complaints Act.

In April of this year we were advised that the Minister for Health had referred the disclosure to the Premier's Department and sought its assistance in reviewing the allegations. In view of the serious nature of the allegations, the department engaged Ms Helen Bauer, former Director General of the departments of Industrial Relations and Community Services and a former President of the Institute of Public Administration NSW, and Ms Robyn Gray, former Deputy Solicitor for Public Prosecutions, to undertake a review of the allegations. When that review was concluded, a copy was provided to us for our consideration. The outcome of the review was that no evidence was found to support or substantiate the allegations that had been made. It appeared to us from the report that a comprehensive assessment of the allegations had occurred.



we want to see **fair accountable** and **responsive** administrative practice and service delivery in NSW in our own organisation and those we oversight we work to **promote good conduct fair**

14. EMPLOYMENT-RELATED CHILD PROTECTION

Highlights

- Delivered training and briefings to in excess of 1000 people in 45 separate sessions.
- Facilitated presentations by specialists in the fields of interviewing children, investigation of child pornography and other child exploitation offences, the psychology and typologies of child sexual offenders, assessing the validity of child sexual abuse allegations, risk assessing child sexual offenders and the Commission for Children and Young People's legislation.
- Held 22 industry forums
- Undertook 10 regional visits spanning a range of agencies
- Received 11.7% more notifications than last financial year and finalised 13.5% more than last year
- Made 24 recommendations for agency systemic improvement following direct investigation
- Ensured 100% compliance by agencies in respect of all investigation recommendations
- Completed an internal work practices review

Introduction

Our child protection team was established in 1998 after the Wood Royal Commission found that NSW workplaces had inadequate systems in place to prevent and respond to child abuse. Part 3A of the Ombudsman Act was introduced to require certain employers to notify the Ombudsman of 'reportable allegations' against their employees within 30 days of becoming aware of them.
A reportable allegation is one that involves:

- an agency within our child protection jurisdiction
- a current employee
- an alleged victim under 18 years
- certain alleged conduct that could be abusive to children.

Agencies within our jurisdiction

All public authorities are required to notify the Ombudsman if it is alleged that one of their employees has engaged in reportable conduct.

Case study 66

We were notified of an allegation that a government bus driver had assaulted a 16 year old high school student after a verbal altercation on the driver's bus. The agency advised us that the employee had a history of inappropriate behaviour towards young passengers over a number of years, including allegedly abducting a child who had thrown an item at the bus. The employee said he had merely tapped the student lightly after the student allegedly spat at him. CCTV footage of the incident was obtained and it clearly showed that the employee had gotten off the bus, chased the student up to 20 metres and then slapped the student forcefully around the head and face several times. The employee was charged with assault and found guilty. The agency sustained the reportable allegation of physical assault, dismissed the employee and notified his details to the Commission for Children and Young People (CCYP).

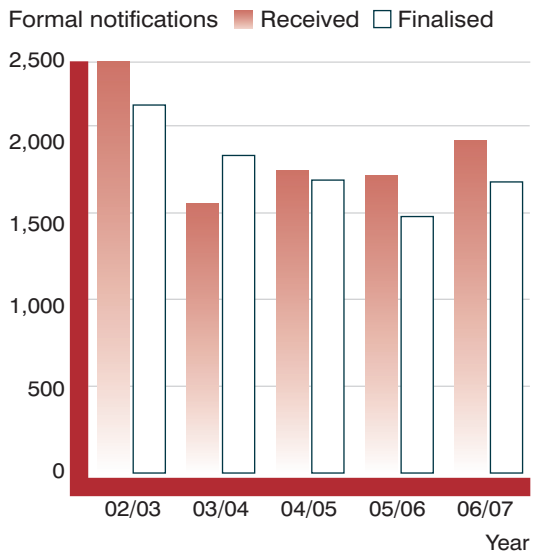
Some public authorities defined by the Act and associated regulations as 'designated agencies' are required to notify reportable allegations against employees, even if the alleged conduct occurred outside the workplace. These public authorities include the departments of Education and Training, Community Services, Juvenile Justice, Health, Corrective Services and Ageing, Disability and Home Care. Employees in these agencies typically have direct care of

and/or contact with children, and employers need to be able to assess the risk they may pose to children in the workplace. Designated non-government agencies include all independent schools, agencies providing substitute residential care to children, licensed children's services and affiliated health corporations. Case study 67 provides an example of the importance of considering conduct outside the workplace as part of the risk assessment of an employee.

Over the last year, notifications have increased by 11.7 % (see figure 56).

Formal notifications received and finalised **fig 56**

	02/03	03/04	04/05	05/06	06/07
Received	2,473	1,620	1,815	1,786	1995
Finalised	2,211	1,908	1,760	1,541	1749



Employees

An allegation is only reportable if it involves a person who is an employee at the time the head of the agency becomes aware of the allegation. The Act defines 'employee' more broadly than other legislation — it includes anyone 'engaged' to provide services to children — so it applies to volunteers providing services to children. It is important that volunteers are covered by our Act so that those who may pose a risk to children are properly investigated and risk assessed. This is particularly the case because the CCYP does not currently conduct 'working with children' checks on volunteers who work with children.

Case study 67

A member of the public alleged that a parent volunteer at an independent school had been charged with sexual offences against a child. The school was advised that the volunteer was considered an 'employee' for the purposes of the Act and that the allegation should be notified to the Ombudsman. The volunteer had not disclosed the charges to the school. They made inquiries and found that the volunteer had been charged with 26 counts of offences relating to a child. A police investigation precluded investigative action by the school.

We maintained regular contact with the school and provided advice about managing the matter during the police investigation. The school implemented sound risk management strategies — including excluding the volunteer from any involvement at the school and escorting them off the premises when they presented at the school.

After a lengthy police investigation and criminal process, the volunteer was convicted of several counts of aggravated indecent assault of a child and sexual assault of a child. We commended the school for implementing sound risk management strategies during the police investigation and minimising any risks to children.

Child

An allegation is reportable if the alleged victim was under the age of 18 at the time of the alleged conduct. We receive many notifications of historical conduct where the alleged victim is now an adult, but was a child at the time of the alleged incident. See case study 68.

Case study 68

We received a notification that a foster carer for a substitute residential care agency had allegedly sexually assaulted two children in their care 15 years ago. One alleged victim made a disclosure to a counsellor that was reported to the Department of Community Services (DoCS) Helpline. However, due to health issues, the alleged victim could not be interviewed by the agency. The agency also had difficulty locating the second alleged victim.

The agency advised us that they would discontinue their investigation because they had insufficient information to act on.

We disagreed, because the initial disclosure was credible and we considered that inadequate efforts had been made to locate the second alleged victim. Although no children were currently living with the foster carer, they remained authorised to care for children. We advised the agency that the investigation could and should continue and identified further lines of inquiry that should be pursued.

A further report was made about alleged sexual and physical assault of a third child by the carer. The agency located the second alleged victim and interviewed them. Around the same time, the first alleged victim was available to be interviewed. Both alleged victims made clear and corroborative disclosures of sexual abuse by the foster carer. The carer declined to be interviewed but provided a written response denying the allegations against them.

As a result of the investigation, the carer's details were notified to the CCYP and their authorisation to care for children was cancelled.

Reportable conduct

If an allegation is, on the face of it, reportable, it must be notified to us irrespective of the results of any subsequent investigation. Please see figure 57 (over page) for a breakdown of the types of allegations we are notified about. Although we have powers to directly investigate reportable allegations, we use them as a last resort. Our main objective is to help agencies improve how they prevent such conduct and respond to reportable allegations. Section 25B of the Act requires the Ombudsman to scrutinise these systems.

One of our key aims is to ensure that agency investigations are conducted in a fair, transparent, sound and timely manner — and potential or actual risks to children are properly assessed and managed. In some cases, we may consider that the investigation was not conducted properly or the outcome was not reasonable. If it is in the public interest to do so, we use our legislative powers to require further information from the agency until we are satisfied that any serious deficiencies have been remedied.

We typically use these powers if:

- risks to children have not been identified or adequately managed (see case study 69)
- procedural fairness has been denied to the employee who is the subject of the allegation (see case study 70)
- systemic issues arising from the investigation have not been addressed.

We also aim to make sure that agencies comply with their other legislative child protection obligations, such as mandatory reporting to DoCS and notifications to the CCYP.

Case study 69

A school notified us of an allegation that a teacher had physically assaulted a student in the classroom. The school finalised the allegation as 'not sustained — insufficient evidence' even though there was corroborative evidence of the assault. We advised the school that the evidence supported a finding of 'sustained' physical assault and questioned its assessment of the behaviour as exempted from CCYP notification. We also noted that the teacher had a history of sustained physical assault allegations involving other students.

The school had assessed that the teacher posed a low risk to students. We challenged this given the previous sustained allegations, questions regarding the teacher's suitability to teach adolescents, concerns expressed by the principal that the teacher may one day 'break' and evidence that the teacher had previously taunted students about allegations they made against him.

The school amended its finding to 'sustained', notified the teacher's details to the CCYP and reviewed its risk management plan. The school concluded that the teacher posed a significant risk to students, the school and himself. We were satisfied that the school's revised risk management strategies were addressing any risks the teacher posed to children.

Case study 70

An area health service notified us of a reportable allegation after a four year old child disclosed to their mother that they had been indecently assaulted by an employee of the agency.

The employee was suspended from duties while the Joint Investigation Response Team (JIRT) and the Health Care Complaints Commission (HCCC) investigated. They both concluded there was insufficient evidence to proceed. The agency reinterviewed the child, made a finding of 'sustained' and notified the employee's details to the CCYP. We considered the evidence to be inconclusive and therefore insufficient to support the finding.

Given the implications of the finding for the employee's future employment, we asked the agency to review their 'sustained' finding. They initially maintained the finding but agreed

to meet with us to discuss the matter. This meeting gave us the opportunity to clarify our expectations with them and explain the process of weighing evidence on the balance of probabilities. The agency amended their finding to 'not sustained — insufficient evidence', resulting in a fairer outcome for the employee. In addition, the agency emerged with a greater understanding of our role and expectations and a commitment to undertake further training of their employees in conducting investigations.

The Act defines reportable conduct as any:

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

The Act also specifies that allegations of 'misconduct that may involve reportable conduct' constitute reportable allegations and must be notified to the Ombudsman. This category typically captures misconduct that could form a pattern of grooming behaviour or could otherwise denote an inappropriate relationship with a child but does not necessarily meet the threshold of 'sexual misconduct' at the time the allegation is made. In many of these matters, the investigation uncovers additional evidence that brings the conduct within the realm of reportable conduct (see case study 71).

Other notifications in this category often uncover systemic or risk issues that warrant being addressed by the agency. It is important we are alerted to such matters in the early stages so we can monitor the investigation — and ensure that a risk assessment has been completed, adequate risk management strategies have been put in place, and the investigation is undertaken in a sound manner (see case study 72).

What the notifications were about **fig 57**

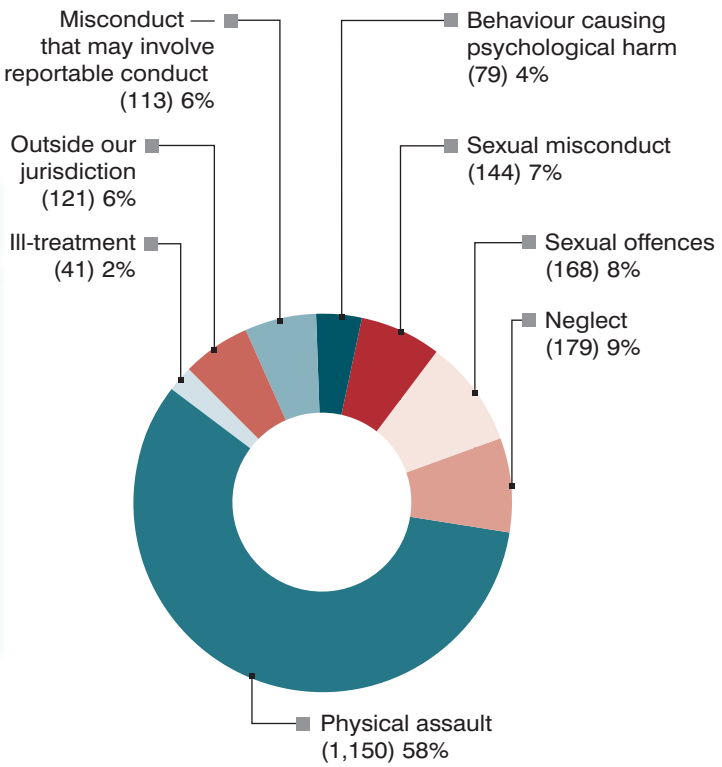
Issue	No.	%
Physical assault	1,150	58%
Sexual offences	168	8%
Neglect	179	9%
Sexual misconduct	144	7%
Behaviour causing psychological harm	79	4%
Outside our jurisdiction	113	6%
Misconduct — that may involve reportable conduct	121	6%
Ill-treatment	41	2%
Total	**1,995**	**100%**

Case study 71

A teacher self-reported driving a 15 year old female student home, and that other students were remarking that the teacher and the student were 'together'. Two weeks before, the school had received a complaint from the student's carer that the teacher was overly friendly with the student and their siblings. The school had no further details but notified the concerns to us as misconduct that may involve reportable conduct.

We monitored the school's investigation, requiring regular updates on their risk management and the progress of the investigation. The student was known to be highly vulnerable. The school constantly reviewed their risk management strategies for the student and their family, the teacher, their work colleagues and witnesses. As more information became available, reports were made to DoCS and the teacher was directed not to have contact with the student outside their normal teaching capacity. This order was breached and the teacher was placed on alternative duties.

The evidence obtained from a range of reliable witnesses supported that the teacher was engaged in an inappropriate relationship with the student. The teacher refused to accept the school's further directions and resigned. At this time, the student was living in the teacher's home. The teacher was notified to the CCYP and flagged as never to be employed by the school.



Case study 72

We received a complaint from a juvenile detainee who was concerned about employees at a juvenile justice facility allegedly touching detainees in an inappropriate manner. The identities of the employees allegedly involved were not provided and the allegation did not detail the alleged conduct.

We categorised the allegation as 'misconduct that may involve reportable conduct' — given the nature of the alleged behaviour and the vulnerability of children in detention. We made contact with the agency and asked them to try to identify the employees allegedly involved and obtain further details about the alleged behaviour.

These inquiries resulted in the notification of several employees for alleged inappropriate touching, inappropriate relationships and other procedural breaches. Following investigation, a number of these allegations were found to be 'not reportable conduct'. However, the agency established that misconduct had occurred and disciplinary action was taken. Systemic issues to do with internal reporting failures and boundary breaching were also addressed. We continue to monitor this last issue within the centre.

Number of formal notifications received **fig 58**

Agency	05/06	06/07
Department of Education and Training	666	819
Department of Community Services	436	469
Substitute residential care	210	255
Catholic systemic and independent schools	109	109
Department of Juvenile Justice	100	91
Independent schools	88	56
Child care centres	68	77
Department of Health	45	27
Councils	20	24
Family day care	19	13
Department of Ageing Disability and Home Care	13	27
Other public authority – not local government	7	13
Department of Corrective Services	3	13
Department of Sport and Recreation	1	1
Other prescribed bodies	1	1
Agency outside our jurisdiction	0	0
Total	**1,682**	**1995**

Who the notifications were about **fig 59**

Issue	Female	Male	Unknown	Total
Physical assault	577	563	10	1,150
Sexual offences	31	136	1	168
Neglect	113	65	1	179
Sexual misconduct	29	113	2	144
Behaviour causing psychological harm	45	32	2	79
Outside our jurisdiction	37	71	5	113
Misconduct – that may involve reportable conduct	25	96	0	121
Ill-treatment	27	13	1	41
Total notifications received	**884**	**1,089**	**22**	**1,995**

How agencies are performing

Education sector

Most of the notifications we receive are from the education sector, with the majority coming from the Department of Education and Training (DET). DET made 41% of all notifications we received in 2006-07 — this is 23% more than last year — with Catholic systemic schools and Catholic independent schools making 5.5% and other independent schools making 2.8% of notifications (see figure 58).

The Department of Education and Training

Over the past year we have raised concerns with DET about the quality and timeliness of investigations conducted by some principals, how they make findings, delays in finalising investigations and the performance monitoring of employees who have been the subject of sustained findings. A small number of investigations by DET's employee performance and conduct unit were also identified as deficient.

In response to our concerns, DET developed a checklist of questions and considerations for principals and continue to consult with us about investigative standards. They have also reviewed their categories of findings — resulting in a system that better enables them to comply with our child protection scheme. We are satisfied that DET is committed to continually improving the quality of their investigations. We continue to maintain close dialogue with them through regular liaison meetings, audits (see case study 73) and case discussions.

Case study 73

In 2006, we conducted the first audits of allegations against employees that are exempted from reporting under our extended 'class or kind' determination with DET. We audited 10% of inquiries and exempted matters on each occasion. We found that DET had generally dealt well with exempted matters and categorised them appropriately. However, we disagreed with their decision-making in a few matters and sought notifications.

For example, we identified an allegation made by a 16 year old student that she had recognised a visiting teacher as the person who had drugged and sexually assaulted her three years earlier. The allegation had not been notified to us as it had been managed as an inquiry only and closed without a finding. DET said their inquiries had established that it was practically impossible for the identified teacher to have assaulted the student as alleged. We advised DET that the allegation was sufficiently detailed to constitute a reportable allegation and should be notified.

We provided feedback to DET about improving the management of information at the intake level and in the decision-making process. DET agreed to more closely review inquiries at intake, particularly the more serious allegations, to determine whether they constituted a reportable allegation. We will review their assessment of inquiries in future audits.

Catholic systemic schools

In last year's annual report, we commented on the positive developments in the employment-related child protection systems in this sector since the head of agency arrangement reverted to the NSW Bishops in July 2005. We have observed continued general improvement in most of the 11 Catholic dioceses, particularly in regard to risk management procedures and competence in conducting investigations.

Over the past year, the sector has shown strong initiative in seeking our advice about aspects of their investigations. Key issues have included gathering and weighing evidence for allegations of grooming behaviour and conduct causing psychological harm, child protection and the internet and apologising to students and their parents about reportable conduct. We have provided guidance on a case-by-case basis as well as at our quarterly systemic school liaison meetings and Catholic chancery forums.

However, we have been concerned by a number of protracted investigations in some dioceses. Several of these involved the employee who was the subject of the allegation applying under the Catholic Commission for Employment Relations Teacher's Award 2006 to access the investigation file before the investigation was completed. This award is unique to the Catholic sector and in many cases has contributed to delays in finalising investigations. We have had discussions with the sector about the award and apparent confusion about the rights that the *Freedom of Information Act 1989* provides for anyone who is the subject of reportable allegations that are finalised as relevant employment proceedings. Other factors contributing to protracted investigations in two dioceses included a reported lack of resources. We will be following up on these systemic issues in 2007–08.

Catholic independent schools

During 2006–07 we held a number of forums for Catholic independent schools. We presented information and training on topics such as grooming behaviour, defining reportable allegations, making findings and how to manage investigations when external agencies such as DoCS or the police are also involved. Given the number of serious allegations that independent schools have had to investigate, this last topic was particularly relevant.

Other independent schools

The non-government or independent schools sector covers a range of schools of different sizes, resources, religious affiliation or philosophical ethos. This presents a particular challenge for us in terms of providing education and training to such a large and diverse sector.

This year we received 36% fewer notifications from these schools than we did in 2005-06. Although a number of schools can now claim an exemption from reporting certain matters through our 'class or kind' determination with the Association for Independent Schools, our 2006 audit of exempted matters indicated that this had not significantly affected the number of matters notified. We are exploring the decline in notifications through our forums, audits and liaison meetings with independent schools.

Nearly half the notifications received from this sector involved allegations of physical assault. The other half were almost entirely made up of allegations of sexual offences, sexual misconduct and misconduct that might constitute grooming behaviour.

Substitute residential care

The substitute residential care sector is our second largest notifier. Substitute residential and foster care homes are inherently high-risk situations for both children in care and the adults who care for them. Carers who provide services to children in their homes

or a residential setting have extensive exposure to children and limited, if any, supervision. They care for children who may have previously been abused or neglected, who often have high needs and/or challenging behaviours and who are otherwise highly vulnerable. The sector is made up of around sixty-two agencies, with DoCS being the largest notifier.

The Department of Community Services

Last year we reported a 10% increase in notifications from DoCS and that we intended to enter into a 'class or kind' determination with them. This was in recognition of improvements in their systems for handling less complex investigations, the particular context in which allegations against their employees arise and our confidence that DoCS would continue to respond to these matters adequately without our oversight. The class or kind determination started in September 2006. However, notifications from DoCS have increased by 7.6 % on last year.

Over the past 12 months — despite our confidence in the systems DoCS have for responding to less complex matters — we have identified concerns about some investigation practices, and delays at local offices (CSCs) in starting and finalising investigations into reportable allegations. We acknowledge the competing priorities for resources at CSCs, but we are concerned that some risk issues to children are not being adequately addressed (see case study 74) and, in some cases, employees are being denied procedural fairness.

We have continued our regular liaison meetings with the Complaints and Review Branch at DoCS and have raised our concerns through this forum — as well as in general feedback to the Allegations Against Employees Unit and the Director General. DoCS have been responsive to our concerns and are currently developing and implementing a range of strategies to address them. We will continue to monitor these initiatives and issues over the coming year.

Case study 74

We were notified of allegations that a foster carer had inappropriately touched and made comments of a sexual nature to an 11 year old child in their care. The child disclosed that the carer allegedly engaged in conduct that could form a pattern of grooming behaviour.

The carer has a history of caring for children with learning and other disabilities. Six allegations of a sexual nature had been made against him over two years, only one of which had been notified to us as required. Police reported the new allegations to the agency, and they then notified us. We were aware that the child was no longer living with the carer.

We made preliminary inquiries with the agency and found out that a child with severe physical disabilities was now living with the carer. The risk assessment the agency did to support their decision to leave that child in the man's care during the investigation was vague and unsatisfactory.

We outlined our concerns about the agency's failure to notify numerous reportable allegations against this carer and their inadequate risk assessment for the child currently in his care. We made formal inquiries about how the agency would address the risk concerns and required notification of the outstanding matters. We later met with the agency to discuss the risk issues surrounding the child in care and concerns that the carer had previously cared for children without authorisation — in breach of the agency's processes.

The agency agreed the risk assessment for the child currently in care had been inadequate, but outlined strategies they had implemented that we accepted as reasonable for this particular child's placement. They also agreed not to place further children in the man's care pending the outcome of the investigation. We continue to monitor the agency's investigation of the current and historical allegations, as well as the implementation of their risk management strategies.

The Department of Ageing, Disability and Home Care

The Department of Ageing, Disability and Home Care (DADHC) is a relatively small notifier, but we closely scrutinise it due to the highly vulnerable children in its care. We have observed a general improvement in DADHC's investigation practices and communication with us over the past year. However, some investigations have given rise to serious concerns

and there continue to be some delays in finalising matters. We are having discussions with DADHC about our concerns.

Other agencies providing substitute residential care to children

We have also been focusing our attention on some small to medium-sized substitute residential care agencies that have inadequate child protection systems — due either to them being relatively new services or to changes in resources and/or structures within the service.

Substitute residential care agencies must often investigate reportable allegations against carers when there are no witnesses to the alleged incident and the alleged victims are very young and cannot communicate well. Risk management during these investigations can be complex and often involves a fine balance between managing potential risks to children and ensuring procedural fairness for employees.

Serial reporting of allegations against employees by a small number of high-needs young people is a problem for some agencies. We have discussed this issue with agencies at our forum, as responding to these allegations can consume considerable resources. However, although the credibility of the alleged victim is relevant when weighing up evidence and making a finding about whether or not a reportable allegation is likely to have occurred, allegations should not be dismissed simply because the child raising them has a history of making allegations. Such a history can of itself make the child a vulnerable target (see case study 75).

Case study 75

We were notified of allegations of sexual assault against a youth worker at a substitute residential care agency. The resident involved had a history of making allegations against workers at a number of agencies where they had been placed. Some of these had been found to be false. The agency was working with DoCS to put a strategy in place for handling these allegations. Although the agency questioned the credibility of the allegations for this reason, we monitored the investigation and provided guidance to the agency throughout the process.

A joint investigation response team (JIRT) interviewed the young person who disclosed three incidents of alleged sexual assault. The employee initially denied the allegations, but was charged by police and remanded in custody. The employee subsequently pleaded guilty to all charges and was sentenced to a minimum period of four years in prison.

The quality of child protection investigations in agencies providing substitute residential care continues to improve. As part of our contribution to this improvement over the past year, we have:

- held regular forums for agencies providing substitute residential care to children — with guest speakers addressing issues such as unfair dismissal claims, interviewing children, child sexual abuse allegations and the role of the CCYP
- delivered training to four substitute residential care agencies
- finalised an audit into the child protection systems of a substitute residential care agency, resulting in the adoption of all 14 of our recommendations and improvements to the agency's policies and procedures and the support and training provided to their employees
- commenced an investigation into a small agency providing residential care to particularly vulnerable children with disabilities
- finalised an investigation into a larger agency providing residential care to a variety of children (see case study 77 on page 146).

Children's services

All licensed children's services — including child care centres, family day care services and mobile and home-based children's services — are within our jurisdiction. Although the children's services sector, with more than 4,000 agencies, is the largest in our jurisdiction, it represents only 5% of the notifications we receive. However, we receive a high volume of telephone inquiries from this sector — over 20% of all the child protection inquiries we receive.

We continue to hold regular children's services forums to assist these agencies to improve their practices. However, the range and diversity of the sector presents some difficulties in providing training and information about their reporting responsibilities. The sector is generally low-risk compared to other agencies in our jurisdiction. This is partly because licensing by DoCS provides a layer of quality control and typically results in these agencies having basic child protection policies and systems in place for preventing reportable conduct — if not for investigating reportable allegations. In addition, council-run child care and family day care schemes tend to benefit from being able to draw on their local council's investigative resources. Conflicts of interest continue to cause difficulties in other child care centres — particularly stand-alone centres — when reportable allegations require investigation. We deal with such conflicts on a case-by-case basis.

Last year we discussed our investigation of agencies that had refused to cooperate with our audits. One of those agencies was a child care provider that subsequently cooperated with our investigation. We identified a number of systemic failures and made

12 recommendations for systemic improvement. The agency has now complied with most of our recommendations and has a further three months to comply with the remainder. We are satisfied that the agency is committed to improving their child protection systems. For example, they have prepared a code of conduct and a policy on the use of restraint, revised their employment screening policy, developed a new centralised complaint recording system, provided widespread training and committed to ongoing training provision for employees. We consider that our investigation — combined with the agency's commitment to implementing our recommendations — has significantly contributed to improved systems within this agency and, as a result, a safer environment for many children and employees in NSW. The agency has acknowledged this and expressed their appreciation for our involvement.

'I COULDN'T SURVIVE WITHOUT YOUR OFFICE. I JUST THINK IT'S SIGNIFICANTLY IMPORTANT THAT WE CAN CONTACT YOU. THE ADVICE IS FANTASTIC. HOW LUCKY ARE WE THAT WE CAN DO THIS? IT JUST PUTS EVERYTHING INTO PERSPECTIVE AND CONFIRMS THINGS FOR YOU. EVERYONE I'VE EVER SPOKEN TO HAS BEEN SO HELPFUL.' — CHILD CARE MANAGER

Eleonora De Michele — Interviewing Children workshop. May 2007.

Department of Health

We hosted two health forums during 2006–07, providing an opportunity for participating agencies to discuss practical aspects of investigating reportable allegations, recent legislative changes and the revised role of the Department's Employment Screening and Review Unit (ESRU). Given that the majority of notifications from health agencies involve reportable conduct of a sexual nature, we also facilitated presentations on grooming behaviour and types of sexual offending. A key issue we have been addressing in this sector is how to weigh evidence and make appropriate findings (see case study 70).

We liaise directly with individual area health services whose chief executives have head of agency responsibilities for reportable allegations. However, as NSW Health retains overall responsibility for managing reportable allegations, we have recently reintroduced regular liaison meetings with the ESRU and participated in training for their staff.

Last year we reported on our concerns about an area health service's handling of sexual assault allegations against a doctor. The agency has since agreed to comply with all eleven recommendations arising from our investigation and has — to date — fully complied with nine of them. Our recommendations included liaising with DoCS about the exchange of information and the development of a training program for employees.

Institutions for juvenile offenders

Department of Corrective Services

The Department of Corrective Services (DCS) is a designated agency under Part 3A of the Act. When Part 3A was introduced in 1999, DCS's inmates were all adults. There were very few reportable allegations about DCS employees at that time, and the majority involved child sexual and indecent assault and child pornographic offences that had occurred outside the workplace.

In November 2005, DCS took over the management of Kariong Juvenile Correctional Centre — formerly a juvenile justice and young adult centre — that caters for juvenile offenders. We had anticipated an increase in notifications from DCS as a result. As this did not eventuate, we conducted an examination of their systems. We identified a number of systemic issues, including:

- a lack of understanding of their responsibilities under Part 3A of the Act
- inadequate systems for preventing and responding to reportable allegations against their employees
- failures to notify reportable allegations
- inadequate record-keeping.

DCS has generally been cooperating with our efforts to address these issues and we will be making a number of recommendations for systemic improvement. However, we are concerned by a recent challenge by DCS in relation to the definition of 'reportable allegation'. Specifically, DCS is disputing one matter that should be notified involving an employee who disclosed they were a child sexual offender. Self-disclosures do not obviate reporting obligations. At the time of writing we are in discussions with the Commissioner about this issue.

Department of Juvenile Justice

Over the past 12 months, the Department of Juvenile Justice (DJJ) has been addressing concerns we raised in last year's annual report about delays in providing us with requested information and completed investigation reports. We have maintained regular liaison meetings with the department's employment relations and professional conduct unit, and overall timeliness in regard to reportable allegations has improved.

During the year, our staff visited a number of juvenile justice centres across NSW. During these visits we spoke to centre managers, employees and detainees to ensure that employees are aware of their reporting obligations under Part 3A, and detainees of their right to complain to the Ombudsman about child protection issues. We also audited centre documents to make sure that all reportable allegations had been notified. These visits have provided us with an opportunity to focus on some of the systemic child protection issues that arise in the centres.

One concern that came to our attention was alleged bullying among employees in some centres. This had apparently, in some cases, prevented the reporting of employees who allegedly engaged in reportable conduct. We discussed this concern with DJJ and we are satisfied that they are addressing the general cultural issue of bullying — including reinforcing their internal reporting policy with staff — and responding appropriately to the particular cases. We will continue to monitor this issue.

Other public agencies

During 2006–07, we have had the opportunity to work closely with a number of other public authorities. For example, we met with RailCorp's workplace conduct unit to discuss one of their investigations of reportable allegations that had not been notified to us. We commended RailCorp on the overall outcome of the investigation, but identified a number of areas for systemic improvement. These included the need to develop relevant child protection policies and improve awareness among staff of reporting responsibilities. Communication from RailCorp has improved and they are in the process of updating their child protection policies and guidelines in liaison with us.

We have also liaised with the Office of the Director of Public Prosecutions and the State Transit Authority about their child protection policies and procedures for responding to reportable allegations.

During the past 12 months we sought notifications from a number of public sector authorities after we received information from other sources — including media reports and complaints — about reportable allegations against their employees that had not been notified. In discussing these matters with the relevant authorities, it was apparent they were not adequately aware of their child protection responsibilities under Part 3A of the Act.

In 2007-08, we plan to increase awareness among all NSW public sector authorities about our role and their responsibilities under the Act. We will begin a process of reviewing agency child protection policies and try to encourage wider representative attendance at our child protection forums. We have identified a number of authorities as priorities — based on factors such as the nature of their work and their degree of contact with children.

Scrutinising systems

Section 25B of the Act requires us to keep under scrutiny the systems agencies have for preventing and responding to reportable allegations against employees. Over time we have observed significant improvements in agencies' systems that have contributed to NSW workplaces being safer environments for children. Our inquiry and complaint-handling function provides one source of information about agencies' systems and can alert us to reportable allegations that have not been notified (see case study 76).

Case study 76

We received a complaint from the mother of a 16 year old adolescent with disabilities who was receiving substitute residential care. The mother alleged that named employees of the residential care agency had repeatedly overdosed the adolescent, resulting in hospitalisation, and that residents were neglected in their hygiene and supervision — resulting in one incident of near-drowning in a bath.

We sought notification from the agency and asked for an explanation for the failure to notify us of the matter previously. The agency had been unaware of their reporting responsibilities. We provided advice about this and the need for the agency to have systems in place to prevent and respond to reportable allegations.

We also provided suggestions to the agency to enable a more thorough investigation of the specific allegations. The agency complied with most of our suggestions, made appropriate findings in regard to the allegations, and reviewed their child protection and other relevant policies and procedures.

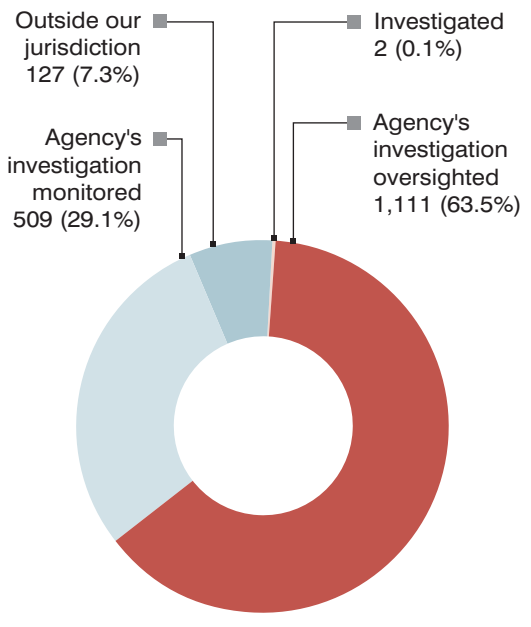
Monitoring agency investigations

We have an investigation oversight role in relation to every reportable allegation notified to us — a total of 1995 notifications in 2006-07. At a minimum, we assess and provide feedback on the adequacy of each investigation. In approximately a fifth of matters, a higher level of oversight is warranted from the outset. We monitor these matters under section 25E of the Act and scrutinise the investigations closely from the initial planning stage through to the completion of the matter. We escalate our oversight to monitoring status in a further 11% of matters, if the need for additional scrutiny becomes apparent.

In total, we monitored 29.1 % of investigations finalised over the past year (see figure 60).

Action taken on formal child protection notifications finalised in 2006–07 **fig 60**

Action	No.
Agency's investigation oversighted	1,111
Agency's investigation monitored	509
Outside our jurisdiction	127
Investigated	2
Total written notifications finalised	**1,749**



Our decision to monitor investigations is based on the level of risk involved to children, employees or the agency. Risks to an agency can arise if they are ill-equipped to investigate the allegations, there are conflicts of interest or the matter is very complex. Monitoring the investigation enables us to mitigate these risks. The majority of matters monitored over the past year involved a high level of potential risk to children. Some examples of the investigations we monitored and finalised over the past year are:

- an allegation that a hospital theatre orderly was charged with four counts of aggravated sexual assault of a person under 16 years. The employee pleaded guilty at court and made separate admissions about the conduct to the agency. On the basis of these admissions, the agency sustained the reportable allegation of aggravated sexual assault and dismissed the employee.
- an allegation that three juvenile justice centre employees neglected the supervision of a 17 year old detainee, and failed to ensure the detainee's safety and security by not responding to threats of assault from other detainees. Although the risk of assault to the detainee had been identified, inadequate steps were taken to protect him. The detainee was assaulted by a number of other detainees during discharge, resulting in injuries. The allegations were sustained and the employees involved were served with a formal letter of caution and notified to the CCYP.
- an allegation that a child care centre employee neglected the supervision of a three year old child, resulting in the child absconding from the centre and crossing a busy road. The child managed to make their own way home unharmed, but the potential for harm was significant. The investigation could not establish precisely how the child exited the centre's security doors, but it was established that they were able to do so because of the lack of supervision by the employee. The allegation of neglect was sustained and the employee was dismissed.
- an allegation that a bus driver for an independent school hit a 10 year old student on the ear causing their nose to bleed. The investigation resulted in a sustained finding of physical assault and the bus driver was suspended. However, we were not satisfied with the agency's advice that they intended to re-engage the bus driver. They had not provided an adequate risk assessment to support this decision and had not addressed additional allegations of physical assault against the driver. We requested further information about risk management and that the additional allegations be investigated. Ultimately, the employee was allowed to resign.

- an allegation that a foster carer dragged a 10 year old child in their care by the hair and threw them into a metal fence, then sat on their chest and slammed their head into the ground, causing bruising and abrasions. Police attended the home and reported it to be in an unhygienic state. The police removed the child from the home and ambulance officers attended to their injuries. The carer pleaded guilty to charges of assault and the substitute residential care agency sustained the reportable allegation of physical assault. The carer's authorisation was cancelled and their details were notified to the CCYP.

Our direct investigations

By overseeing and monitoring agencies' investigations, our aim is to ensure both appropriate outcomes in individual matters and continual systemic improvement in child protection systems. We use our direct investigative powers as a last resort. Generally, our decision to investigate an agency follows unsuccessful informal efforts to address systemic concerns within the agency — and the failure to address those concerns is posing a risk to children or staff. Over the past year we finalised two such investigations, continued three direct investigations, and started a further two.

Case study 77

We held concerns about the adequacy of the child protection systems of an agency providing substitute residential care for children. We started an investigation into their delays in providing us information, the poor quality of documentation supporting their decision-making and their understanding of their responsibilities under the *Commission for Children and Young People Act 1998*.

We conducted formal interviews with the head of the agency and other senior managers and obtained relevant documentation from the agency and third party sources. We concluded that the agency had failed to implement effective systems to ensure that reportable allegations against their employees were reported to us and responded to appropriately. We made findings about a number of specific deficiencies and in May 2007 issued a report outlining ten recommendations for systemic improvement.

We required initial compliance within one month of issuing the report and received it within this timeframe — and have staggered compliance reporting over the next 12 months. Meanwhile, we have set up regular liaison meetings with the agency to help them comply with our recommendations and ensure their case-by-case management of reportable allegations against their employees is timely and otherwise appropriate. We were encouraged by the agency's open communication with us during the investigation and their clear commitment to improving their systems.

Audit work

Wherever practical, we prefer to scrutinise agencies' systems less formally through audits. Section 25B of the Act empowers us to require agencies to provide us with information about their systems for preventing and responding to reportable allegations. We identify agencies that might be suitable for audit through our oversight role and other sources of information, including media reports. If an agency provides services to vulnerable children and does not appear to have adequate systems in place, we may make a preliminary decision to audit the agency.

Our approach to audits is consultative and agencies are generally cooperative. Many agencies welcome the opportunity to be audited and provided with comprehensive feedback and recommendations for systemic improvement — a service that otherwise involves a significant financial cost. In preparation for an audit, we generally ask for the agency's child protection policies and procedures so we can assess the systems currently in place. We then conduct an agency visit to establish the level of adherence to policy in practice, look at relevant records and speak to the head of agency, other employees and, if possible, clients of the service.

We monitor compliance with all recommendations arising from our audits. Generally, agencies fully comply with our recommendations in the first instance and we do not have to escalate our involvement.

Internal scrutiny

In addition to scrutinising the systems that agencies in our jurisdiction have in place, we constantly scrutinise our own systems to make sure we are operating efficiently and effectively and providing a quality service to agencies. Over the past year, we have taken a number of steps to improve our internal systems and service provision. For example, we have conducted:

- research, in liaison with specialist consultants, on current theory and good practice in interviewing children and in the relatively unexplored area of civil risk assessment and risk management. We have done this work to make sure we are able to provide agencies with advice that is based on contemporary academic thought and practice.

- a review, in consultation with stakeholders, of our guidelines for employers on responding to allegations against employees. This review identified a number of areas requiring update or further information and we will be issuing updated guidelines in 2007–08.
- an internal audit of open investigation files that were more than 12 months old. An initial assessment of risk identified 50% of these as being high priority matters for review. Of those, 86% were subjected to a full internal review, with the remaining 14% being finalised during the review. The review focused on two main areas. The first was to identify ways in which the investigation could be progressed by the agency — sometimes this involved our direct intervention with third parties on behalf of the agency. The second was the identification of aspects of our oversight or monitoring of the investigation that could have been improved. As a result of the review, a number of recommendations were made for internal procedural change — including our procedures for scrutinising agencies' investigation updates.

Child exploitation and telecommunication devices

In each annual report for the last five years we have drawn attention to the phenomenon of 'grooming'. Before 2004, allegations that employees were engaging in a pattern of conduct that might constitute grooming behaviour were captured by the 'misconduct that may involve reportable conduct' category. Many activities that could form a pattern of grooming behaviour were overlooked by agencies as examples of 'poor boundaries', but not otherwise concerning. In many instances, these behaviours escalated because they were not identified as posing a risk and therefore were not managed. Also, unless the alleged grooming activity actually resulted in a sexual offence, the conduct — even if sustained — was not regarded as reportable conduct. This was not consistent with our aim of preventing sexual offences by identifying grooming conduct in its early stages. The change to our legislation that took effect in April 2004 introduced 'sexual misconduct' in the definition of reportable conduct. 'Grooming' is now regarded as sexual misconduct.

Over the years we have worked to improve agencies' understanding of the grooming process — and their ability to recognise indicators of grooming and implement steps to help prevent children in their care from being groomed. We have achieved this through education and training, the presentation of our own research in the area and close liaison with agencies investigating grooming allegations involving their employees (see case study 78).

Case study 78

A school notified us of an allegation that a casual teacher was involved in grooming a 14 year old student. The teacher's conduct included sending numerous letters to the student of an intimate and emotionally charged nature, attempting to establish a rapport with them while isolating them from their peers, giving them gifts and asking them to keep these gifts a secret. The teacher maintained contact with the student via email while on an overseas holiday. Parents of other students became alarmed at the alleged behaviour and reported it. The agency sustained the allegations, but concluded that it did not amount to reportable conduct and did not warrant notification to the CCYP.

We did not agree with this assessment and were concerned that no action had been taken to manage the risks the teacher may pose to other students, particularly given the teacher's casual status. We outlined our reasons for considering that there was evidence the conduct amounted to grooming. We asked the agency to review their finding and action taken, and provide us with the outcome of this review. A senior manager within the agency reviewed the matter and agreed with our concerns. The agency amended their finding to sustained sexual misconduct, notified the CCYP, and implemented risk management strategies to help prevent the teacher from engaging in further inappropriate conduct. They also identified internal systemic issues relating to the assessment of this type of allegation and made recommendations to address these.

Today, agencies in our jurisdiction are more likely than previously to identify and notify allegations of grooming in the early stages. This helps them to avoid potential abuse by effectively managing any risks. The prevalence of online targeting of children by sexual predators has increasingly brought the term 'grooming' into our society's everyday vocabulary.

Each year we have reported with escalating concern on the increasing use of telecommunication devices in the grooming process. In our 2001–02 annual report, we reported on an investigation of inappropriate text messaging and emails sent by an employee to a child that resulted in criminal charges. In our 2002-03 annual report, we highlighted the use of online chat rooms as an emerging tool for grooming children, and in 2003–04 we noted the growing use of the internet to target and groom children. Every year the number of notifications of grooming or sexual offences against children that have involved the use of telecommunications devices has increased

— and each year the technology that offenders are using has advanced.

Whereas five years ago the number of children with their own mobile telephones was causing concern about risk, it is now common for young children to have 'online' identities that reveal personal details that are accessible to unknown people. The ease with which vulnerable children can be targeted has increased through this technology. Many offenders are not reported because their targets do not want to alert their parents or authorities to the risks they have been exposed to, for fear of losing their internet 'privileges' (see case study 79).

Case study 79

An independent school became aware of an allegation that a teacher was grooming a 16 year old student via the internet. This allegedly involved the teacher showing their genitals to the student online and attempting to engage them in sexual discussion and get them to show their own genitals via 'webcam'. The student's mother reported the concerns to the school after accessing the child's chat logs and the school immediately contacted us for advice. We provided guidance about the initial action that needed to be taken. After liaising with the NSW Police Force child exploitation internet unit, we provided the school with advice about relevant federal laws and the matter was referred to the police.

The teacher admitted to the conduct when faced with indisputable evidence, but attempted to minimise the behaviour. The teacher has since been dismissed from the school and charged by police with multiple offences. Information is emerging that the teacher groomed other children, indecently filmed students at his previous school and may have attempted direct contact offences with other students. Had the mother of the student not been alert to her child's internet activity, obtained transcripts of chat logs and been willing to report the matter, the extent of the teacher's crimes may not have been uncovered.

Last year we reported on our work to ensure that schools' policies keep pace with technology. We have continued to provide guidance to agencies during investigations of these types of allegations. This year we have facilitated presentations by the NSW Police Force sex crimes squad's child exploitation and internet unit to a number of agencies in our jurisdiction. In 2007–08, we will continue to work with agencies to help them improve their preventative and response systems. We will also continue our research in the area of child exploitation and the use of telecommunication devices and issue a paper aimed at addressing systemic issues that come to our attention.