NSW Ombudsman

Annual report 2007–2008

We are **fair**, impartial and independent of the Government of the day.

fair

To promote good administrative conduct, *fair* decision-making and standards of service delivery, we try to visit as many communities across the state as possible.

Bangalow, NSW

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We are fair, impartial and **independent** of the Government of the day.

We are *independen*t of the government of the day and are accountable to the public through Parliament itself.

Parliament House, Sydney NSW

Letter to the Legislative Assembly and Council

22 October 2008

The Hon. Peter Primrose MLC
President Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

The Hon. Richard Torbay MP
Speaker Legislative Assembly
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr President and Mr Speaker

I am pleased to present our 33rd annual report to the NSW Parliament.

This report contains an account of our work for the 12 months ending 30 June 2008 and is made pursuant to ss.30 and 31 of the *Ombudsman Act 1974*.

The report also provides information about my office's functions under the *Police Act 1990* and information that is required pursuant to the *Annual Reports (Departments) Act 1985*, Annual Reports (Departments) Regulation 2005, *Freedom of Information Act 1989* and *Disability Services Act 1993*.

The report includes updated material on developments and issues current at the time of writing (July–September 2008).

Yours sincerely

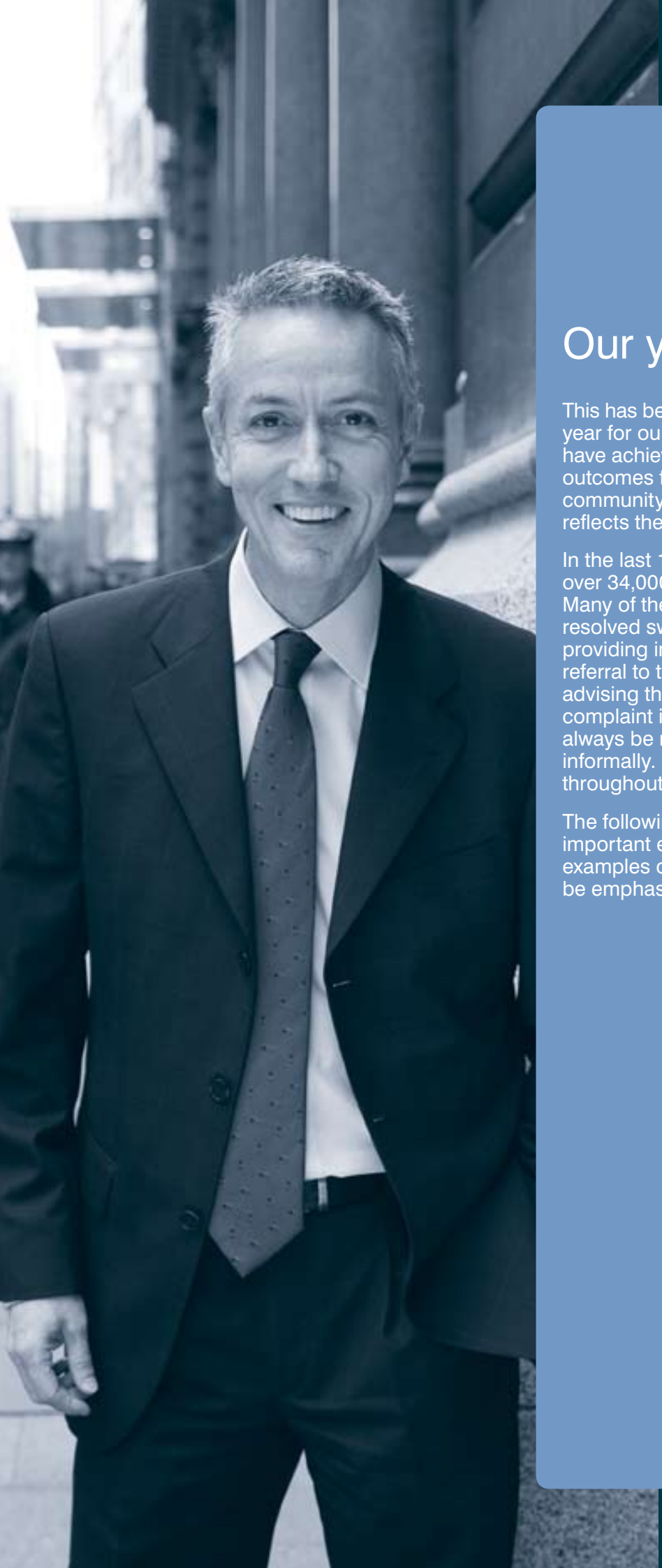
Bruce Barbour
Ombudsman

We are fair, **impartial** and independent of the Government of the day.

impartial

The NSW Ombudsman is an independent and *impartial* watchdog established by the *Ombudsman Act 1974*.

Bruce Barbour, Ombudsman
Martin Place, Sydney NSW



Our year in review

This has been another busy and challenging year for our office. I am pleased that we have achieved a large number of positive outcomes for both complainants and the community, and this year's annual report reflects these outcomes.

In the last 12 months, we have received over 34,000 complaints and notifications. Many of these matters were able to be resolved swiftly and informally, either by providing information or an explanation, referral to the relevant agency, or by advising the individual to put their complaint in writing. However, there will always be matters that we cannot resolve informally. Many of these are detailed throughout the report.

The following pages outline a number of important events of the past year, and examples of our work, that I think should be emphasised.

Our year in review

Assessing our role

In 2002, the Community Services Commission was merged with my office. In June this year, the Parliamentary Joint Committee (PJC) that oversees our work completed a statutory review of the *Community Services (Complaint, Reviews and Monitoring) Act 1993*. This review assessed, among other things, the effectiveness of the merger and the success of the community services work we do. The outcome was very positive. The PJC expressed strong support for our work and suggested that additional funds be allocated to certain areas, such as the official community visitors program.

Earlier this year, my senior staff and I met with the PJC for our 14th general meeting. These meetings allow us to provide the PJC with an update on our work, as well as answer any questions they may have. The meeting was successful, with the PJC supporting a suggested change to our legislation which will bring it into line with other Ombudsman Acts around Australia.

Much of our work relates to the adequacy of the various child protection services in NSW, and we welcome any attempts to ensure that these services and their supporting systems are operating as effectively as possible. In November 2007, the state government established a Special Commission of Inquiry into Child Protection Services in NSW, headed by Justice James Wood. The commission has conducted public hearings across the state and received a large number of written submissions. We have provided Justice Wood with a range of information he has requested — as well as a large amount of additional information that we believe to be relevant. This has included ten detailed submissions on various different topics. They are expected to issue their final report later this year. For more information about the Wood Inquiry, see pages 63 to 66 in Chapter 3: Children and young people.

Working proactively across the community

Although there are often systems in place to provide essential services, it is important to monitor these systems to ensure they are being implemented correctly and consistently. Our proactive project work allows us to identify gaps in services, as well as assess how effective existing policies and procedures actually are in practice.

These projects also give us the opportunity to speak with a range of people across the community — such as foster carers, parents, teachers, children and young people, police officers and staff from community service centres — who deal with these policies and procedures every day. In the last year, staff from our corrections unit have spent 167 days at 28 different correction centres, talking with both inmates and staff. We have also made 17 visits to the State's nine juvenile justice centres. All of these groups, either as providers or recipients, have an interest in ensuring that systems operate properly and their input is invaluable to our work.

This year we have examined the way in which people with a mental illness access and maintain social housing, the processes around suspensions in our public schools, and the level of support provided to foster carers looking after Aboriginal children. We have also commenced two reviews of the services provided to people with a disability by the Department of Ageing, Disability and Home Care (DADHC). When we have completed systemic investigations such as these, we continue to monitor the progress of our recommendations. A good example of this is our continued interest in the policing of domestic violence. Since releasing our final report at the end of 2006, we have worked with police and other involved agencies to improve interagency responses to instances of domestic violence.

Reviewing legislation

In addition to examining the way in which policies and procedures are implemented, we also review the operation of certain pieces of legislation.

In April this year, I announced that we would be conducting a comprehensive review of the NSW *Freedom of Information Act 1989*. This important legislation helps to ensure that the public are able to access information held by government, and that decision makers can be held to account for their actions. I do not believe that the FOI Act in NSW is operating as effectively as it should, and I have been calling for an independent review of the Act for some time. As there has been no response from government, we have decided to conduct our own review.

As part of our review of the *Law Enforcement (Powers & Responsibilities) Act 2002*, we conducted a survey of defendants to assess their experiences when searched by police. These first hand accounts are very useful as they provide us with a better understanding of the way in which the legislation is being applied. We have also finalised our review of the emergency powers provided to police in the wake of the Cronulla riots. Our final report was tabled in Parliament in November 2007.

Improving customer service and complaint-handling

While our proactive projects can help ensure that government services are properly implemented, it is also important to monitor the way in which agencies interact with the community. We work with agencies to improve their day-to-day contact with the public by reviewing their complaint-handling systems, conducting mystery shopper audits, and providing training to frontline agency staff.

JGoS investigation

Following an investigation involving a long term public housing tenant, we decided to conduct a broader investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). JGoS is an agreement between the Department of Housing, NSW Health, the Department of Community Services, the Aboriginal Housing Office and the Aboriginal Health and Medical Research Council. As part of our investigation, we have met with over 450 people — including those working directly in the area and acting as advocates for those receiving the services. For more information, see page 31 in 'Our organisation'.

Foster carer project

More than 30% of children and young people living in out-of-home care in NSW are Aboriginal. In the past year, we have conducted a detailed review of the services and support provided to those caring for these children. We travelled throughout the state, speaking with over 100 carers as well as service providers and others working in the area. We found that, although there were services in place, many carers had little contact with them and were often unaware of the support systems that they should be able to access. For more information, see page 49 in Chapter 1: Community engagement.

School suspensions

We have recently completed an investigation into the Department of Education and Training's procedures for school suspensions. We found that the existing procedures provide a strong framework for managing long suspensions, but they were not always fully and correctly implemented. We have made a number of recommendations that have been welcomed by the department. For more information, see page 134 in Chapter 8: Departments and authorities.

FOI review

Our review of the FOI Act involves a number of different elements. We are looking into the FOI practices and procedures of 18 government agencies. This will involve speaking with FOI staff, a random audit of FOI files, and a detailed request for information relating to processing FOI applications. We have also asked for information from councils and the Administrative Decisions Tribunal.

We are collecting as much information as possible about approaches in other jurisdictions, and released a discussion paper for public comment in early September. The information collected through this process, along with our long experience dealing with the FOI Act, will be used to prepare a final report and recommendations to Parliament. For more information about our FOI review, see page 146 in Chapter 10: Freedom of information.

Last year we reported that we had started a review of the complaint-handling systems of 350 NSW government agencies, public authorities and councils. By assessing responses to a detailed questionnaire and documents provided by the agencies involved, we have been able to draw a high level picture of complaint-handling across the state. We have also been able to identify changes over time, as we conducted similar reviews in 1994 and 1999.

Our community services division also completed a smaller, more targeted complaint-handling review of 20 agencies providing family support services. This review identified areas where further education was needed, and we have worked with the Department of Community Services and Families NSW to implement training to provide guidance to workers in this sector.

In 2006, we began work on a framework for managing unreasonable complainant conduct. Although the majority of complainants act reasonably, a small number are unwilling to accept our decision or the decisions they receive from other agencies. These individuals can become aggressive, threaten to harm themselves or others, withhold relevant information or flood us with irrelevant information, make unreasonable demands, or insist on impossible or inappropriate outcomes.

Mystery shopper audits

This year's mystery shopper audit assessed the customer service provided by 30 councils. We called, emailed and wrote to the councils, asking for information that they should be able to provide fairly easily. We have given detailed feedback to all the councils involved, and have received a number of positive responses. For more information about the audit, see page 142 in Chapter 9: Local government.

Unreasonable complainant conduct project

The trial of the interim unreasonable complainant conduct practice manual, which has involved all the Parliamentary Ombudsman offices in Australia, ended in April this year. Over the last 12 months, we have provided training to staff from all of the offices involved — as well as to a number of other government agencies both here and interstate. Several of our facilitators recently travelled to New Zealand to provide training to staff from the New Zealand Ombudsman. The feedback we have received from participants in these training courses has been overwhelmingly positive. We are currently drafting a final report for the project and revising the practice manual. It will be available on our website once it is finalised.

The framework we have developed can help reduce the level of stress experienced by staff and complainants, as well as allow agencies to better manage their time and resources. This means they will be able to deal more equitably with all complainants.

We have worked closely with the New South Wales Police Force to streamline their complaint-handling procedures. This project should simplify the management of less serious complaints, which will allow investigators to allocate greater time and resources to more serious complaints. We have monitored a trial of this new system, and support its broader use in the future.

Providing training

As well as reviewing and auditing their actions, we also offer agencies a number of practical training courses aimed at improving their customer service. Training in areas such as frontline complaint-handling, conflict management, and dealing with unreasonable complainant conduct provides complaint-handling staff with the tools they need to deal with difficult situations. In the last 12 months, we have provided training to NSW and interstate government agencies, as well as staff from other Ombudsman offices.

Our training is not only aimed at agency staff. This year our community education unit held 80 workshops and training sessions for over 1,600 consumers, staff and community service providers. It is vital that members of the public are aware of their rights, as well as the services they are able to access. This 'community contact' is an important part of our work and we plan to expand it next year through an online newsletter.

Working with other oversight agencies

Mr Bill Angrick, President of the IOI thanking Bruce Barbour, for hosting the 2007 annual meeting of the IOI Board.

Contact with other oversight agencies, both here and overseas, allows us to share our experience and learn how we can improve our own practices. We are an active member of the International Ombudsman Institute (IOI), take part in a number of federally funded regional development projects, drive nationwide improvements in Ombudsman practice, and provide information and practical training to staff from state, national and international agencies and organisations.

The IOI is the only truly international grouping of Ombudsman offices. Membership provides us with an opportunity to exchange ideas and experiences with over 150 international Ombudsman, many of whom deal with very different jurisdictions and issues to us. In November 2007, I hosted the annual meeting of the IOI Board. This was a particularly important meeting as it involved discussion of the future direction of the IOI. The Board considered the future location of the IOI head office, the IOI's relationship with other international organisations, and the type of services IOI members wanted and expected from the institute.

In addition to the IOI, we also participate in a number of projects to assist less established international oversight agencies. Along with the Commonwealth and Western Australian Ombudsman, we are involved in a three-year project aimed at developing stronger links between Australian and Indonesian Ombudsman, improving Indonesian Ombudsman practice and procedures, and increasing the Indonesian people's understanding of their rights. This year, staff from the National Ombudsman Commission of Indonesia (NOC) have spent time at our office, several of our staff travelled to Indonesia to provide assistance, and I was invited to Jakarta in August 2007 to take part in a panel discussion on the future of the NOC.

We are also closely involved with Pacific Island Ombudsman offices and work with them through the Australasian and Pacific Ombudsman Region (APOR) of the IOI, as well as the Pacific Island Ombudsman Network. The Assistant Ombudsman and I, along with staff from a number of other Ombudsman offices, have recently taken part in a scoping exercise to identify the best possible oversight model for smaller Pacific nations who currently do not have any form of oversight.

Reviewing the way we operate

We have achieved a great deal in the past year, but it is important that we are always looking for opportunities to further improve the way we work. This year, for example, we have refined our information technology systems and accounting practices to make them as efficient as possible. We are also standardising the terminology used by different parts of our office to streamline our performance management.

Our last annual report outlined the creation and initial work of our cross agency team, or CAT. The inclusion of CAT in the office has successfully driven much of our project work, and following an external evaluation, I decided to establish CAT as a permanent unit within our office.

I hope that this brief summary has demonstrated what a demanding, but productive, year it has been. None of the positive work I have described would have been possible without the high level of professionalism and dedication shown by my staff. I would like to thank all of them for their hard work and look forward to continuing to work to this high standard in the coming years.

Bruce Barbour
Ombudsman

IOI Board members at the 2007 annual meeting.

Snapshot of the year

Responding to complaints and notifications

This year a total of 34,021 complaints and notifications were brought to our attention by a variety of people — including members of the public, families of people who are receiving community services, Members of Parliament and staff who work in the public sector. They brought to our attention a broad range of concerns via 9,320 formal complaints and notifications and 24,701 informal complaints and inquiries.

This year we finalised more formal complaints and notifications than we received (see figure 1).

As we have jurisdiction over a range of agencies and specific functions under a number of pieces of legislation, we categorise matters to ensure that we provide the most appropriate response. Figure 2 shows a breakdown of the complaints and notifications we received this year.

How we handle different types of matters

We divide the complaints we receive into formal and informal matters. This determines the process we use to handle them. Generally, we define formal matters as written complaints and notifications and informal matters as complaints that are made over the telephone or in person.

If a complainant is a vulnerable member of the community and it may be unreasonable to ask them to make a written complaint, we will take their complaint verbally and treat it as a formal complaint. People who may be considered vulnerable include inmates of correctional centres, young people and people with a disability.

Informal matters

We categorise most telephone calls, visits to our office and inquiries made to our staff when they are working out in the field as informal. In these situations, we are usually able to help people by giving them information or an explanation, referring them to another agency or the agency they are inquiring about, or advising them to make a complaint to us in writing.

Formal matters

This year we finalised 9,544 formal matters. These can take anywhere from a few days to several months to finalise. Our response may be a clarifying phone call to the agency concerned or a full-scale investigation.

The main pieces of legislation that govern this aspect of our work are the *Ombudsman Act 1974* and the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. Although we have coercive powers to require agencies to provide us with documents or answer our questions, we generally try to resolve complaints without using them. Most agencies that we contact are cooperative and understand that resolving a person's dissatisfaction with their organisation is usually beneficial to the agency as well.

If we do use our coercive powers, we classify the complaint as being 'formally investigated'. The actions that we take to finalise complaints include:

- resolving a complaint by persuading the agency concerned to take some action
- resolving a complaint by undertaking a formal investigation and making findings and recommendations — this year we finalised 47 matters this way (see figure 3)
- providing detailed information or advice to the complainant
- making inquiries and finding no wrong conduct.

Figure 1 — Formal complaints and notifications received and finalised by our office — five year comparison

Year	03/04	04/05	05/06	06/07	07/08
Received	9,167	10,714	10,304	9,692	9,320
Finalised	9,159	10,866	10,096	9,576	9,544

Figure 2 — Complaints and notifications we received in 2007–2008 — by subject area

Subject area	Formal	Informal	Total
Departments and authorities*	1,348	3,962	5,310
Local government	768	1,965	2,733
Correctional centres and Justice Health	840	3,143	3,983
Juvenile justice	99	243	342
FOI	225	422	647
Child and family services	501	922	1,423
Disability services	218	216	434
Other community services**	48	238	286
Employment-related child protection***	1,920	695	2,615
Police	2,969	2,994	5,963
Outside our jurisdiction*	384	6,396	6,780
Requests for information	0	3,505	3,505
Total	**9,320**	**24,701**	**34,021**

* We sometimes receive written complaints about public sector agencies that are within our jurisdiction but the conduct complained about, on assessment, is found to be outside our jurisdiction. We initially classify these as 'formal' complaints received about public sector agencies. Written complaints received about agencies outside our jurisdiction, and oral complaints about both agencies and issues outside our jurisdiction, are dealt with informally by referring the complainant elsewhere. They are classified as 'outside our jurisdiction' from the outset.

** This includes complaints about DoCS, DADHC and non-government agencies that are funded by one of those departments.

*** This includes notifications and complaints received.

Figure 3 — Number of formal investigations finalised — five year comparison

Year	03/04	04/05	05/06	06/07	07/08
Total	**42**	**67**	**66**	**63**	**47**

Figure 4 — Formal complaints and notifications finalised — by subject group — two year comparison

Subject	06/07	07/08
Departments and authorities	1,167	1,354
Local government	837	788
Corrections and Justice Health	662	918
Juvenile justice	47	11
FOI	205	197
Community services*	569	737
Employment-related child protection	1,749	1,921
Police	3,555	3,254
Agency outside our jurisdiction	392	364
Total	**9,183**	**9,544**

* This figure includes formal matters finalised in relation to child and family services, disability services and community services.

Reviews of our decisions

When we finalise a complaint that we have been dealing with directly, we write to the complainant and give reasons for our decision. If they are not happy with the decision and ask us to reconsider we:

- explain our decision-making process in more detail — including the evidence and factors we took into account in making the decision
- respond to any requests for a further review of our decision by having a senior officer — who was not involved with the original decision — review the file and provide advice to the Ombudsman.

The Ombudsman will then consider the matter and write to the complainant explaining the outcome.

Figure 5 shows that, compared with the number of formal complaints we finalised during the year, the percentage of cases where we were asked to review our decision was very low. Figure 6 shows that in 91% of cases the Ombudsman considered that the original decision made by the delegated officer was correct.

Performance indicator

Requests for a review of our decision as a percentage of complaints finalised

Division	Target	06/07	07/08
Child protection	<6.0%	2 (2.5%)	5 (7.1%)
Community services	<6.0%	8 (1.4%)	3 (5.8%)
General	<6.0%	197 (5.9%)	211 (5.8%)
Police	<1.8%	61 (1.7%)	55 (1.5%)

Figure 5 — Requests for a review of our decision as a percentage of formal complaints finalised

Subject	No. of requests	No. of formal complaints finalised	06/07 %	07/08 %
Employment-related child protection*	5	70	2.5%	7.1%
Community services***	3	737	1.4%	0.4%
Corrections/juvenile justice / Justice Health	14	929	3.0%	1.5%
Freedom of information	6	197	3.4%	3.0%
Local government	93	788	10.2%	11.8%
Other public sector agencies	88	1,354	7.0%	6.5%
Police**	55	3,254	1.7%	1.7%
Outside our jurisdiction	3	364	1.0%	0.8%
Total	**267**	**7,693**	**3.6%**	**3.5%**

* The majority of our work in the child protection area is overseeing how certain agencies handle allegations of conduct by employees that could be abusive to children. Only a small part of our work is handling complaints made directly to our office about how those allegations have been handled. We deal with those complaints in much the same way as with complaints about NSW public sector agencies — we may decide to decline the complaint, make preliminary inquiries or investigate. This table shows that, of the 70 complaints made directly to our office, five complainants asked us to review the decision we made on how to handle the complaint.

** Although the system of handling complaints about police requires the NSW Police Force to directly investigate each complaint, and our office plays an oversight role, the police division considers all requests to review the way a complaint about a police officer was handled as request to review our decision in relation to the NSW Police Force outcome. This table shows that, of the 3,254 complaints about police officers that we oversighted this year, 55 complainants asked for the outcome to be reviewed.

*** This figure includes requests for a review of our decision in relation to child and family services, disability services and community services.

Figure 6 — Outcomes of reviews conducted

Area	Original outcome affirmed: After reviewing the file only	Original outcome affirmed: After further telephone inquiries	Resolved	Reopened	Total
Employment-related child protection	2	3	0	0	5
Community services	2	1	0	0	3
Corrections	13	1	0	3	17
Freedom of information	4	1	2	0	7
Local government	50	35	1	5	91
Other public sector agencies	56	30	1	6	93
Outside our jurisdiction	2	1	0	0	3
Police	58	0	6	0	64
Total	**187**	**72**	**10**	**14**	**283**
% of total (07/08)	66%	25%	4%	5%	100%
% of total (06/07)	70%	21%	3%	6%	100%
% of total (05/06)	70%	25%	2%	3%	100%

Compliments and complaints

Compliments and complaints help us to identify the aspects of our work that we do well, the areas of our service that need improvement, and expectations that exceed what we can reasonably deliver. We have an internal compliments and complaints policy, and we inform people who use our services about how to make a complaint about us. This year we received 211 compliments by letter, fax, email or phone about the quality of our advice, the assistance we gave to customers, and the information provided to agencies within our jurisdiction.

Against the 32,245 formal and informal complaints and notifications we finalised this year, we received 27 complaints about our work (see figure 7).

If a complaint is justified, we will generally take some form of action to resolve it. During 2007–2008, our responses to 10 complaints included apologising, providing explanations, and giving greater priority to identified files (see figure 8).

Other work of the Ombudsman

In addition to handling complaints and notifications, we undertake systemic and proactive work such as conducting audits and review work, including child death and disability death reviews, legislative reviews and visits to the community to better inform our work. Figure 9 outlines the type of work we have undertaken in this area in 2007–2008. This work is also detailed in other chapters of this report.

Figure 7 — Complaints about our office

Issue	Total
Bias/unfair treatment/tone	6
Confidentiality/privacy-related	1
Delays	5
Denial of natural justice	1
Failure to deal appropriately with complaint	11
Lack of feedback/response	5
Limits to jurisdiction	0
Faulty procedures	2
Inaccurate information/wrong decision	2
Poor customer service	5
Corruption/conflict of interest	2
Other	3
Total issues	**43**
Total complaints	27
% of all matters finalised (formal and informal)	**0.1%**

Figure 8 — Outcomes of complaints about our office

Outcome	Total
Unjustified	13
Justified or partly justified	4
Some substance and resolved by remedial action	10
Total	**27**

Figure 9 — Outline of other work of the Ombudsman

Category	Type of work	07/08
Audits	Number of police records audited	8,800
	Number of child protection audits conducted	16
	Controlled operation records audited	364
	Witness protection appeals and complaints	3
Police powers under review	Number of legislative reviews conducted conferring new police powers	6
Visits	Number of hours spent on visiting services (Official community visitor program)	9,193
	Number of visits to residential services (Official community visitor program)	3,289
	Correctional and juvenile justice centre visits	45
	Visits to regional and remote communities	68
Reviews*	Complaint-handling systems	370
	Number of individual reviews (section 13) of the circumstances of children and other persons in care	50
	Reviews (section 11(c)) of the delivery of community services	1

* The number of reviewable deaths are recorded by calendar year. In 2007, the deaths of 98 people with a disability in care and 169 children were reviewable.

Our organisation

The NSW Ombudsman is an independent and impartial watchdog established by the *Ombudsman Act 1974*. We are independent of the government of the day and accountable to the public through Parliament itself. Our central goal is to keep government agencies and some non-government organisations accountable — by promoting good administrative conduct, fair decision-making and high standards of service delivery — and protect the rights of people in NSW. We are responsible for keeping the following types of organisations under scrutiny:

- Agencies delivering public services — including police, correctional centres and state-owned corporations.
- Organisations delivering services to children — including schools and child care centres.
- Organisations delivering community services — including services for people with a disability, people who are homeless and elderly people.
- Agencies conducting covert operations — including the Crime Commission and the Independent Commission Against Corruption.

We have other specific functions that relate to:

- the causes and patterns of deaths of certain children and people with a disability
- decisions made by public sector agencies about freedom of information applications
- the administration of the witness protection program
- the implementation of new pieces of legislation conferring additional powers on people such as police and correctional officers.

We investigate and resolve complaints from members of the public and from people who work for the organisations we scrutinise. Our work is aimed at exposing and eliminating conduct that is illegal, unreasonable, unjust or oppressive, improperly discriminatory, based on improper or irrelevant grounds, based on a mistake of law or fact, or otherwise wrong.

We aim for outcomes that are in the public interest. We investigate some of the more serious complaints, but in many cases we encourage the organisation being complained about to handle the matter themselves. We monitor the progress of these matters and provide advice where necessary. Our focus is on helping organisations to satisfactorily resolve any problems identified.

We help organisations to prevent or reduce the level of complaints made about them by reviewing their systems. Our proactive work also allows us to address problems if members of the public have legitimate grievances but, for whatever reason, do not or cannot take up the complaint themselves. We aim to reduce the volume of complaints to our office by providing training and advice to the organisations we scrutinise about how to effectively resolve and manage complaints. We also provide assistance, guidance and training to other watchdog agencies.

Our office is divided into four specialist divisions — police, general, child protection and community services — and two teams that support these divisions, our corporate and cross agency teams.

The police division is responsible for work relating to the NSW Police Force and for reviewing certain legislation giving powers to police officers. The general division is responsible for performing our other legislative functions — including reviewing legislative compliance and handling inquiries and complaints about a wide range of public sector agencies. The child protection division handles notifications from organisations providing services to children about conduct of their staff that could be abusive to children. The community services division is responsible for work relating to the delivery of services by the Department of Community Services and the Department of Ageing, Disability and Home Care, as well as non-government organisations providing community services.

Our corporate team manages our personnel, financial services, public relations and publications, information and records management, library services and information technology. They provide support for the core activities of our office. The role of the cross agency team is to strengthen communication and collaboration between our specialist areas and strategically target systemic issues involving one or more of our jurisdictions. This team includes our Aboriginal Unit and youth liaison officer.

How we keep organisations accountable

Agencies delivering public services

Who we scrutinise

We scrutinise:

- several hundred NSW public sector agencies including departments, statutory authorities, boards, correctional centres, universities and area health services
- the police
- over 160 local and county councils
- certain private sector organisations and individuals providing privatised public services.

How we keep them accountable

We investigate and resolve:

- complaints about the work of public sector agencies
- complaints about the merits of agency decisions about freedom of information requests
- protected disclosures from public sector staff and complaints about the way agencies have handled disclosures.

We oversee the NSW Police Force's investigations into complaints about police officers and check their complaint-handling systems.

We visit juvenile justice centres and correctional centres to observe their operations and resolve concerns of inmates.

We scrutinise legislation giving new powers to police and correctional officers.

We hear appeals against decisions by the Commissioner of Police in relation to the witness protection program.

We provide training and guidance in investigations, complaint management and good administrative conduct.

Senior Executive Team (left to right): Julianna Demetrius, Manager (Cross Agency Team); Anita Whittaker, Manager (Corporate Team); Steve Kinmond, Deputy Ombudsman and Community and Disability Services Commissioner; Greg Andrews, Assistant Ombudsman Police; Bruce Barbour, Ombudsman; Anne Barwick, Assistant Ombudsman Children and young people; Chris Wheeler, Deputy Ombudsman.

Organisations delivering services to children

Who we scrutinise

We scrutinise:

- over 7,000 organisations providing services to children — including schools, child care centres, family day care, juvenile justice centres and organisations providing substitute residential care and health programs
- the conduct of paid staff, contractors and thousands of volunteers working for these organisations.

Child Protection Division Manager: Natasha Mewing.

How we keep them accountable

Organisations are required to notify us of any reportable allegations about, or convictions for, conduct that could be abusive to children. We oversee (and sometimes investigate) how organisations investigate these allegations about their staff, and keep under scrutiny their systems for handling such matters.

We deal with complaints from parents and other interested parties about how organisations have investigated allegations.

We keep under scrutiny the systems organisations have to prevent employees from behaving in ways that could be abusive to children.

We provide training and guidance about how to handle these kinds of allegations and convictions.

Community Services Division Managers (left to right): Gary Dawson, Michele Powell, Monica Wolf.

Organisations delivering community services

Who we scrutinise

We scrutinise:

- licensed boarding houses and fee-for-service organisations
- child protection and family support services
- out-of-home care services for children and young people
- home and community care services
- services for people with a disability
- supported accommodation and assistance program services.

The Department of Community Services and the Department of Ageing, Disability and Home Care provide many of these services. Non-government organisations providing these services also fall within our jurisdiction if they are funded, licensed or authorised by the Minister for Community Services or the Minister for Ageing and Disability Services.

How we keep them accountable

We investigate and resolve complaints about the provision, failure to provide, withdrawal, variation or administration of community services.

We review:

- standards for the delivery of community services
- the systems organisations have to handle complaints about their services
- the situation of children, young people and people with a disability who are in out-of-home care
- the deaths of certain children, young people and people with a disability in care.

We inspect certain services where children, young people and people with a disability live.

We coordinate the official community visitors scheme.

We provide information and training to consumers of community services and to organisations about complaint-handling and consumer rights.

We promote improvements to community service systems and access to advocacy support for people who are receiving, or are eligible to receive, community services.

General Division Managers (left to right): Anne Radford, Jennifer Agius, Helen Ford.

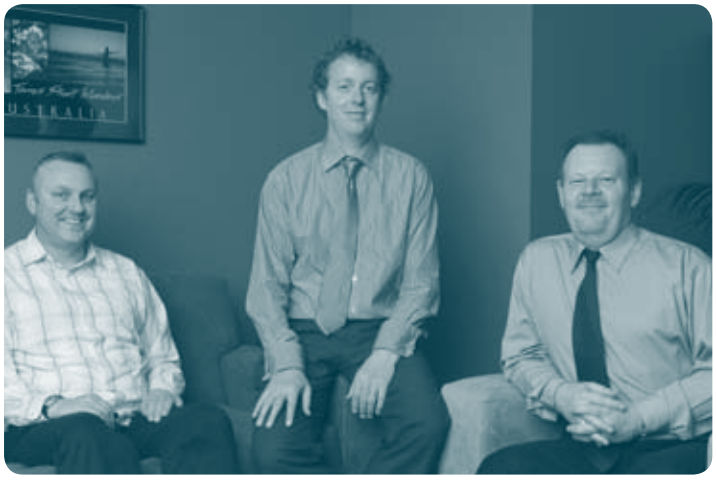
Agencies conducting covert operations

Who we scrutinise

We scrutinise law enforcement agencies such as the NSW Police Force, the Crime Commission, the Independent Commission Against Corruption and the Police Integrity Commission.

How we keep them accountable

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



Police Division Managers (left to right): Vincent Riordan, Michael Gleeson, Peter Burford.

Corporate governance

We aim to be an effective organisation. One way to achieve this is by developing, implementing and maintaining a robust system of corporate governance. This also provides assurance to the Parliament, government and the public that we are using our resources appropriately and achieving our stated outcomes.

We pride ourselves on the quality of our work and the standard of our service. Our governance framework brings together policies, systems and processes that promote accountability, transparency and ethical practices. As an independent and impartial oversight agency, we are responsible for ensuring that the organisations within our jurisdiction fulfil their functions properly.

We do our best to make sure we 'practice what we preach' and work to the same standards of good administration that we promote.

Our corporate plan

Our vision is to see fair, accountable and responsive administrative practice and service delivery in NSW. We work to promote good conduct, fair decision-making, the protection of rights and the provision of quality services. Our corporate plan sets out the direction for what we do and outlines the goals and strategies that will support our vision. It consists of a statement of corporate purpose and strategic plans for each of our divisions.

The statement groups our work under four purposes. The first and second relate to our core work, the third is about working with similar agencies to promote professional work practices and improve our service, and the fourth deals with our office as an effective organisation. Each division develops their own business plan to align their activities with our overall strategic direction. These plans guide the day-to-day work of our staff.

Accountability

The Ombudsman is answerable to Parliament through the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission (the PJC). This ensures we are accountable to Parliament rather than the government of the day and is crucial to our independence.

In March 2008, the Ombudsman and other senior staff appeared before the PJC at our 14th general meeting to answer a range of questions about our work. We also sent a detailed submission to the PJC about their statutory review of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. For more details about this review, see 'Our year in review'.

We are also accountable to the public in much the same way as any other NSW public sector agency. We come under the scrutiny of agencies such as the Auditor-General, the Independent Commission Against Corruption, the Privacy Commissioner, the Anti-Discrimination Board, State Records and NSW Treasury. We are required to provide an annual report for our office, as well as a number of other annual reports on specialised areas of our work such as reviewable deaths. These provide Parliament and the community with information about what we have achieved during the year.

We provide each complainant with reasons for our decisions when resolving or discontinuing complaints. If a complainant believes our decision is wrong, they can ask for their case to be reviewed.

Statement of responsibility

The Ombudsman, senior management and other staff have put in place an internal and external control process designed to provide reasonable assurance about the achievement of the office's objectives. The Ombudsman, two Deputy Ombudsman, each Assistant Ombudsman and the managers of the respective corporate and cross agency teams assess these controls.

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

Bruce Barbour
Ombudsman

Our guarantee of service

We will:

- consider each matter promptly and fairly, and provide clear reasons for our decisions
- where we are unable to deal with a matter ourselves, explain why, and identify any other appropriate organisation where we can
- help those people who need assistance to make a complaint to the Ombudsman
- add value through our work.

Our vision

We want to see fair, accountable and responsive administrative practice and service delivery in NSW.

Our mission

In our own organisation and those we oversight, we work to promote:

- good conduct
- fair decision-making
- protection of rights
- provision of quality services.

Our values

We will:

- provide the same high quality service that we encourage other organisations to offer
- be fair, impartial and independent, and act with integrity and consistency
- be accessible and responsive to all who approach us, and seek solutions and improvements that will benefit the broader NSW community
- be a catalyst for change and a promoter of individuals' rights.

Our purpose

We aim to:

1. help organisations meet their obligations and responsibilities and promote and assist the improvement of their service delivery
2. deal effectively and fairly with complaints and work with organisations to improve their complaint-handling systems
3. be a leading watchdog agency
4. be an effective organisation.

Performance statement

To retain the independence of the Ombudsman, the position is not responsible to an individual minister. Instead the Ombudsman appears before the PJC to answer questions about the performance of our office. Our performance statement is a summary of our achievements against the purposes outlined in our corporate plan.

Performance statement

Purpose 1

Help organisations meet their obligations and responsibilities and promote and assist the improvement of their service delivery

Goals

- Review and report on the service, systems and conduct of agencies.
- Monitor and report on compliance with legislative obligations and responsibilities.
- Make recommendations and suggestions for agency improvements and/or for improving the circumstances of individuals.
- Promote best practice standards for agency service delivery and good conduct.
- Provide training in delivery of service, good conduct and the rights of consumers to quality services.

Performance 2007–2008

- Conducted mystery shopper audits of 30 councils in NSW to assess their customer service standards and received positive feedback from the councils audited, many of whom have made improvements to their systems and processes.
- Completed 47 investigations that assisted agencies to improve their delivery of services and complaint-handling practices in areas such as policing, local government, corrections and systems for the care and protection of children and people with a disability.
- Started an independent and comprehensive review of the implementation of the *Freedom of Information Act 1989* (FOI Act) by 18 agencies, and released a public discussion paper to provide all interested parties with an opportunity to contribute to the review.
- Clarified the use of clause 13(a) of the FOI Act to exempt documents such as employment contracts, from being released due to a breach of confidence.
- Completed an investigation into the implementation of the Department of Education and Training's policy and procedures for long suspensions, and made recommendations across four key areas.
- Completed a review of the supports provided to carers of Aboriginal children and examined the health, educational and cultural needs of Aboriginal children in care and identified critical data deficiencies.
- Prepared a report that was tabled in Parliament on the use of emergency powers to prevent or control disorder, enacted in response to mob violence at Cronulla.

- Finalised the report on our review of the implementation of the *Police Powers (Drug Detection Trial) Act 2003* and delivered it to the responsible ministers.
- Conducted a major survey of defendants in local courts to assess the experiences of victims of police searches conducted under the *Law Enforcement (Powers & Responsibilities) Act 2002.*
- Monitored the NSW Police Force's implementation of the recommendations from our 2006 report *Domestic Violence: improving police practice*, and found significant progress had been made.
- Worked cooperatively with the NSW Sentencing Council on their research into the effectiveness of fines as a sentencing option, particularly for vulnerable people.
- Made ten detailed submissions to the Wood Special Commission of Inquiry into Child Protection Services in NSW, outlining our views on topics such as assessment practices, privacy, interagency cooperation and children in out-of-home care.
- Tabled our reports on reviewable disability and child deaths in Parliament, including 16 recommendations for systemic and procedural change.
- Completed our review of the circumstances of 50 children and young people under five in out-of-home care and started a review of 36 children aged between 10 and 14.
- Prepared a detailed submission to the Parliamentary Joint Committee's review of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, and received strong support for our work. Additional funding for the official community visitors program was recommended.
- Started a major investigation into the implementation of the Joint Guarantee of Service (JGoS) for people with mental health problems and disorders living in Aboriginal, community and public housing, and conducted consultations with 450 stakeholders in 25 locations across the state.
- Ran 80 workshops and training sessions for over 1,600 consumers, staff and providers of community services and conducted 161 presentations for more than 4,000 staff of agencies within our jurisdiction, community service workers and community groups to increase awareness of our role and good complaint-handling practices.
- Presented over 40 education and awareness briefings or forums on child protection to 100 agencies, reaching more than 1,000 people.

Future plans

- Finalise our investigation into the implementation of the JGoS.
- Complete our review of the circumstances of 36 children aged between 10 and 14 in out-of-home care.
- Finalise our reviews into the adequacy of DADHC's actions to identify and meet the needs and goals of 60 people living in nine large residential centres and the complaint-handling practices of agencies providing services under the DADHC funded community participation program.
- Prepare final reports for our review of the implementation of the *Law Enforcement (Powers & Responsibilities) Act 2002* and the impact of the criminal infringement notices scheme on Aboriginal and Torres Strait Islander communities.
- Conduct mystery shopper audits of selected agencies to assess their customer service standards and complaint-handling systems.
- Report to Parliament on our review of the *Freedom of Information Act 1989*.
- Prepare final report for our review of the *Terrorism (Police Powers) Act 2002.*

Performance statement

Purpose 2

Deal effectively and fairly with complaints and work with organisations to improve their complaint-handling systems

Goals

- Implement and promote best practice investigation and complaint-handling methodologies within our office.
- Use client feedback to improve our work.
- Implement and promote best practice investigation and complaint-handling methodologies in agencies we oversight.
- Help achieve redress for justified complaints.
- Identify systemic causes of complaints and propose solutions.

Performance 2007–2008

- We participated in the Senior Officers Working Group on State Plan Priority S8: Customer Satisfaction. This group recommended strategies for improving customer satisfaction within the public sector.
- In November 2007 the Premier issued a memorandum to all agencies promoting our *Complaint-Handling Guidelines* as the standard to be used when reviewing and improving their complaint-handling systems as required by the State Plan's customer service priority.
- We provided advice and support to agencies for implementing State Plan strategies, particularly those relating to complaint-handling and customer service. We made our guidelines and other information available to agencies through our website.
- Achieved 367 positive outcomes for complainants in relation to 442 complaints we investigated involving councils, including Wollongong City Council properly investigating allegations of illegal work and setting up a regulation and enforcement division, and several councils apologising for delays or not responding to customer correspondence.
- Supported 36 official community visitors making 3,289 visits to 6,578 people living in residential services across the state, and assisted them to finalise 63% of the 3,634 issues identified this year.
- Held a complaint-handling forum for all NSW universities to discuss the implementation of our guidelines on complaint-handling in universities. A number of universities have now implemented these guidelines.
- Conducted a survey of complaint-handling systems across all NSW government departments and authorities, and analysed similarities and differences between different size agencies.
- Promoted the implementation of the recommendations of the 2006 Parliamentary review of the *Protected Disclosures Act 1994*.

- Consulted with stakeholders and worked with various child protection specialists to complete a thorough review of our guidelines for preventing and responding to reportable allegations, and incorporated updated information on areas such as interviewing children, conduct causing psychological harm and grooming behaviour.
- Conducted 15 investigations into child protection issues, highlighting the critical importance of effective liaison and communication and identifying concerns about the adequacy of responses to chronic neglect of children. A number of our investigations also examined the adequacy of certain organisations' policies and procedures to deal with allegations of reportable conduct involving their employees.
- Assisted agencies with complex child protection issues such as preserving evidence and investigating historical allegations.
- Cut red tape in police complaint-handling by introducing electronic delivery of complaint notifications and final investigation reports.
- Evaluated the streamlined complaint-handling trial in 13 NSW Police Force commands and supported its general roll out to all commands, simplifying the management of less serious complaints.
- Prompted the Department of Corrective Services to review their compassionate leave policy and procedures to include the involvement of the Aboriginal Planning and Support Unit and allow for the approval of compassionate leave at a regional level.
- Made suggestions about appropriate timeframes for responding to inmate applications for classification reviews, and had these suggestions accepted and implemented by the Commissioner of Corrective Services.
- Worked with Justice Health to address issues such as behaviour management and poor access to dental services.
- Worked with agencies on a range of FOI issues including advance deposits, applications for electronic documents, and the need for good communication with applicants.
- Intervened in a journalist's unsuccessful FOI application to eight area health services in NSW and The Children's Hospital for access to clinical indicator reports, which resulted in NSW Health directing all the reports to be released in the public interest.
- Resolved a range of complaints about disability accommodation and support services and facilitated outcomes such as new premises, an increase in staff training, and improved communication and complaint-handling.
- Travelled to 68 regional towns and communities throughout NSW to audit agency systems, provide training, visit correctional and juvenile justice centres, and examine the quality of the services provided to Aboriginal communities.
- Identified 328 police investigations where there were defects in the investigation or proposed management outcomes, and provided advice that led to over three quarters of the identified deficiencies being remedied by the NSW Police Force.

Future plans

- Work with the NSW Police Force to ensure streamlined complaint-handling procedures are used effectively.
- Undertake a systemic review of the child protection policies of public authorities, including a focus on complaint-handling systems.
- Enter into or extend class or kind determinations with agencies that have demonstrated good practice in responding to reportable allegations about employees in relation to child protection.
- Host a second forum for NSW universities to discuss complaint-handling in universities.

Performance statement

Purpose 3

Be a leading watchdog agency

Goals

- Create positive relationships and work collaboratively with other Ombudsman and watchdog agencies.
- Promote professional work practices with other Ombudsman and watchdog agencies.
- Continuously improve our work practices.

Performance 2007–2008

- Developed *Guidelines for Dealing with Youth Complaints* to assist other state and national organisations to make their complaint practices more accessible to young people, and received positive feedback from all sectors about the value of these guidelines.
- Developed a framework of management strategies to deal with unreasonable conduct by complainants, and delivered a two-stage training program to staff in all Parliamentary Ombudsman offices in Australia and staff in government agencies in six states.
- Participated in a three-year AusAID project to support the National Ombudsman Commission of Indonesia and provided technical consultancy services to the Indonesian Australian Ombudsman Linkages and Strengthening Project, funded by the Commonwealth Government Partnership Fund.
- Worked with the Commonwealth Ombudsman to scope the Regional Ombudsman Initiative for the Pacific Plan and identify the best possible oversight model for smaller Pacific nations who currently do not have any form of oversight.
- Continued our four year involvement in the Whistling While They Work project, with our Deputy Ombudsman co-authoring two chapters in the project's final report — *Whistling While They Work: Enhancing the theory and practice of internal witness management in public sector organisations*.
- Provided advice to agencies in a guideline called *Reporting of Progress and Results of Investigations*, outlining what information can be given to interested parties about the progress and results of investigations into complaints or protected disclosures.
- Conducted eight *Better management of protected disclosures* workshops with the ICAC, with over 90% of the 160 nominated disclosure officers who attended providing feedback that the workshops were very useful and relevant to their work.

- Chaired the awards committee for the Corruption Prevention Network Conference and attended regular meetings as a charter member of the multi-agency network.
- Participated in the working group on the implementation of the *Surveillance Devices Act 2007* to develop compliance tools in relation to the Act.
- Participated in a steering committee to establish the International Network for the Independent Oversight of Police.
- Developed a series of project management templates to improve consistency, efficiency and accountability in our project work.
- Accepted complaints by young people under the age of 18 as oral complaints — instead of asking them to put their complaints in writing — to help make our office more accessible to young people.
- Produced information about the work we do in 10 additional community languages — including some spoken by new and emerging communities — to ensure information about our office is accessible to cultural and linguistically diverse communities.
- Implemented a watching brief system about a range of significant issues such as homelessness, emerging communities, social housing and youth-at-risk to help us improve our understanding of whole-of-government initiatives across these areas.
- We received international recognition for our work on apologies and dealing with unreasonable complainant conduct. The Deputy Ombudsman was invited to address the United States Ombudsman's Association (USOA) conference in Alaska in September 2007, outlining our work on apologies. We conducted a number of workshops for the USOA on how to better manage unreasonable complainant conduct. We also addressed Ombudsman staff in New Zealand on our work in these areas.
- We hosted the annual board meeting of the International Ombudsman Institute (IOI) in November 2007 and played an active role in discussions about the future direction of the IOI.

Future plans

- Evaluate the unreasonable complainant conduct project trial, issue the final project report and update and publish the final version of the Interim Practice Manual.
- Revise our *Protected Disclosure Guidelines.*
- Host and help to organise the 7th National Investigations Symposium for public sector staff who want to maintain and increase their investigative knowledge, skills and techniques.
- Supported the Corruption Prevention Network Conference in September 2008.
- Host a child protection symposium in May 2009. The symposium will coincide with the planned release of our report to Parliament on the last ten years of our oversight in the employee-related child protection area.
- The Deputy Ombudsman will conduct three workshops on dealing with difficult complainants with staff from Ombudsman offices in Canada.
- Use information gathered during our unreasonable complainant conduct project to develop a risk assessment tool to assist in evaluating risks to the safety of frontline staff.
- Revise our *Apologies Guidelines*.
- Continue our support of the National Ombudsman Commission of Indonesia, providing technical advice and mentoring to staff.

Performance statement

Purpose 4

Be an effective organisation

Goals

- Have appropriate structures, policies and systems to support and enhance our service delivery.
- Attract, develop, support and encourage skilled and committed staff.
- Capture, use and share information and knowledge to support and enhance our service delivery.
- Be an effective public sector agency that complies with applicable laws and policies and is accountable and transparent for our actions and decisions.

Performance 2007–2008

- Formally established the cross agency team within our office to better respond to emerging whole-of-government, multi-agency and 'across-office' issues.
- Allocated primary responsibility for audits, training and project work to one unit within our child protection division, resulting in an increased capacity and more streamlined approach to conducting agency audits and training.
- Continued a multifaceted office-wide training program that included coordinated induction sessions, skills for supervisors, job specific training and in-house workshops delivered by external training providers.
- Developed and implemented a comprehensive Aboriginal cultural appreciation training package for all Ombudsman staff to gain a better understanding of Aboriginal culture and improve their work practices with Aboriginal complainants.
- Developed disability awareness training for our staff, focusing on attitudinal and practical issues facing people with a disability and improving our work practices when dealing with people with a disability. So far, four sessions have been delivered.
- Organised for external providers to present cultural awareness training sessions for our staff and deliver specific sessions on our complaint-handling functions and other core business activities.
- Updated the complaint-handling procedures for our community services division.
- Reviewed the current materials for our office-wide investigation training course to ensure they include current and significant issues to improve the work practices of our investigation officers.
- Provided staff with opportunities to participate in training and cross agency projects to improve their knowledge and experience of community issues and how we conduct stakeholder consultations.
- Developed a new module in our complaint case management system to enable better tracking of compliance with recommendations made in major reports.

- Created consistency in recording and reporting across the office by transferring the recording and reporting of community services complaints to our office-wide complaints database.
- Integrated intelligence information into our case management system.
- Used the information security management system model to identify all the functions we perform, the potential risk factors and the controls we should put in place to mitigate each risk, and improved our security policy to help us to better manage potential risk.
- Continued our work on developing a data classification system to better record and report on disability and out-of-home care issues identified by OCVs.
- Enhanced Resolve, our case management system, to enable more timely data capture of initial receipt and assessment information of police complaints, better tracking and timelier processing.
- Redesigned and upgraded our general division's intranet page which allows staff to access information and contact details about agencies in our jurisdiction.
- Upgraded Microsoft office products and our accounting system.
- Reviewed our performance indicators to have a consistent way of measuring our work across all business units, and started to plan new indicators for implementation in 2008–2009.
- Reviewed our complaints & compliments and review policy.
- Reviewed the terminology used throughout our office to ensure consistency across all our business areas.
- Reviewed and updated several policies — including our code of conduct and policies on occupational health and safety, performance management, delegations to special officers, and our use of office cars and access controls.
- Developed a ten year asset strategy.
- Received an unqualified audit report.
- Received a bronze award for our 2006–2007 annual report.

Future plans

- Review our statement of corporate purpose and related business plans for 2008–2010.
- Conduct a review of our publications procedures — including establishing more environmentally-friendly printing processes.
- Completing our 'computer-server virtualisation' project which aims to significantly reduce the number of servers being used.
- Upgrading our electronic document management system and delivering associated training to staff.
- Redesigning our website to ensure consistency with the NSW web directive and accessibility standards.
- Enhancing our personnel database to make it easier for staff to access and update information.
- Finalise our review of the recording and measurement of outcomes and performance indicators across the different divisions and teams in our office.
- Provide training for all our staff in Aboriginal cultural appreciation and disability awareness.

Monitoring our performance

Tracking performance

Developing appropriate measures to assess the impact and effectiveness of our work is crucial, especially with the wide range of jurisdictions and functions we cover. We have developed performance indicators to help us measure efficiency at corporate, team and individual staff levels.

We track our performance in relation to individual complaint, investigation and review files as well as our systems and structures for completing work. In particular, we look at the timeliness and quality of our decision-making. We set performance benchmarks for file turnaround times and monitor our workflow to identify where there may be backlogs, delays or inefficiencies. We also conduct regular internal audits on complaints that have been open for more than six months.

We continually review our work and use the results to improve our performance evaluation systems. Last year we reviewed our performance indicators to improve the consistency of how we record and report on performance across all our divisions. As a result, we introduced changes in July 2008 to enable us to better capture the value that we add to the provision of government services. This has included standardising our procedures, actions and outcomes for consistency and better reporting of outcomes achieved.

Managing risk

Our statutory officers are responsible for identifying and measuring risk and developing mitigation strategies for our core business-related activities. The Ombudsman and senior staff meet weekly to review the progress of work, exchange information and discuss any issues of concern. Using an information security management system model, we identify all the functions we perform, the potential risk factors, and what controls should be put in place to mitigate each risk. These controls might include appropriate plans, procedures, processes, policies, guidelines, standards, record-keeping requirements, reporting of incidents/errors, supervision or training for staff.

We achieve results in our core work through our ability to persuade organisations to adopt the recommendations we make to them about individual matters, as well as to draw generally on the principles we advocate. This ability depends on our reputation as a credible organisation. It is this credibility that constitutes the Ombudsman's primary asset, and the things most likely to damage it are our key risks. These are:

- Unauthorised disclosure of information

  Our work is subject to the secrecy provisions of the Ombudsman Act and the other legislation under which we operate. We understand that the inappropriate or unauthorised disclosure of information can have a detrimental impact on an individual, organisation or minister. It can also negatively impact on the credibility of our office and reduce our effectiveness.

- Damage to the credibility of our work or to our reputation

  We rely on our reputation for maintaining high standards in administrative conduct and focusing on practical outcomes as it helps ensure that agencies accept our advice and implement our recommendations. We continually monitor our performance to ensure our work is of a high standard. We develop relationships with agencies to make sure we understand the environment in which they operate. This helps us to provide practical solutions to the issues we identify.

- Increasing complaint levels

  To address the increasing volume of complaints to our office, our focus continues to be on addressing systemic issues. We have also negotiated 'class or kind' agreements with a number of agencies to reduce the number of matters they have to notify to us, developed training courses to help agencies improve their complaint-handling performance, and published guidelines on topics such as good public administration and giving apologies.

We also have programs to manage risk in areas such as occupational health and safety, business continuity planning, accounting, leave management and payroll. We are subject to independent reviews of some of our risk management practices. For example, our accounting, personnel and payroll activities and our information security program are audited annually.

Security accreditation

We have procedures in place to manage the physical security of our staff and our office, the security of the confidential information we hold, and the integrity of our information technology systems.

We handle an enormous amount of information about individuals and organisations within our jurisdiction — much of which is sensitive or confidential — so it is essential that we effectively manage any risks to our information security systems. After a review of our information security policy in early 2008, we identified six main information security risks. They are:

- unauthorised disclosure of information held by our office
- unauthorised access to information in agency databases to which we have access
- significantly inaccurate or incomplete information used in reports, correspondence or as the basis for findings, recommendations, suggestions or decisions
- inadequate documentation or unintended destruction of business information and/or corporate knowledge
- software and hardware problems resulting in major operating systems being out of action for significant periods
- an inability to comply with statutory obligations.

International Information Security Standard

After being accredited to the Australian Standard in 2002, we upgraded our Information Security program and were accredited to the International Standard in 2007. This accreditation brings us into line with worldwide best practice in information management security. It affirms that we have appropriate systems in place to secure our information assets.

Information is broadly defined and includes paper and electronic records. Our information security program covers our paper based systems as well as our computer network and databases, external access to the internet and supporting policies and procedures. We have also set up systems to restrict and monitor how our staff access external databases and information that we access in the course of our work.

Our information security objectives, reflected in the international standard, ensure:

- availability — authorised users have timely and reliable access to information
- confidentiality of information — we restrict access to and disclosure of information to authorised personnel only
- integrity — information is protected against unauthorised alteration or destruction and successful challenges to its authenticity are prevented.

Information security management is aimed at protecting information assets from potential security breaches. It involves reviewing risks, developing and implementing policies, processes and controls and establishing a compliance program to ensure that the goals are met. Most importantly, staff need to be aware of their responsibilities and take an active role in appropriately managing and securing information. Our staff have accepted this responsibility and we support them through a targeted induction program and ongoing training.

The success of our program is reflected in the positive audit reports we receive. The audit of our information security system is undertaken by an independent and accredited company — SAI Global.

Our security committee is responsible for ensuring risk assessments are carried out on all critical systems when major changes occur to those systems or new systems are introduced. They also ensure that there is a comprehensive review of our risk matrix at least annually.

We were accredited under the Australian Information Security Standard AS7799 in December 2002, to AS7799.2 in December 2005 and to the International Information Security Standard ISO/IEC 27001 in 2007.

We also have corruption prevention and fraud control measures, disaster recovery plans and preventative maintenance programs for our equipment. There are vigorous checks and balances in areas of high risk such as those where money, staff entitlements or our computer network could be compromised.

Making changes to how we work

During 2007–2008 we made several structural changes to improve how we work. These included:

- Reviewing the terminology used throughout our office to ensure consistency across all our business areas.
- Reviewing and developing our training courses, including a new investigations training module to improve our staff's skills in handling investigations.
- Continuing to develop a data classification system to better record and report on disability and out-of-home care issues identified by OCVs — we reported last year that we were undertaking this initiative.
- Accepting complaints by young people under the age of 18 as oral complaints, instead of asking them to put their complaints in writing — this will help to make our office more accessible to young people.
- Allocating primary responsibility for audits, training and project work to one unit within our child protection division, resulting in an increased capacity to conduct agency audits and training and a more streamlined approach to these functions.
- Developing a series of project management templates to create consistency, efficiency and greater accountability in our project work.
- Initiating a review of our complaint-handling procedures in our community services division.
- Implementing a watching brief system about a range of significant issues such as, homelessness, emerging communities, social housing and youth-at-risk to help us improve our understanding of whole-of-government initiatives across these areas.
- Enhancing Resolve, our case management system, to enable more timely data capture of initial receipt and assessment information of police complaints, better tracking and more timely processing.
- Successfully trialling and implementing the electronic receipt of notifications of police complaints and final police investigation reports — which has led to a more streamlined process.
- Redesigning and upgrading our general division's intranet page which allows staff to access information and contact details about agencies in our jurisdiction.
- Reviewing office performance indicators to have a consistent way of measuring our work across all business units. Work is still progressing, with new indicators being implemented in 2008–2009.
- Reviewing and updating several policies — including our code of conduct.

Consolidation of case management tools

We use a number of different systems to manage our core work. We have been reviewing our use of these systems and have implemented a staged plan of consolidation. We are aiming to have most of our business units and discrete functions use our main case management system — Resolve.

On 1 July 2007 the community services division's complaint-handling was transferred to Resolve. This means that all our complaints are now recorded in the one system.

We have begun a project to transfer both our child death and disability death case management functions to Resolve, which should be completed within the next reporting year. The project involves our programming staff modifying the database to ensure that the required information can be captured. Reports will also need to be developed.

We are continually enhancing Resolve. From July 2007 we introduced an agency hierarchy, which allows us to capture complaints about an agency as a whole, as well as drill down to regional and local offices. The introduction of this hierarchy required an extensive review of how our agency information was structured and extensive consultation with our divisions. We also reviewed our system for managing agency information, including how we add, change and delete it.

We also introduced a "recommendation case". This allows staff to enter details of any recommendation, suggestion or undertaking that they make to an agency when dealing with complaints and notifications. Staff use this to record whether an agency implements our recommendations, suggestions or undertakings. We can also monitor and report on the progress of implementation. The recommendation case replaced manual records kept by each business unit.

During the year we also reviewed how each of our divisions used Resolve to determine if there was any scope to implement more consistent practices. Where possible, the business processes we use and the data we collect and report on should be the same. Following input from our business units, we developed a common set of performance indicators, agreed terminology and complaints outcomes. We will be making changes to our case management system to reflect this.

Our cross agency team

In March 2007, we began trialling a new cross agency team (CAT) from within our existing resources. The team was created to help us respond to emerging whole-of-government, multi-agency or across office issues — particularly those that affect some of the more vulnerable sections of the community. Increasingly, our work involves issues that cross more than one of our traditional jurisdictions. This partly reflects the business of government, which is increasingly focused on promoting interagency approaches to service delivery.

The CAT is led by a senior officer and brings together a project team, our Aboriginal Unit and our youth liaison officer. The CAT's main functions are to:

- direct, coordinate and manage the work of our Aboriginal Unit and youth liaison officer
- provide advice and information to staff about significant Aboriginal and youth issues and initiatives
- undertake major investigations into issues that cross a number of agencies
- develop expertise in relation to whole-of-government initiatives in relevant areas, and provide ongoing advice to divisions about significant issues and progress in these areas.

An external evaluation of the CAT after 12 months found the team had achieved their agreed performance indicators. The Ombudsman subsequently decided to establish CAT as a permanent business unit within our office.

In our first year of operation, we undertook a diverse range of projects and initiatives. These included completing a review into the supports provided to carers of Aboriginal children and starting a major investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS).

Supporting carers of Aboriginal children

This year, the CAT completed a detailed review of the adequacy of supports provided to carers of Aboriginal children. The review involved interviews with 100 carers as well as Aboriginal out-of-home care agencies and other stakeholders. We also examined the health, educational and cultural needs of Aboriginal children in care. The final report was given to the Departments of Community Services, Education and Health for their consideration, as well as the Wood Special Commission of Inquiry into Child Protection Services in NSW. For more details about this review, see Chapter 1: Community engagement.

Helping people with a mental illness access and sustain social housing

Last year we reported on an investigation prompted by the eviction of a long term public housing tenant whose lease was terminated due to rental arrears. The tenant sustained serious injuries after a struggle ensued when police accompanied Department of Housing (DoH) staff to his premises to carry out the eviction. Our investigation found that DoH staff did not follow departmental procedures for dealing with tenants who have a known mental health condition, despite their awareness of the man's chronic mental illness. In particular, the investigation revealed a limited awareness by staff of the JGoS. Our inquiries also suggested that the JGoS was not being consistently implemented across the state.

Based on this information and further complaints and information received, we decided to conduct an investigation to examine the effectiveness and implementation of the JGoS.

The JGoS is an agreement between the Department of Housing, NSW Health, the Department of Community Services (on behalf of SAAP services), the Aboriginal Housing Office and the Aboriginal Health and Medical Research Council. Our investigation is examining the steps taken by the Department of Housing and NSW Health to meet the objectives of the JGoS. These objectives are to:

- better assist and enhance the wellbeing of existing social housing tenants whose tenancy may be otherwise at risk
- assist housing applicants who may be homeless or at risk of homelessness to successfully establish a tenancy.

As part of the investigation, we have consulted extensively with the JGoS agencies and relevant peak bodies. During visits to 25 regional and metropolitan locations across the state, we also consulted with more than 450 local housing and mental health workers, consumer advocates, supported accommodation providers, mental health non-government workers, community housing providers, Aboriginal housing staff, Aboriginal medical services, DoCS officers and tenant advocates. These consultations will inform our findings and recommendations and have also generated an increased awareness of the JGoS — particularly in areas of the state where engagement to date has been minimal.

We expect to issue our investigation report to the Department of Housing and NSW Health in late 2008.

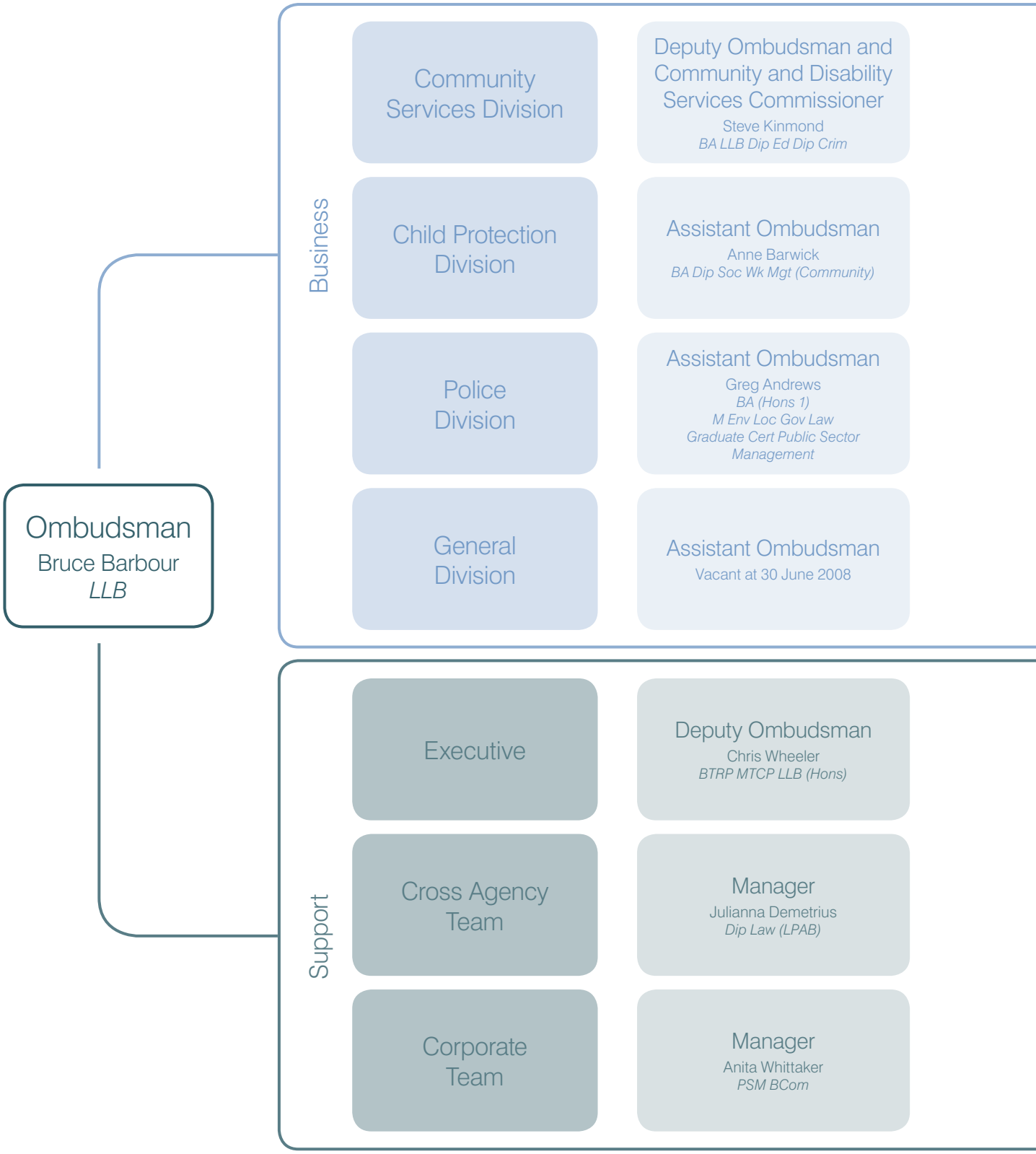
Our other initiatives

In addition to these large scale projects, the CAT has also:

- Developed *Guidelines for Dealing with Youth Complaints* to help agencies in NSW and other states to make their complaint practices more accessible to young people.
- Prepared a detailed submission in response to the Sentencing Council's interim report on the effectiveness of fines as a sentencing option. Our submission was based on observations from our research and community liaison work over several years into the impact of fines on vulnerable groups.
- Continued to monitor compliance by the NSW Police Force with the recommendations of our 2006 special report to Parliament, *Domestic Violence: improving police practice*, including participating in a steering committee established by the NSWPF to implement our recommendations and providing feedback on several operational policies.
- Made significant contributions to the Ombudsman's submissions to the Wood Special Inquiry into Child Protection Services in NSW on interagency practice, youth-at-risk and Aboriginal communities.
- Conducted consultations with community based juvenile justice staff and youth services across the state to identify current issues for youth-at-risk and increase their awareness of our work.
- Consulted nine multi-cultural resource centres about agency practices for assisting newly settled migrants.
- Conducted 29 presentations to 700 agency staff, community members and workers to inform them of our work and how to make complaints.
- Developed and implemented a comprehensive Aboriginal cultural appreciation training package for all Ombudsman staff. This training is designed to help staff gain a better understanding of Aboriginal history and culture and improve their work practices with Aboriginal complainants.
- Started a review of the Department of Ageing, Disability and Home Care's (DADHC) implementation of their Aboriginal Policy Framework and Aboriginal Consultation Strategy to meet the needs of their Aboriginal clients with a disability and their carers.
- Aboriginal Unit staff accompanied staff from our Corrections Unit on 15 visits to juvenile justice and correctional centres to speak with Aboriginal detainees and inmates. Our Aboriginal Unit also conducted visits to Aboriginal child care services to outline their obligations to notify our office about reportable allegations involving their staff.
- Drafted a fact sheet to help staff in juvenile justice centres understand the types of complaints we deal with, how we deal with them, and how they can support detainees to make complaints.

These initiatives are described in more detail in the relevant sections of this report.

Organisational chart



Division Manager
Gary Dawson
Principal Investigator & Projects Officer
Michele Powell
Manager, Systemic Oversight & Review
Monica Wolf

Division Manager
Natasha Mewing
Principal Investigation Manager
Kelvin Simon (Acting)

Division Manager
Michael Gleeson (Acting)
Principal Investigation Manager
Peter Burford
Intel & Information Manager
Vincent Riordan

Division Manager
Anne Radford
Manager, Projects & Major Investigations
Helen Ford
Manager, Corrections & Compliance
Jennifer Agius

Manager, Legal
Monique Adofaci
LLB (Hons) MBA

Our office is divided into four specialist divisions — police, general, child protection and community services — and two teams that support these divisions, our corporate and cross agency teams.

Community Service Division
- Policy and community education
- Service improvement and review
- Reviewable deaths
- Complaint resolution and investigation
- Official community visitor scheme

Child Protection Division
- Schools
- Non-schools
- Investigation and training
- Research

Police Division
- Serious misconduct
- Legislative review
- Projects, intelligence and auditing

General Division
- State and local government
- Corrections
- Universities and protected disclosures
- DoCS and DJJ
- Inquiries and resolution
- Freedom of information
- Secure monitoring unit

Executive
- Legal services
- Special projects and investigations
- Policy development
- Development of public sector guidelines and standards

Cross Agency Team
- Aboriginal Unit
- Youth liaison
- Cross-jurisdiction and cross-office projects

Corporate
- Personnel
- Accounts
- Publications
- Public relations
- Records and information management
- Information technology
- Library

Our people

We have 200 people working for our office on either a full or part-time basis. This equates to just over 175 full-time equivalent (see figure 10). These people are an energetic and diverse mix of experience and skill and come from a range of backgrounds — including investigative, law enforcement, community and social work, legal, planning, child protection and teaching. Our collective experience gives us insight into the agencies we keep accountable and helps us to be a persuasive advocate for change.

Human resources

Any exceptional movement in wages, salaries or allowances

A 4% salary increase was paid to staff covered by the Crown Employees (Public Sector — Salaries 2007) Award from 13 July 2007.

Executive remuneration

In its annual determination, the Statutory and Other Officers Remuneration Tribunal awarded increases to our statutory officers. Both our Deputy Ombudsman and each of our Assistant Ombudsman were awarded a 2.5% increase effective 1 October 2007. The Ombudsman's remuneration increased by 2.5%.

Figure 11 details the Ombudsman's remuneration which includes salary, superannuation and annual leave loading.

Chief and senior executive service

Our office has six senior positions — the Ombudsman, two Deputy Ombudsman and three Assistant Ombudsman. A woman currently holds one of those positions. There was no change in the number of senior positions during the reporting year, however one position of Assistant Ombudsman was vacant as at 30 June 2008, following the departure of Simon Cohen, who was appointed Public Transport Ombudsman in Victoria. We thank Simon for his contribution to the office. Recruitment action for this position was finalised in September 2008 and a woman was appointed. Please see figure 12 for details of the levels of our senior positions as at 30 June 2008.

Monique Adofaci was appointed to Assistant Ombudsman position, General Division in September 2008.

Personnel policies and practices

Our staff are employed under the provisions of the *Public Sector Management and Employment Act 2002*. This Act, the associated regulations and the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2006 set the working conditions of public servants. We therefore have little scope to set working conditions and entitlements for our staff. The Public Sector Workforce Office (PSWO), a division of the Department of Premier and Cabinet, is the employer for this purpose and negotiates conditions and entitlements with the relevant unions.

We systematically review our personnel related policies and systems to ensure that they help us to achieve purpose 4 of our statement of corporate purpose — to be an effective organisation. We finalised the review of our occupational health and safety (OH&S) policy in August 2007 and our performance management policy in April 2008. We began the consultation process for the review of our recruitment policy, and started reviewing our harassment, grievance and equal employment opportunity policies. These will be finalised next year. We will also be reviewing our co-lateral flexible working hours agreement.

We upgraded our human resources/payroll system in 2007–2008. This was a substantial project, requiring changes to business practice, significant testing and staff training.

Industrial relations policies and practices

We have a Joint Consultative Committee (JCC) that meets regularly to discuss how we might adopt and implement policies negotiated by the PSWO and the relevant unions and, if necessary, develop local policies. The JCC includes management and staff representatives.

During the year, the JCC discussed a number of policies that were reviewed and a range of issues relating to working conditions and entitlements — including the results and improvement plans following the staff climate survey in June 2007.

Next year, the JCC will be involved in the review of the co-lateral flexible working hours agreement as well as providing input on policy development and review.

Equal employment opportunity

We are committed to the principles of EEO and have a program that includes policies on performance management, grievance-handling, ensuring a harassment-free workplace and reasonable adjustment. Our staff come from a variety of backgrounds and experience. Figures 13 and 14 show the gender and EEO target groups of staff by salary level and employment basis — permanent, temporary, full-time or part-time.

The NSW Government has established targets for the employment of people from various EEO groups. Measurement against these targets is a good indication of how effective our EEO program has been. The performance indicator on page 36 compares our performance to government targets.

We met our targets for 2007–2008, which included:

- offering flexible working conditions
- providing student placements and work experience opportunities
- providing developmental opportunities for EEO groups.

EEO strategies

Our priority EEO strategy this year was training, although we continued our program of updating position descriptions and reviewing personnel policies. A key element of our training program was to improve our understanding of access and equity issues by developing and implementing in-house training on Aboriginal cultural appreciation and disability awareness. All staff are required to attend these two half day training sessions. We also engaged external agencies to conduct cross cultural awareness sessions.

We focused on improving the skills of our supervisors by organising training in fundamentals for supervisors, performance management, managing unsatisfactory performance and merit selection. These courses are offered on a regular basis.

We expanded our training on harassment prevention and grievance-handling to include all staff. These sessions, conducted by the Anti-Discrimination Board, were well received by staff.

In 2008–2009 we will continue to promote flexible work options to staff, promote a consultative work environment and provide opportunities for staff to participate in staff development and training activities.

Figure 10 — Staff levels

	03/04	04/05	05/06	06/07	07/08
Statutory officers	6.00	6.00	6.00	6.00	5.00
Investigative	70.11	67.12	69.60	66.17	65.90
Investigative support	37.34	30.64	30.44	34.00	35.65
Project and research	19.40	12.80	15.60	16.60	15.60
Training and community education	3.60	3.30	3.20	3.58	3.50
Inquiries	8.40	8.00	8.00	9.00	10.00
Community visitor support	1.80	2.80	2.80	3.00	2.80
Systemic review	10.40	10.29	11.70	12.10	13.40
Corporate	22.40	23.80	25.86	29.43	23.97
Total*	**179.45**	**164.75**	**173.20**	**179.88**	**175.82**

*full-time equivalent

Figure 11 — Executive remuneration

Position	**Ombudsman**
Occupant	Bruce Barbour
Total remuneration package	$399,320
$ Value of remuneration paid as a performance payment	nil
Criteria used for determining total performance payment	n/a

Figure 12 — Chief and Senior Executive Service

	2005	2006	2007	2008
SES Level 4	2	2	2	2
SES Level 2	3	3	3	2
CEO*	1	1	1	1
Total	**6**	**6**	**6**	**5**

* CEO position listed under section 11A of the *Statutory and Other Offices Remuneration Act 1975*, not included in Schedule 2 to the *Public Sector Employment and Management Act 2002*.

Performance Indicator

Trends in the representation of EEO groups

Interpretation: A distribution index of 100 indicates that the centre of the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicating that the EEO group is less concentrated at the lower levels. Where n/a appears, the sample was not sufficient to draw a conclusion. The Distribution Index is automatically calculated by the software provided by the Premier's Department.

EEO Group	Government target (%)	Ombudsman representation (%)				
		03/04	04/05	05/06	06/07	07/08
Women	50	73	72	72	71	73
Aboriginal & Torres Strait Islander people	2	1.5	2.1	2	2	2.50
People whose language first spoken as a child was not English	20	17	18	18	17	20
People with a disability	12	8	6	7	7	6
People with a disability requiring work-related adjustment	7	2.5	2.1	1.5	2	2

Performance Indicator

Trends in the distribution of EEO groups

EEO Group	Benchmark or target	Ombudsman				
		03/04	04/05	05/06	06/07	07/08
Women	100	89	88	89	90	88
Aboriginal & Torres Strait Islander people	100	n/a	n/a	n/a	n/a	n/a
People whose language first spoken as a child was not English	100	84	83	88	89	86
People with a disability	100	n/a	n/a	n/a	n/a	n/a
People with a disability requiring work-related adjustment	100	n/a	n/a	n/a	n/a	n/a

Occupational health and safety

In 2005, the NSW Government released *Working Together — the public sector OHS & injury management strategy* to improve health and safety performance in the public sector, with a specific focus on injury management. This strategy commits public sector agencies to a number of improvement targets — including reducing workplace injuries, reducing the cost of claims, and training managers on their occupational health and safety (OH&S) roles and responsibilities.

We reviewed our OH&S policies and procedures and adopted a risk management approach to our OH&S activities. Our revised policy was approved by the Ombudsman in August 2007. The policy and supporting programs provide guidance to both managers and staff in a range of areas including:

- OH&S strategies and procedures
- return to work programs
- first aid plans
- workplace inspections.

We have an OH&S action plan that brings together our OH&S activities for the year in one document. It documents responsibilities and timeframes as well as performance indicators.

All new supervisors are required to attend OH&S risk management training and are trained in how to conduct workplace inspections. They are required to inspect the work areas of their staff and identify any improvements needed. We plan to conduct formal inspections at least once a year.

During the year, we trained our wardens to respond to a number of emergency situations and participated in the building emergency evacuation drills.

We provide an employee assistance program (EAP) including a free 24-hour counselling service for staff and their families. Information sessions about the EAP were conducted during the year.

We have a number of other programs that help us to meet our health and safety obligations including:

Figure 13 — Percentage of total staff by level

		Subgroup as an estimated percent (%) of total staff at each level						
Level	Total staff (no.)	Men	Women	Aboriginal & Torres Strait Islander people	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
< $35,266	1	0	100	0	0	0	0	0
$35,266 – $46,319	10	0	100	10.0	60	50	10	10.0
$46,320 – $51,783	8	0	100	0	63	38		0
$51,784 – $65,526	33	24	76	0	33	36	6	3.0
$65,527 – $84,737	103	24	76	1.9	24	16	6	1.9
$84,738 – $105,923	37	46	54	5.4	11	11	3	0
> $105,923 (non SES)	4	25	75	0	0	0	33	0
> $105,923 (SES)	4	75	25	0	0	0	25	0
Total	**200**	**27**	**73**	**2.5**	**26**	**20**	**6**	**2.0**

Figure 14 — Percentage of total staff by employment basis

		Subgroup as an estimated percent (%) of total staff in each employment category						
Employment basis	Total staff (no.)	Men	Women	Aboriginal & Torres Strait Islander people	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
Permanent Full-time	114	31	69	2.7	30	20	5	0.9
Permanent Part-time	39	8	92	2.6	21	21	8	5.1
Temporary Full-time	37	32	68	2.7	22	22	3	2.7
Temporary Part-time	5	0	100	0	20	20	0	0
Contract – SES	4	75	25	0	0	0	25	0
Contract – Non SES	1	100	0	0	0	0	100	0
Training Positions	0	0	0	0	0	0	0	0
Retained Staff	0	0	0	0	0	0	0	0
Casual	0	0	0	0	0	0	0	0
Total	**200**	**27**	**73**	**2.5**	**26**	**20**	**6**	**2.0**

- Hepatitis vaccinations — staff who visit correctional centres are vaccinated against Hepatitis A and B.
- Eye examinations — our staff spend a lot of time using computers and this can lead to eyestrain, so we organise an eye examination for all staff every two years so that any potential problems can be detected.
- Flu shots — we organised flu shots for staff to prevent high levels of absenteeism during the flu season.

To respond to minor workplace injuries, we have appointed a number of staff as first aid officers. We cover the costs of initial and any ongoing training and pay these staff a yearly allowance for undertaking this role.

We participate in the NSW Treasury Managed Fund, a self-insurance scheme for the NSW public sector. One of the goals of *Working Together — the public sector OHS & injury management strategy* is to improve our workers' compensation performance. Six workers' compensation claims were reported in 2007–2008. This means we reduced the number of claims reported to our insurer, compared to previous years (see figure 15).

Figure 15 — Workers' compensation

Claims entered in the year	06/07	07/08
Claims brought forward	9	9
New claims	9	6
Claims closed	9	9
Open claims 30 June	9	6

Learning and development

One of the goals of our statement of corporate purpose is to attract, develop and encourage skilled and committed staff. One way of achieving this is to provide learning and development opportunities that enable staff to effectively perform their current role and gain skills to help them to progress their careers.

This year we provided staff with a multifaceted training schedule that included coordinated induction sessions, job specific training and in-house workshops held by external training providers. Staff also attended a range of external courses to gain job specific skills.

Figure 16 — Training expenditure

Year	03/04	04/05	05/06	06/07	07/08
Value	$151,000	$78,000	$117,000	$220,000	$180,000

Raising awareness

Our major focus this year was improving how we deal with the public. Two of our staff members developed and conducted disability awareness and Aboriginal cultural appreciation training sessions to improve our understanding of the needs and issues affecting these groups as well as improving how our staff interact with them. We also organised for external providers to present cultural awareness training sessions.

Carolyn Campbell-McLean (Community Services Division) providing disability awareness training to our staff.

Treating each other with respect

This year all our staff attended equal employment opportunity/harassment prevention training to highlight the importance of treating everyone with respect. These sessions were conducted by the Anti-Discrimination Board.

Supervisors training

Staff appointed to supervisory positions were provided with training in EEO and grievance-handling, recognising and assisting staff with depression, fundamental supervisory skills, performance management and occupational health and safety.

Laurel Russ and Kylie Parsons (Aboriginal Unit) providing Aboriginal cultural appreciation training to our staff.

Better equipping new staff

We have a formal induction program to make sure that all new staff receive consistent information about our office and our policies, processes and obligations. Within their first three months, all new staff are given training on security awareness and our electronic document management and case management systems. In addition, they attend an information session where representatives from across the office provide a brief overview of the role and structure of their area. We also hold 'Ombudsman What, When, Where and Why' training sessions — the first module of our investigation training program — to inform new staff about the work we do and our jurisdictions and responsibilities.

Developing professional skills

As part of our commitment to professional development, all complaint-handling staff attend our investigation training program. This is an in-house developed course that covers various aspects of investigation work — including report writing, planning, managing parties and evidence collection. One module is scheduled each month.

During the year staff also participated in workshops on presentation skills, public policy process, workplace effectiveness, communication skills, introduction to project management, and merit selection in the public sector. They also attended a number of conferences on topics ranging from reviewing child deaths, housing issues and residential care.

In addition:

- We arranged for external presenters to deliver training sessions on a range of issues specific to our complaint-handling and other activities.
- Corporate staff attended a range of courses to enhance their skills, as a result of changes to our payroll/personnel system and our accounting package.
- A number of complaint-handling staff attended public training sessions run by our own training staff on, for example, the art of negotiation and dealing with difficult complainants.

Improving our computer skills

Computer based training was also a focus this year following the upgrade of our word processing and Excel programs. All staff attended information sessions outlining the new functionality. A number of staff also attended external training in Excel, Word, Outlook and PowerPoint.

Supporting other programs

Staff development also means encouraging staff to undertake further study to enhance their skills. During 2007–2008 one staff member joined the Public Sector Executive Development Program sponsored by the Premier's Department, and a second staff member started the program in July 2008. Eight of our staff used study leave provisions to undertake tertiary education courses.

Balancing our books

Most of our revenue comes from the government in the form of a consolidated fund appropriation. Our final consolidated fund allocation for 2007–2008 was $20.069 million. The government also makes provision for certain employee entitlements such as long service leave. We were allocated $300,000 for our capital program, which was spent on upgrading our computer systems, purchasing new office equipment and updating and improving our fitout

We generated $263,000 through the sale of publications, bank interest, fees for service training courses and our consultancy services to AusAid.

Most of our revenue is spent on employee-related expenses including salaries, superannuation entitlements, long service leave and payroll tax. Last year we spent more than $17.1 million on these items. The day-to-day running of our office costs over $4.2 million a year.

Further details of our financial position can be found in our financials.

Environmental issues

Our agency, like all agencies, has an impact on the environment. Our work leads to the generation of emissions and the production of waste, and we use resources such as electricity and water. We have a number of programs in place to monitor and reduce this impact, including energy management and waste reduction programs, and have integrated environmental issues into our business plans. The success of our environmental programs depends on the commitment of our staff, so one of our key environmental activities is staff awareness and education.

Energy management

Petrol consumption

To ensure we meet public sector requirements, we have a fleet improvement plan that identifies a number of strategies aimed at improving our fleet performance score. We travelled fewer kilometres this year, reducing the amount of petrol used. We have also been replacing our fleet with smaller, more energy efficient vehicles.

Performance Indicator

Petrol consumption

	95/96	04/05	05/06	06/07	07/08
Petrol (l)	4,296	5,326	5,159	4,787	4,145
Total (GJ)	147	182	176	162	142
Distance travelled (km)	53,018	54,738	51,602	35,086	32,963

Electricity consumption

We had an increase in energy use in 2007–2008, following a significant decrease the year before. We are unable to account for this increase, but it is still lower than our 2005–2006 usage. We have engaged our electricians to review this matter. Next year, we will be installing virtual servers in our computer room to reduce the number of servers that use power and generate heat, and this should have a positive impact on our consumption.

Future direction

We are committed to improving our environmental performance and will benchmark our performance annually against government and internal targets. We will continue our staff awareness program to ensure that all staff contribute to the achievement of targets.

Performance Indicator

Energy consumption

	95/96	04/05	05/06	06/07	07/08
Electricity (kWh)	133,630	304,716	355,301	311,713	348,358
Kilowatts converted to gigajoules	481.07	1,097	1,279	1,222	1,254
Occupancy (people)	69.7	187	187	191	187
Area (m^2)	1,438	3,133	3,133	3,133	3,133

Greenhouse performance

Australian Building Greenhouse Rating (ABGR)

We are continually working to improve our ABGR rating by using more energy efficient systems/controllers throughout the office. We have also implemented a program to educate staff on ways to conserve energy.

Waste reduction program

We are committed to reducing the amount of waste going to landfill. Our waste reduction and purchasing program has resulted in a reduction in waste, increased recycling and greater purchasing of recycled content products.

Reducing generation of waste

We are continually looking at ways to improve our waste management practices. We promote email as the preferred internal communication tool and encourage staff to print double-sided. We have an electronic record system that allows staff to access information such as policies, procedures and internal forms — reducing the need for paper copies. Our publications are available to download from our website so we now print smaller quantities than in the past.

Resource recovery

We have individual paper recycling bins at workstations and larger 240 litre bins throughout the office for secure destruction. All office wastepaper, cardboard, glass, plastic and aluminium is collected for recycling. We are a member of Planet Ark Close the Loop Resource Recovery Program and recycle our used toner cartridges, bottles, drums, inkjets and ribbons. We do regular checks of our general waste and recycling bins to identify any recyclable paper in the general waste stream or any contamination in the recyclable paper bins.

Using recycled material

We use Australian recycled paper containing 80% waste fibre diverted from Australian landfills. Our stationery and publications are printed on either recycled, acid free or chlorine free paper. We purchase recycled content product when feasible and cost effective.

Reducing water usage

The owners of our building have implemented a water saving strategy throughout the building. During 2007–2008, we participated in a trial of waterless urinals. Following positive trial results, building management have replaced the urinals in the building with a waterless system.

Our publications area is currently focusing on providing more environmentally friendly publications. We are auditing our whole print process — including sourcing printers that provide cleaner print processes that use natural inks and print finishes that use water soluble coatings and processes. We currently use a digital process for smaller print runs because digital printing is better for the environment than traditional offset printing.

We are also reviewing the paper stocks we use in printing. In future, where possible, we will be using Forest Stewardship Council (FSC) certified stock. The FSC is one of the few independent bodies capable of accurately determining fibre origin by tracking it from forest to printer (see inside back cover for further information).

Paper accreditation icons we are eligible to include on printed products.

Community engagement 1

An essential part of our work involves engaging effectively with the community to develop relationships, identify and respond in a proactive way to issues and complaints, and increase awareness of the role of our office. Community consultation also forms an important part of our investigative and research work. When we talk about 'community' we include local agency staff, community workers, consumers of services, peak bodies, advocacy groups and the public.

Highlights

- Supported 36 official community visitors (OCVs) to make 3,289 visits to 6,578 people living in residential services across the state. OCVs identified 3,634 issues this year — 63% of these have been finalised.
- Ran 80 workshops and training sessions for over 1,600 consumers, staff and providers of community services.
- Worked cooperatively with the NSW Sentencing Council on their research into the effectiveness of fines as a sentencing option, particularly for vulnerable people. Our submission will form part of the council's final report.
- Completed a review of the supports provided to carers of Aboriginal children. We also examined the health, educational and cultural needs of Aboriginal children in care as well as critical data deficiencies.
- Prepared a comprehensive submission to the Wood Inquiry which outlined our views on child protection and neglect in Aboriginal communities.
- Commenced a major investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing. Consultations were held in 25 locations across the state and involved over 450 stakeholders.
- Developed disability awareness training for our staff. So far, four sessions have been delivered.
- Delivered three workshops on complaint-handling and advocacy for domestic violence workers.

A key focus of a number of our systemic investigations in recent years has been examining how well government policy is being implemented at community level. Our investigations into issues such as policing domestic violence, police work with Aboriginal communities, and supporting people with mental health problems to maintain their social housing have all involved extensive consultations with frontline agency staff, service providers and members of the public in numerous locations across the state. For example, we interviewed 100 foster carers as part of our review of the adequacy of supports provided to the carers of Aboriginal children and held over 250 meetings with agency staff, community workers and advocates to inform our investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS).

These consultations help us to understand how government service delivery can impact on individuals, identify common systemic issues that need to be addressed, and explore what works in local areas and why. They also allow us to test ideas and possible solutions to ensure that our final recommendations are workable.

As well as the community liaison and consultation work carried out by our staff during projects and investigations, we have dedicated units and positions within our office that focus on working directly with the community. These include our community education unit, Aboriginal Unit, youth liaison officer and training officer. Some examples of their activities include:

- conducting community education workshops about our role and how to make complaints
- providing training on advocacy, complaint-handling and dealing with unreasonable complainants
- attending community and cultural events and distributing information about our services.

We also gain direct access to many community members through our role in administering the official community visitor scheme (OCV). We support OCVs to visit consumers of residential services in the community and help them to address matters that fall outside the scope of their powers, particularly matters of a serious nature. Our role also provides us with valuable insights into the quality of service provision to some of the most vulnerable people in the state.

In this chapter, we discuss our community education work and our work with OCVs — as well as our work across specific groups in the community such as Aboriginal people, people from different cultural and linguistic backgrounds (CALD), young people, women and people with a disability.

Official community visitors

Official community visitors (OCVs) are statutory appointees who provide an independent mechanism to ensure that people living in residential services in NSW receive the highest standard of service provision possible. They are appointed by the Minister for Ageing and Disability Services and the Minister for Community Services for a period of up to six years.

The residents they visit live in services funded, licensed and/or authorised by either the Department of Ageing Disability and Home Care (DADHC) or the Department of Community Services (DoCS). This includes services for:

- people with a disability
- children and young people in out-of-home care
- children and young people with a disability in out-of-home care.

OCVs also visit people living in licensed residential centres or boarding houses.

They are required to:

- inform the Ministers and the Ombudsman about matters that affect 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
- help to resolve any grievances or concerns residents may have.

OCVs try to resolve issues at the service level to minimise their impact on the daily lives of the individuals concerned. If the issues and concerns cannot be resolved — or are serious and outside the powers of the OCV — they can raise them with us or the relevant minister.

This year the Parliamentary Joint Committee of the NSW Parliament reviewed the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and recommended that:

- the resources of the OCV program be increased to enable more visits to take place
- we continue to actively recruit OCVs from Aboriginal and other CALD backgrounds
- a legislative amendment be made to impose sanctions for obstructing, hindering or restricting OCVs in the exercise of their functions.

We support these recommendations and await the government's response.

Administering the scheme

We administer the OCV scheme, set visit priorities and give support to the OCVs.

We do this by:

- recruiting and inducting new OCVs, through a six month training and mentoring program
- providing them with up-to-date information about departmental policies and procedures
- supporting them at meetings and conciliations aimed at resolving issues between services and residents
- providing training programs addressing practice issues to support their professional development
- helping them with the logistics of travel and accommodation
- coordinating meetings of OCVs at a regional level and through specific sector discussion groups
- meeting periodically with OCVs to discuss the operation of the scheme and policy initiatives to enhance its development
- coordinating an annual conference for OCVs to meet with ministers, senior public sector officials, peak agency representatives and our staff to discuss community sector matters and issues affecting the care and welfare of residents.

Figure 17 — Outcome of issues identified by OCVs finalised in 2007–2008

Target group of services	No. of visitable services	No. of issues identified	Percentage of issues identified	Percentage of issues finalised* (resolved issues)	Percentage of issues finalised** (unresolved issues)	Percentage of issues finalised*** (closed issues)
Children and young people	106	427	276 (64.6%)	105 (38.0%)	17 (6.2%)	154 (55.8%)
Children and young people with a disability	39	204	126 (61.8%)	62 (49.2%)	38 (30.2%)	26 (20.6%)
Children, young people and adults with a disability	18	67	44 (65.7%)	32 (72.7%)	0 (0%)	12 (27.3%)
Adults with a disability including residents of boarding houses	1,074	2,936	1,829 (62.3%)	1,636 (89.5%)	50 (2.7%)	143 (7.8%)
Total	**1,237**	**3,634**	**2,275 (63%)**	**1,835 (80.7%)**	**105 (4.6%)**	**335 (14.7%)**

* 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.

Figure 18 — Number of visits made by official community visitors in 2007–2008

Target group of services	No. of services	No. of residents	No. of activity hours	No. of visits 06–07	No. of visits 07–08
Children and young people	106	204	877	370	307
Children and young people with a disability	39	120	344	142	137
Children, young people and adults with a disability	18	63	123	54	46
Adults with a disability in residential care, including boarding houses	1,074	6,191	7,849	2,598	2,799
Total	**1,237**	**6,578**	**9,193**	**3,164**	**3,289**

In 2007 we undertook extensive recruitment across NSW. We received over 150 applications for OCV positions and, after an extensive process based on demonstrated skills and abilities, 12 people were appointed and started work on 1 March 2008.

Issues raised by visitors

In 2007–2008 the budget for the OCV scheme was $754,000. This enabled 36 OCVs to go to 1,237 services, conducting 3,289 visits to 6,578 residents. OCVs provided 9,193 hours of service to residents, which is a small decrease on the 9,507 hours in 2006–2007.

Some of the most common issues raised with OCVs this year included concerns about:

- provision of individualised service — 654 issues
- provision of a well maintained and home-like environment — 404 issues
- provision of appropriate and meaningful behaviour management plans and implementation of those plans — 356 issues
- provision of appropriate monitoring to ensure good health management, choice of healthy food and access to heath care — 292 issues
- provision of a service environment that is safe and has appropriate emergency procedures, is free from abuse and neglect and that also allows residents the right to make informed choices — 284 issues.

During 2007–2008, OCVs identified 3,634 issues, of which 2,275 were finalised (63%). Services, with the assistance and oversight of OCVs, resolved 1,835 (81%) of the service provision issues that were finalised (see figures 17 and 18). OCVs continue to monitor services' action about 1,359 ongoing issues that were identified during the year.

Case study 1

A man living in a residential group home with four other residents told the OCV that he wished to have some individual community access with the support of one staff member, instead of always having to go as part of a group. When the OCV inquired about whether he had raised this issue at his service's last individual planning meeting, he said that they did not have individual planning and he wanted to be able to have a say in issues that affected his life.

The OCV raised the issue with the manager of the service. The service advised that they did not see formal individual planning as an important aspect of service delivery and that residents of their service were able to set their goals informally. The OCV pointed out that, without formal individual planning, residents' issues and goals were unlikely to be addressed. The OCV also advised that the Disability Service Standards make individual planning for residents mandatory and that the service's funding could be at risk if they did not comply with this.

The service agreed to implement individual planning. However after deadlines passed with limited progress, the OCV escalated the issue as a complaint to our office. As a result, the service responded and individual plans with meaningful goals were developed for all residents.

Each year we table a report to Parliament on the work of the OCVs, providing further details about the issues and outcomes that have been achieved for residents. Case studies 1, 2 and 3 provide examples of some of the individual outcomes our OCVs have achieved this year.

Providing community education

This year our community education unit developed, implemented and consolidated a significant communication and education strategy. The aim of the strategy was to develop a systematic approach to promoting our work to consumer advocates and service providers throughout NSW. It involves placing information in publications distributed by peak body organisations and initiating direct contact with targeted special interest and consumer groups via presentations and local media.

Our general information and awareness strategies also continue to target groups that are key stakeholders or those who may be disadvantaged because of disability, location, language or other circumstances.

In 2007–2008, our program of education activities with consumers of community services and their families trained approximately 60 people. These activities are designed to inform consumers and their families of their rights, how to communicate effectively, and how to make complaints. We worked with consumers from culturally and linguistically diverse backgrounds, older people using Home and Community Care (HACC) services and families of young children with a disability.

We reprinted our Rights Stuff toolkit and distributed it to consumers and service providers throughout the year. We also undertook the 'Solving Problems — Right at Home' program with 13 residents and 14 workers at Carinya Arncliffe Licensed Boarding House to inform participants of our role and to allow them to raise individual, service and systemic issues. Another forum was held for 14 boarding house staff in the Hunter region. We also held joint disability intermediaries forums — with the Energy and Water Ombudsman (EWON) — in Chatswood, Parramatta and Sutherland. Over 150 disability workers and advocacy providers attended to learn more about our work.

Case study 2

An eleven year old with autistic spectrum disorder and severe language and behaviour deficits attends a local school with daily support from committed carers. The boy was under a joint care arrangement organised by a government and a non–government agency. This joint care arrangement had resulted in confusion about which group was taking responsibility for his recreational and leisure program. The OCV found out that the recreational program had not changed or developed over time in accordance with the boy's age, skill or ability, so raised this concern with both organisations. A review meeting resulted in the development of a specific focus program for the boy. The new program gave him a wider range of activities and resulted in significant improvements in his behaviour.

Case study 3

Four and a half years ago a boarding house closed, leaving 18 residents in interim housing for six months. Four years later the residents were still in the temporary premises, with no indication by DADHC of when they might move to permanent accommodation. Family members of some of the residents contacted the OCV, seeking assistance in finding out when and where the residents might move.

Initial attempts by the OCV to seek clarification from DADHC were not successful. There were no clear timeframes for moving residents and a lack of clarity about where they would be living in the future.

The OCV raised the issue with us and we sought confirmation from DADHC of their plans for the residents. The information we received was passed on to the residents and families by the OCV. The residents have now moved to new accommodation and the OCV reports that they are happy with the arrangements.

Our membership of the Joint Outreach Initiatives Network — which includes staff from other complaint-handling bodies such as the Commonwealth Ombudsman, Independent Commission Against Corruption (ICAC) and the EWON — enables us to exchange information about outreach activities and strategies and work together on joint projects. These include the Office of Fair Trading Community Access Program and the joint information stall at the Royal Easter Show on Seniors Day. We also hosted a one day meeting with staff from the Victorian and Queensland Ombudsman to exchange information on communication strategies and outreach initiatives.

In November 2007, we gave a presentation at the rural and remote communities drugs, alcohol and substance abuse workshop in Katherine in the Northern Territory. The two day workshop involved police drug policy coordinators from Queensland and the Northern Territory, some key Aboriginal health representatives and a number of remote area police. The aim was to put processes in place to implement recommendations from a 2005 report, *The policing implications of cannabis, amphetamine and other illicit drug use in Aboriginal and Torres Strait Islander communities*. The report, produced by the Australian Institute of Aboriginal and Torres Strait Islander Studies and the Australian Institute of Criminology, featured information about our work with Aboriginal communities and generated enormous interest from police practitioners.

Places visited 2007–2008

Albury
Armidale
Batemans Bay
Bathurst
Bega
Bellbrook
Blue Mountains
Bodalla
Bourke
Bowral
Brewarrina
Broken Hill
Cabarita Beach
Caroona (Walhallow Village)
Casino
Cessnock
Charlestown
Cobar
Coffs Harbour
Coonamble
Cootamundra
Dareton
Deniliquin
Dubbo
Eden
Fassifern
Forbes
Glen Innes
Goodooga
Gosford
Goulburn
Grafton
Guyra
Inverell
Junee
Kingscliffe
Kempsey
Lightning Ridge
Lismore
Lithgow
Maitland
Merimbula
Milton
Mogo
Moruya
Murwillumbah
Muswellbrook
Narooma
Newcastle
Nowra
Oberon
Orange
Parkes
Port Kembla
Port Macquarie
Queanbeyan
Quirindi
Singleton
Tamworth
Taree
Tingha
Tweed Heads
Wagga Wagga
Walgett
Wallaga Lake
Wellington
Wilcannia
Wollongong

One outcome of this workshop was to create a network for practitioners involved in remote area policing issues. This network has the potential to give us direct access to significant developments in other jurisdictions, particularly in relation to addressing issues such as substance abuse, family violence and more effective protective responses for children and young people in rural and remote communities.

The more than 240 information and education activities we undertook during 2007–2008 included:

- Running 80 workshops and training sessions — reaching over 1,600 providers, staff and consumers — including complaint-handling for frontline staff, protected disclosures, unreasonable complainant conduct, art of negotiation, responding to allegations against employees, dispelling the myths (for senior police managers) and Rights Stuff (for consumers of disability services).
- Conducting 161 presentations to agencies and community groups to increase awareness of our role and complaint-handling.
- Publishing several articles and stories in community sector publications about our work and specific projects — including sector specific overviews of our annual report.
- Participating in a range of conferences, community expos, cultural events, and international days for women and people with a disability.
- Producing several new resources — including guidelines for dealing with youth complaints, a community languages poster, complaints policy information kits, a fact sheet for juvenile justice workers and an 'Easy English' brochure for people with low literacy or an intellectual disability.
- Distributing information to over 1,000 sector workers and managers through conference satchel inserts and post conference mail-outs — as well as information to community and neighbourhood centres, councils, legal centres and libraries.

Visiting regional and remote communities

Over the past 12 months we have travelled to 68 regional and remote towns in NSW — to visit correctional centres and juvenile justice centres, conduct consultations for investigations and audits of agencies and services, and deliver presentations, training sessions and forums.

Our official community visitors also visited 120 regional and remote towns in NSW while visiting people in residential services.

A significant initiative this year was the introduction of our regional outreach program facilitated by the Deputy Ombudsman. This program was delivered in Wollongong, Tamworth, Dubbo, Coffs Harbour and Wagga Wagga.

Each forum consists of two sessions — one for workers in child and family services and another for those in disability and other community services. The Deputy Ombudsman provides a general overview of the role of our office and then outlines our specific work in the relevant community service sector. Time is allowed for questions from the floor and informal discussion about local issues.

The program is intended to provide information and resources to rural and regional workers in a direct and meaningful way, to encourage the community services sector in rural and regional areas to share their views, and to provide an opportunity for the Deputy Ombudsman to hear first hand the unique experiences and concerns of people living and working outside the metropolitan area.

Working cooperatively with other agencies

The impact of fines on vulnerable members of the community — such as young people, Aboriginal people and people with a disability — was a recurring theme that emerged during our audits of the NSWPF's implementation of their *Aboriginal Strategic Direction* (ASD). We also received feedback about this issue from our youth liaison officer (YLO) and from complaints and inquiries received by our office.

Last year we were alerted to research by the NSW Sentencing Council into the effectiveness of fines as a sentencing option. There was significant overlap between the council's research and a project we planned to undertake. Rather than pursue this project directly, we decided to contribute our own research to the work of the Sentencing Council.

Our submission to them addressed issues such as:

- the use of discretion by transit officers, police and revenue protection officers when dealing with the community — particularly vulnerable groups
- available alternatives for issuing officers — such as warnings, cautions and diversionary programs
- the adequacy of training for issuing officers about the use of discretion and dealing with vulnerable groups
- options for internal review of a fine by different agencies
- public scrutiny of issuing agencies
- the quality of information provided by issuing officers to recipients — such as the consequences of receiving the fine
- State Debt Recovery Office strategies for community education about the consequences of fines and how to negotiate the enforcement system
- corporate strategies to measure the effectiveness and adequacy of compliance with relevant procedures and diversionary options
- the need for policies to be consistent across agencies.

In February this year the Sentencing Council advised us that our submission 'concisely captures the key issues facing vulnerable groups.' They intend to refer to it extensively in their final report and plan to include our full submission as an appendix.

Aboriginal communities

This year, much of our work with Aboriginal communities has focused on addressing child protection issues. The need for agencies and the community to work together to address family violence and child protection is repeatedly raised during our consultations with Aboriginal community members and service providers across the state. Our work in this area is, as well as several of our other activities, aimed at improving service delivery to Aboriginal people.

Responding to child protection issues in western NSW

In response to a specific complaint made to us by a prominent member of a remote community in western NSW, we held discussions with DoCS about how they might improve their caseworker presence and service delivery in the region. We also sought specific advice from the NSW Police Force about their plans for responding to Aboriginal child sexual assault, and consulted with the Department of Aboriginal Affairs about their coordinating role for the *NSW Interagency Plan to tackle Aboriginal child sexual assault.*

From these discussions, we are aware that DoCS is considering particular strategies to both increase caseworker numbers to cover high-need areas and provide their staff with better infrastructure and support. We have asked DoCS to identify the communities likely to benefit most from this approach and the anticipated increase in the number of operational positions. We have also asked them to consider this planned increase in child protection case workers in the context of their other work in this region, such as out-of-home care, family support and early intervention services.

An increased child protection presence, without a corresponding strengthening of family support services, may result in a community backlash. Increased child protection intervention is also likely to require more out-of-home care options across the region. We await DoCS' response to our suggestions.

We were pleased to see the $22.9 million allocation in this year's state budget to combat child sexual abuse through the expansion of the 'Safe Families' program to the Orana Far West Region. We are hopeful that this announcement is linked to a broader response for dealing with serious child abuse and neglect issues in these areas.

Special Commission of Inquiry into Child Protection Services

In June this year, we outlined our views on child protection and neglect in Aboriginal communities in a submission to the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry).

Our submission noted that an obvious starting point in addressing Aboriginal child protection issues is to undertake a frank assessment of the needs of Aboriginal communities, find out whether those needs are being adequately addressed through either mainstream or Aboriginal specific services or programs, and look for opportunities to build on positive initiatives already in place. This means accurately determining the nature and extent of the need and evaluating which programs actually work.

An important first step is to consider whether essential services are available where and when they are needed. The delivery of policing, health, welfare, housing and other essential services in high-need areas can often be hampered by skill shortages and high staff turnover. In many cases, these can be successfully addressed by providing better incentives to attract and retain suitably qualified and experienced staff — especially in remote locations where vacancies can take time to fill. This is critical if agencies are to make improving Aboriginal access to mainstream services a priority.

A key challenge is making services more responsive to and accessible by local Aboriginal people. Meeting this challenge does not involve a 'one size fits all' approach in the design and delivery of services. Instead, service delivery needs to be tailored to suit the needs of particular communities. Enhancing services to Aboriginal communities should also involve establishing or extending the capacity of Aboriginal-specific or community-controlled organisations, and helping those bodies to collaborate with other agencies to deliver a coordinated suite of services.

Our submission to the Wood Inquiry highlighted the need to examine:

- the quality of current planning, implementation and accountability processes — including the alignment of these processes with state and federal objectives
- existing data collection practices and agency performance measures — including the need to provide more detailed information about results, rather than activities and outputs
- the type of partnerships that need to be built between agencies, Aboriginal services and communities to deliver a broad range of holistic services
- the complexity of current funding arrangements and whether there is sufficient flexibility to promote genuinely innovative local initiatives
- what kind of service models are required to respond to the complexity of need, particularly in high need communities
- workforce capacity and other requirements to make these models work, including an expansion of the Aboriginal workforce.

We also noted that progress reports from agencies need to present a realistic picture, not only of the successes but also the unmet challenges in individual communities.

Caring for Aboriginal children

In 2007, we undertook a detailed review of issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them to provide quality care. Our report, *Supporting the carers of Aboriginal children*, was based on interviews with over 100 Aboriginal and non-Aboriginal carers, Aboriginal out-of-home care service providers and health/education professionals.

Supports for carers

We found that carers emphasised the value of regular, quality contact with caseworkers. They also generally had realistic expectations of the ability of DoCS to help them provide quality care. We suggested that DoCS tries to ensure there is appropriate, regular and ongoing communication between caseworkers and carers. Good support to carers not only encourages their retention, but well-supported carers are an effective recruitment tool. We also suggested improving coordination of carers' training needs, strengthening and monitoring carer support initiatives, and ensuring a prompt and appropriate response to any complaints raised by carers.

Cultural support

If children have to be placed with carers with no kin connection, then care planning — especially cultural care planning — is crucial. We asked DoCS about the steps they are taking to develop, implement and monitor appropriate and consistent cultural support planning processes to foster cultural identity and connectiveness for Aboriginal children in out-of-home care.

Consultation processes

We also asked DoCS to develop, implement and monitor clear and consistent guidelines for how they consult with communities about placement decisions for Aboriginal children to ensure proper compliance with the Aboriginal Placement Principles.

Health

Good health screening and coordinated follow-up is critically important as poor health issues disproportionately affect children in out-of-home care. As Aboriginal children in care are particularly susceptible to certain health problems, we found significant benefits in DoCS establishing formal agreements with out-of-home care service providers and public health services to provide comprehensive health assessments for all Aboriginal children entering out-of-home care placements.

Education

Few of the carers we interviewed considered that caseworkers had an active interest in meeting the educational needs of children in care, except to help respond to particular incidents or crises that threaten the viability of a school placement. We suggested that urgent consideration be given to:

- individual education case planning
- strategies to bring carers, caseworkers and schools together to address any learning impediments or schooling problems
- collecting, analysing and reporting on the education participation and performance of all children in out-of-home care
- tracking performance over time to determine the effectiveness of strategies to enhance learning outcomes.

Data collection

Our review showed that DoCS needs to address critical deficiencies in their data on carers of Aboriginal children. For example, although DoCS could provide figures on the number of Aboriginal children in out-of-home care, they had no reliable data about the ratio of non-Aboriginal and Aboriginal carers of Aboriginal children.

The Wood Inquiry is examining a number of the issues that we canvassed in our report. We have asked DoCS to provide us with formal advice on how they intend to respond to our observations within two months of the Wood Inquiry findings. However, DoCS has already taken steps to address several of our recommendations. For full details of our report, see our website at www.ombo.nsw.gov.au.

Policing Aboriginal communities

In the early days of our Aboriginal Unit, much of the field work we conducted was reactive. This changed in late 2002 when we began our policing Aboriginal communities audit program. Since then, we have reported on police efforts to create and strengthen partnerships with local Aboriginal communities. Last year, we finalised our four year program of audits of 36 local area commands to assess the implementation of the NSW Police Force's *Aboriginal Strategic Direction 2003–2006.* We now intend to start a new audit program that will focus on police work to address child sexual assault and substance abuse in Aboriginal communities. Given the sensitive and complex nature of this work, our Aboriginal Unit has spent time visiting several communities this year to talk with community members about the impact of these issues and the type of strategies and supports currently in place. This information will help inform our audit strategy. For more details about our work in this area, see page 109 in Chapter 5: Policing.

The impact of criminal infringement notices

Since 1 November 2007, police across NSW have been able to issue on-the-spot fines or criminal infringement notices (CINs) to adults for certain minor offences such as offensive language, offensive conduct and some stealing related offences. CINs give police an additional way of dealing with a person suspected of committing any of these offences. Before the introduction of CINs, police either cautioned or warned the person about the offence, or they may have charged them. Anyone who is given a CIN can pay a fine and avoid going to court. If the fine is paid, the offence is not put on the person's criminal record. We reviewed a trial of the CINs scheme several years ago and found that it had been largely successful. It provided police with another option for dealing with minor criminal offences in a quick and simple way, without taking away the option of having a matter heard in court.

As our initial trial did not include areas with large Aboriginal populations, it was unclear how CINs might affect them. For instance, analyses of past data showed that Aboriginal people were up to 15 times more likely to be prosecuted for offensive language. On the one hand, CINs may help reduce the number of criminal prosecutions for offensive language. On the other, CINs could also lead to more people being fined — instead of just receiving a warning or caution. As it may be difficult for some Aboriginal people to pay a fine, this may result in further consequences — such as their driver's licence or vehicle registration being suspended or cancelled.

Parliament has again asked us to review the CINs scheme, this time focusing on its impact on Aboriginal communities. During our review, we plan to talk to a range of people and organisations to gain a better understanding of the impact of CINs — and fines generally — on Aboriginal people. We are keen to hear about people's experiences with the police who issue CINs and the State Debt Recovery Office — the organisation responsible for collecting fine payments.

Reviewing services for Aboriginal people with a disability

This year we commenced a review into the implementation of the Department of Ageing, Disability and Home Care's (DADHC) *Aboriginal Policy Framework* and *Aboriginal Consultation Strategy* which aims to help staff in their work with Aboriginal people and their communities.

So far, we have monitored the implementation of these key documents through regular meetings with peak Aboriginal bodies such as the Aboriginal Disability Network and the NSW Aboriginal Community Care Gathering Committee and, more recently, meetings with senior representatives from DADHC.

In August this year we commenced our program of reviews in each DADHC region to explore the adequacy of consultation mechanisms in place between DADHC, relevant service providers and Aboriginal communities at a local, regional and state level. We also want to find out if these mechanisms are providing Aboriginal people with better access to DADHC's services and to the services they fund.

Our region reviews involve holding consultations in selected locations within DADHC's six regions, including interviews with DADHC staff, local partners and service providers, consumers, carers and community groups.

Community outreach work

Our staff attend a range of regular liaison meetings with peak Aboriginal bodies, Aboriginal service providers and Aboriginal staff in key agency roles. We distribute our Aboriginal fact sheet and information packages at these meetings and when we visit communities for consultations. Our police audit program in particular has increased our profile and has led to regular requests for us to take part in conferences, community working party meetings, training sessions and workshops.

This year we participated in several NAIDOC Week events across Sydney and the North Coast and more than 2,400 members of Aboriginal and Torres Strait Islander communities were informed about our role. We also participated in 'Good Service Forums' at Broken Hill, Wilcannia and Lismore. These forums involve staff from a range of agencies — including the Office of Fair Trading, EWON and the Commonwealth Ombudsman — visiting selected Aboriginal communities to explain how to access services and make complaints.

Juvenile justice and correctional centres

We regularly visit juvenile justice and correctional centres in NSW. A representative from our Aboriginal Unit attends visits to those centres that have high numbers of Aboriginal detainees or inmates. This is to ensure that inmates have the opportunity to speak with another Aboriginal person about any concerns they may have associated with their detention. It also helps us to find out if their cultural needs are being addressed.

Mental health and housing support

This year we started an investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). JGoS is an interagency agreement to help people with mental health issues access and sustain social housing. The Aboriginal Housing Office and Aboriginal Health and Medical Research Council of NSW are signatories to the agreement, and Aboriginal housing providers and health services may become members of local JGoS committees.

In 2007, an independent evaluation of the JGoS found a low level of participation by Aboriginal organisations. During our extensive consultations across the state, we met with a number of Aboriginal housing and health providers to canvass their experiences and ideas about how to improve Aboriginal participation in the JGoS. Our final report will address how this section of the Aboriginal community can be better supported to maintain and/or access social housing.

Aboriginal cultural appreciation

This year our Aboriginal Unit developed and began implementing Aboriginal cultural appreciation training for all Ombudsman staff. The aim of the training is to help our staff learn more about Aboriginal culture and identity and develop strategies for communicating effectively with people from Aboriginal and Torres Strait Islander backgrounds. The training allows participants to:

- better identify Aboriginal and Torres Strait Islander people
- appreciate the impact of European colonisation on Aboriginal people
- identify and develop strategies for effective communication with people from an Aboriginal background
- develop skills required to work effectively with Aboriginal people
- appreciate the diversity of Aboriginal culture.

The training has been extremely well received by the 100 staff who have participated so far. It has been particularly beneficial for our frontline complaint-handling and research staff who come into frequent contact with Aboriginal people. We aim to have 80 per cent of our staff trained by the end of 2008.

Culturally and linguistically diverse communities

Newly emerging communities

This year we conducted preliminary research into government responses to newly emerging communities from countries such as Sudan, Iraq and Burma. We looked at the types of programs that are in place to assist newly settled migrants at a federal, state and local level.

One of the most significant documents we considered was the Community Relations Commission's (CRC) September 2006 report, *Investigation into African Humanitarian Settlement in NSW.* The CRC found a lack of communication and coordination between agencies, sometimes resulting in duplication of work. For example, there are often multiple meetings about the same issues without any formal ways to share information or create a consistent response. The report made 41 recommendations aimed at federal and state agencies. We are exploring how these recommendations are being implemented by relevant agencies and what sort of monitoring process is occurring in NSW.

Overall, it appears that the issues for humanitarian entrants are well known and there is recognition that a whole-of-government response is required. Of particular interest to us is whether individual agencies are responding in a planned, appropriate and coordinated way to address these issues. To assess this, we conducted some preliminary consultations with nine migrant resource centres across Sydney, Newcastle and the Illawarra and met with several multicultural interagency groups and health and youth multicultural services.

We also conducted presentations on the role of the Ombudsman to seniors groups at St George Migrant Resource Centre and to over 200 new arrivals who attend English classes at the Bankstown Adult Migrant English Services. These consultations allowed us to improve awareness of our office among culturally and linguistically diverse (CALD) communities as well as respond to individual complaints that arose during the meetings.

Information expos

During the year, we attended several information expos across Sydney including the Youth Harmony Day in Darling Harbour run by the Community Relations Commission and expos at Bankstown, Holroyd and Cabramatta. These events enabled us to distribute information to people from Arabic, Chinese, Korean, South East Asian, Middle Eastern, African and Spanish communities.

Multilingual brochures

Information about our office is available in 16 community languages. This year we contacted 1,851 community organisations, individuals and public libraries to promote our multilingual brochures and seek information and comments about community language needs. The response was overwhelming. As a result, we produced our brochure in ten more community languages — including some languages spoken by new and emerging communities. We have also been given opportunities to promote our services to CALD communities via a range of other media, including websites and radio programs.

Cross cultural training

This year we invited the Parramatta/Baulkham Hills/Holroyd Migrant Resource Centre to provide training to approximately 60 of our staff on cross cultural issues and skills for communicating effectively with CALD communities. The half day African communities session raised awareness of the various African cultures and the issues faced by the emerging African communities. The Middle Eastern communities session included a particular focus on relationships between young people and adults within these communities. Feedback from our staff was positive and the combination of presentations by community workers and personal experiences by new arrivals was particularly well received.

Young people

We recognise the importance of communicating with young people and their advocates to ensure their voices are heard and their opinions considered. Our staff, and particularly our youth liaison officer (YLO), engage with young people and youth workers using a range of community education and consultation methods. Through these contacts, we are able to identify common issues affecting young people and then use this information to inform our projects, submissions and investigations. For more details about our work in this area, see Chapter 3: Children and young people.

Consultations

This year our YLO has assisted with consultations in regional and metropolitan NSW to inform investigations and projects that involve young people and youth services. For example, as part of our investigation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS), the YLO conducted interviews with youth accommodation services and other non-government agencies. These contacts also provided the opportunity to explain our role and bring information back to our investigative staff about particular local issues. For more details about this investigation, see page 31 in 'Our organisation.'

The YLO also worked with our police division to ensure young people's experiences were taken into account as part of our review of the *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA). After discussing consultation methods with members of the Youth Justice Coalition, we approached young people attending Bidura Children's Court and asked a series of questions about their experiences of police searches following arrest. We also surveyed a number of young people who we met while accompanying youth workers in Cronulla, Marrickville and Riverwood during their regular outreach walks.

Young people 'at risk'

Many of our investigations into the reviewable deaths of children have revealed a lack of effective coordination between agencies and services coming into contact with young people reported to be at risk. Late last year our YLO visited youth services in the Kings Cross/Darlinghurst area to discuss issues affecting vulnerable young people at risk of homelessness and substance abuse. One of the key projects operating in the area involved a number of local services working together and sharing resources to improve the efficiency and effectiveness of the services they provided to these young people. A key feature of the model was that it involved close collaboration between local services and government agencies.

Our YLO began to conduct research into other interagency initiatives and collaborative service delivery models. We spoke to the coordinators of many programs in NSW and Victoria, as well as staff from key government agencies. We also attended and presented at several conferences addressing issues for young people 'at risk'.

Our research into collaborative service delivery models at a federal, state and local level formed the basis of our submission on young people at risk to the Wood Inquiry. The submission highlighted several programs that we consider particularly noteworthy. For more details about our submission, see page 64 in Chapter 3: Children and young people.

Young offenders and accommodation

This year our consultations with youth services, particularly juvenile justice community service officers across NSW, alerted us to the issue of young people being held in detention because suitable bail accommodation was not available.

There is a growing challenge for the Children's Court when making bail decisions for young people facing criminal charges who do not have stable accommodation. If a young person is homeless, the court may be forced to consider the welfare of the person and how he or she will be supported if they are released back into the community on bail. There seems to be a gap in accommodation for accused young people who don't have stable homes, especially as many of them are hard to place in youth refuges and other temporary accommodation because of their complex needs.

To find out more about this issue, we have started to identify relevant complaints to our office and are continuing to meet with relevant agencies. After the findings of the Wood Inquiry have been reported, we will start to plan our response.

Legal Aid and the police

In 2005, widespread concerns were raised by police and youth advocates about the quality of legal advice provided to young people in police custody. Young people were often being advised by solicitors not to make admissions, leaving police with few options other than to press charges. Although the Young Offenders Act allows police to take action other than charging a young person, the young person must first admit the offence. Following our involvement, the NSW Police Force (NSWPF) and Legal Aid took some steps to improve communication with each other, and this appeared to make a difference. However, we were subsequently advised that the problem had resurfaced again in certain locations.

After we requested information from the Aboriginal Legal Service (ALS), Legal Aid Hotline and NSWPF about this issue, it became apparent that high staff turnover, lack of resources, and lack of corporate level support were all contributing to the problem. Legal Aid are taking steps to improve the service provided by their Hotline, but the ALS is considering shutting down some of their services — including their telephone advice line — because of expected funding shortfalls. Unless the Legal Aid Hotline takes over this role, this would potentially further reduce the number of young offenders able to be diverted through the *Young Offenders Act 1997.* We are continuing to work with these agencies to ensure the principles of the Act are being followed.

Education and awareness

Our YLO regularly conducts education sessions with youth work students at TAFE colleges and legal studies students in Year 11 and 12 at school. These sessions are designed to increase the students' awareness of the role of the Ombudsman and the importance of young people speaking up when they have complaints.

People with a disability

We recognise how important it is for our office to be accessible to people with a disability and responsive to their needs and concerns. One way we demonstrated our commitment this year was to develop disability awareness training for all our staff. This training aims to develop a general awareness of disability and focuses on attitudinal and practical issues for people with a disability.

We make sure our information brochures are accessible to people with a disability by making them available in a number of accessible formats — including large print, Braille, discs with Braille labels, audiotapes and Compic symbols.

People in residential care

Many people in residential care are highly vulnerable because they rely on their service provider for all aspects of their needs. Our community engagement work, and the work of official community visitors, is critical to ensuring these people have access to our services and their concerns are addressed.

This year we started a review of the adequacy of DADHC's actions to identify and meet the needs and goals of 60 people who currently live in their nine large residential centres. For more details about this review, see page 92 in Chapter 4: People with a disability.

Youth Week 2008

This year, to help students learn more about the Ombudsman, we ran a Youth Week competition asking them to answer in 100 words or less the question, 'Why is it important for young people to have access to the NSW Ombudsman?' We received 57 entries from 15 schools across the state. The winning entrant was Gabrielle Yeomans from Stella Maris College, Manly who contributed the following:

youth *(noun)*

1 young person. 2 not always believed. 3 inexperienced. 4 easily misled by others. 5 unaware of their rights. 6 unequipped to deal with legal process and complaints. 7 vulnerable to those in authority.

ombudsman *(noun)*

1 government watchdog. 2 independent body. 3 unbiased. 4 educator. 5 listener. 6 assists youths, (and other persons) in the investigation of complaints against government bodies.

importance of access *(noun)*

1 fundamental right and opportunity to be heard. 2 solves issues in appropriate and structured forum. 3 may help others in similar positions. 4 identify problems within organisations and individuals. 5 satisfaction.

Women

In December 2007, we wrote to the Commissioner of Police to commend the progress made by the NSWPF domestic and family violence steering committee in implementing the recommendations of our 2006 report to Parliament, *Domestic violence: improving police practice*. For more details about our work in this area, see page 110 in Chapter 5: Policing.

This year, as part of a focus on child and family issues, we have delivered workshops on complaint-handling and advocacy to people who work in the area of domestic violence. So far we have presented to three groups of workers in Newcastle, Liverpool and Mt Druitt — with plans to deliver the workshop in other parts of the state. Workers who participated identified the need for effective advocacy and complaint-handling/management to ensure the best outcomes for their clients. We also give advice to workers about the best way to take up their concerns directly with agencies such as the NSWPF and DoCS, and how to advocate for systemic change. The workshop component on advocacy skills was particularly well received.

We frequently consult with women, and workers who provide services for women, as part of our project and investigative work. For example, this year we consulted a number of women's refuges as part of our investigation into the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). One outcome of these consultations is that we are regularly contacted by women's services we have visited — such as domestic violence court assistance schemes and women's refuges — to provide advice about issues affecting their clients.

To inform women about our services and to respond to individual complaints, we conduct presentations and attend relevant information days. This year we gave presentations on the role of the Ombudsman to the Assyrian, Middle Eastern, Turkish and Arabic Women's Groups at the Fairfield Immigrant Women's Health Service and spoke to 35 newly arrived women migrants and refugees from various African and South East Asian communities. We also attended the annual International Women's Day event at Hyde Park where we spoke to approximately 100 women about our work and their individual concerns.

Inquiries 2

We receive over 24,000 inquiries a year from members of the community contacting us to complain or inquire about a wide range of NSW public sector agencies. Providing access to information and assistance in relation to complaints and inquiries is the key function of our inquiries and resolution team.

Tips for making a complaint

Briefly explain your concerns in your own words. You should include enough information for us to assess your complaint and determine the most appropriate response.

When writing your complaint, consider:

- What happened? Where did it happen? When did it happen (time and date)? Who was involved?
- Were there any witnesses? (include details)
- What evidence is there to support your complaint?
- Is there any medical evidence? Are there photographs or documents that may be relevant?
- If police officers were involved, can you identify the officers?
- Have you complained to another agency or taken any other action (include details)?
- What action or outcome would you like to see as a result of your complaint?

Not all of these questions may be relevant. However, you should include all relevant information so we have a clear picture of the problem.

As soon as the phones are turned on at 9am each week day, a steady stream of calls arrive. A 'typical' call may come from a correctional centre inmate complaining about segregation, a resident complaining about council failing to act against a neighbour's noisy dogs, a person arrested over the weekend complaining about police treatment or a parent complaining about the removal of their children.

There are times when people call us to complain about an agency and we assess the agency's action as reasonable. In these cases, we assist the caller by explaining why this is the case. A sound explanation from an independent agency with reference to specific policies, procedures and the law can often satisfy a complainant.

Case study 4

A public housing tenant called us after the Department of Housing had issued her a notice of termination for outstanding rent. The department set a meeting time with the tenant to discuss resolving the arrears. The tenant had recently started a job, and believed she would risk losing it if she had to attend the meeting at the time set by the department. She spoke with her client service officer, but could not resolve the issue. We contacted the client service officer who agreed to meet with the tenant at an alternative time.

On other occasions, we provide advice to callers about the process they should follow to allow an agency the chance to address their problem. We also have specialist knowledge about a number of agencies and specialist staff who handle calls about the provision of community services, child protection allegations, policing and corrections. If we are unable to help a caller directly, we can draw on our extensive referral network to find the right person to deal with a problem or complaint.

However, when a caller has a problem that warrants action by our office, we do one of two things:

- We explain the need to make a formal complaint to us in writing, particularly if we need relevant documentary evidence or the complaint does not require urgent attention.
- We accept an oral complaint.

Many of the complaints we accept orally are from people who need help complaining. Generally these are community members who are more vulnerable than most — through homelessness, age, poverty, disability, incarceration or a combination of these factors. They often have a greater need than others in the community to contact and rely on public services.

Case study 5

A woman called to say that she had been stopped for a random breath test by police and they subsequently discovered her driver's licence was cancelled. The woman was unaware of this, but was fined for unlicensed driving. She needed her licence to drive her children to school and other activities. The woman contacted the Roads and Traffic Authority (RTA) and said she was advised that the problem had resulted from someone with the same licence number moving interstate and cancelling their NSW licence. The RTA was waiting for documentation from interstate before taking any action.

We recognised the immediate needs of the woman and contacted the RTA. The RTA confirmed that the problem had been generated interstate and the licence was immediately reinstated. The RTA also told the woman how to request a waiver of the fine.

In other cases, we may recognise an immediate need for action to address conduct that might cause unreasonable detriment or hardship to the caller. These matters often relate to housing, correctional centres, police and the fine enforcement system and are usually managed by large administrative organisations. Individual people and their specific problems may not always be properly dealt with by these organisations. Other people have problems with residential and other community service providers and we do what we can to help these people.

We pursue these matters like any complaint we act on — until we are satisfied the agency understands the problem and takes action to address it, or provides a reasonable explanation for their actions. We often receive inquiries about matters where the agency has already resolved the problem or given an alternative and satisfactory explanation for it. In these cases, we explain and/or confirm the agency's action. Hearing this information from an independent source often satisfies any remaining concerns people may have.

Systemic issues

This year a number of callers complained about the Registry of Births, Deaths and Marriages and their guaranteed timeframes for issuing certificates and providing other information to applicants. The complaints were that the registry was not meeting these timeframes and people paying for priority applications were actually receiving them later than the regular application timeframe. It also appeared that the registry did not inform all applicants about the delays. We contacted the registry about these concerns and they agreed to review their guarantee of service and ensure all applicants were adequately informed of delays.

We also received a number of complaints this year about councils dealing with tenants of properties that had overdue water charges. The law in NSW makes owners of properties responsible for the rates and charges that apply to their land. The owner recoups some of these charges through their lease with a tenant. However, we found some councils were dealing directly with tenants about water rates and charges — and restricting or cutting off their water supply because of outstanding payments. In our view, councils do not have the legal authority to make direct contact with tenants about water charges. We are also concerned that this contact may interfere with the civil legal relationship between owner and tenant. At the time of writing, we are awaiting a reply to our suggestion that this practice cease.

Case study 6

A correctional centre inmate complained that three months had lapsed since it had been recommended that his classification security level, and that of another inmate, be lowered. The recommendations, if approved, would allow the inmates to apply for access to leave to begin the process of reintegrating with the community. They spoke with staff at their centre about the delay in approval, but could not resolve the matter.

External leave opportunities are usually for short periods before release. A delay of three months is therefore a significant period of time. We decided to contact the centre to find out the status of the recommendations, and found the delay had been caused by miscommunication between staff members.

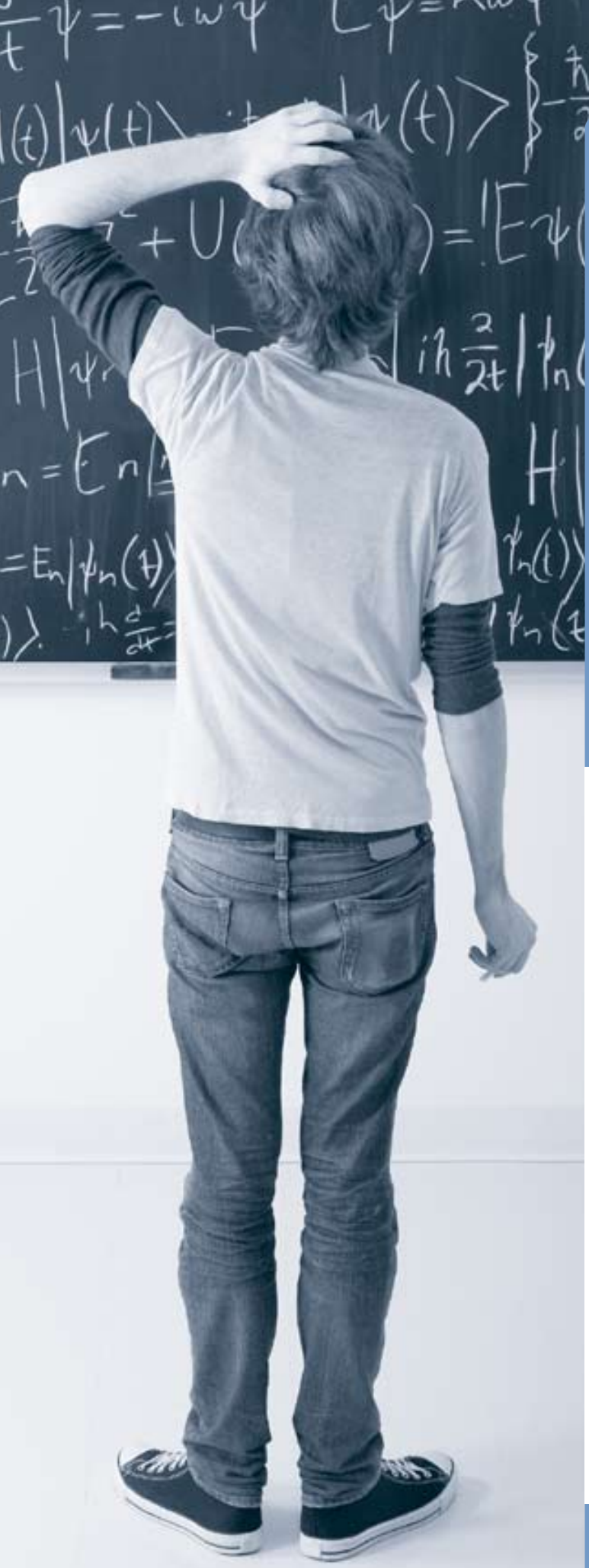
Following our inquiries, the recommendations were approved and the inmates were allowed to apply for external leave.

Case study 7

We took a telephone call from an officer of a council who had made a disclosure to the general manager about another officer's conduct which, if proven, was criminal in nature. The police were called in to investigate the matter and this led staff at the council, perhaps naturally, to be curious about who had blown the whistle. The circumstances surrounding the matter seemed to make it clear that the whistleblower had information only an 'insider' would know, and so they could easily be identified by others. The whistleblower was extremely distressed by the thought that her identity could be revealed.

We contacted the council immediately. The acting general manager agreed to issue an urgent instruction to all staff that no one was to take any action or seek further information about the matter.

This case illustrates the importance and need for swift and decisive action by senior management to appropriately manage what can be extremely difficult workplace situations after a protected disclosure has been made.



Children and young people 3

In previous annual reports we have reported on our work with children and young people in two separate chapters — community services and employment-related child protection. This year, we have dedicated a single chapter to children and young people to provide a stronger focus to this important area of our work.

Highlights

- Provided detailed submissions to the Wood Special Commission of Inquiry into Child Protection Services in NSW, outlining our views on a range of different topics such as assessment practices, privacy, interagency cooperation and children in out-of-home care.
- Reviewed the circumstances of children and young people in care, with a particular focus on Aboriginal children, children between 10 to 14 years and children under five.
- Finalised 15 child protection related investigations.
- Undertook a consultative process with stakeholders and worked with various child protection specialists to complete a thorough review of our guidelines for preventing and responding to reportable allegations, incorporating updated information on areas such as interviewing children, conduct causing psychological harm and grooming behaviour.
- Developed *Guidelines for dealing with youth complaints* to assist other organisations to make their complaint practices more accessible to young people.
- Tabled in Parliament our *Report of Reviewable Deaths in 2006 Volume 2: Child deaths*, including eight recommendations for systemic and procedural change.
- Presented over 40 education and awareness briefings or forums on child protection to 100 agencies, reaching more than 1,000 individuals.
- Assisted agencies with complex issues such as preserving evidence and investigating historical allegations of offences against children.

Our responsibilities for protecting children

Community services

The Ombudsman has broad ranging responsibilities in relation to children and young people and people with a disability under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and Part 3A of the *Ombudsman Act 1974*.

Under CS-CRAMA, we are required to:

- Review the deaths of certain children and people with a disability. This includes children, or siblings of children, who were reported to the Department of Community Services (DoCS) as being at risk of harm at some time in the three years before their death, children in statutory care and children living in disability accommodation services (Part 6).
- Review the situation of children and people with a disability in care (s.13).
- Handle complaints about the provision of community services (Part 4).
- Review the complaint-handling systems of community service providers and provide advice and training about making and handling complaints about community services (s.11 and s.14).
- Coordinate and oversee official community visitors who visit out-of-home care services for children and accommodation services for people with a disability (s.9).
- Monitor, review and inquire into the delivery of community services and make recommendations for improvements in service delivery (s.11).
- Promote the development of standards for the delivery of community services and provide education in relation to those standards (s.11).
- Promote access to advocacy supports for people receiving community services (s.11).

Our work under CS-CRAMA covers two main areas:

- Community services provided to children and young people and their families.
- Community services provided to people with disabilities and their families.

For services provided to children and young people, our jurisdiction includes DoCS and services licensed, funded or authorised by the Minister for Community Services.

For services for people with a disability, our jurisdiction includes the Department of Ageing, Disability and Home Care (DADHC) and services licensed, funded or authorised by the Minister for Disability Services. Our work in the disability area is discussed in Chapter 4: People with a disability.

Employment-related child protection

We are also responsible for overseeing investigations into allegations against employees of certain agencies. Part 3A of the Ombudsman Act requires or enables the Ombudsman to:

- Scrutinise the systems put in place by designated agencies and other public authorities for preventing reportable conduct by employees, and for handling and responding to allegations of reportable conduct or convictions by those agencies and authorities (s.25B).
- Receive and assess notifications concerning reportable allegations or convictions against an employee (s.25C).
- Monitor investigations of reportable allegations and convictions against employees (s.25E).

- Conduct investigations concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable notification or conviction (s.25G).
- Conduct audits and education and training activities to improve understanding of, and responses to, reportable allegations (s.25B).

All public authorities are subject to the requirements of Part 3A if the reportable conduct arises in the course of a person's employment. Some public authorities are designated agencies and also need to notify reportable allegations if they arise from conduct that takes place outside of employment, such as the Department of Education and Training (DET) and DoCS. Some non-government agencies are also subject to Part 3A requirements and must notify reportable allegations that arise both within and outside of employment.

Special Commission of Inquiry into Child Protection Services

Last year we contributed to a review by DoCS of the *Children and Young Persons (Care and Protection) Act 1998*. In that review, DoCS identified a number of challenges for the child protection and out-of-home care systems in NSW.

In November 2007, this review was suspended when the NSW Government established the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry) to undertake a wholesale review of the child protection system.

We have provided the Wood Inquiry with a substantial body of child protection related information from our child death review, investigative and inquiry work. In addition, we have made detailed submissions on the following child protection issues. For full details of our submissions to the Wood Inquiry, see our website at www.ombo.nsw.gov.au.

Mandatory reporting

In this submission we acknowledged the challenge presented by the massive numbers of child protection reports — approaching 300,000 annually. In NSW, the legislative threshold for determining when a risk of harm report should be made to DoCS is expressed as 'reasonable grounds to *suspect* that a child is at risk of harm'. We have suggested the commission consider supporting a legislative amendment requiring reasonable grounds to *believe*, rather than suspect, risk of harm. Also, to provide a greater focus on the degree of perceived risk, the legislation could be amended to refer to *substantial* risk of harm rather than just risk of harm.

The NSW Police Force (NSWPF) have consistently been the biggest reporting group by a substantial margin. NSWPF policy requires police to immediately notify DoCS when a child has been present at a domestic violence incident. Our submission notes that this requirement goes beyond legislative provisions for mandatory reporting and does not provide for professional judgement about whether a child is at risk. In this regard, we discuss the scope for a risk assessment tool that is currently being developed to assist police to make sound professional judgement about reports to DoCS, and potentially reduce the number of child protection reports that police make. A more detailed discussion of this issue can be found on page 73.

There is also a need to improve the level of feedback that DoCS provides to reporters. They are currently trialling electronic reporting with certain agencies, and we support exploring whether they could provide electronic feedback to key reporting agencies. DoCS have already indicated that they are keen to develop this capacity, but will need additional resources.

Our work has shown that chronic truancy is a particular risk factor for children. We have therefore suggested that there may be merit in amending the legislation to specify habitual non-attendance at school as specific grounds for reporting that a child is at risk of harm.

Assessment practices

In discussing DoCS' assessment of child protection reports, we highlight in this submission poor assessment practices identified through our work.

We also discuss weaknesses in assessment practices arising from current resource constraints. In this regard, we note that for a very large number of matters which are closed at various stages under the current risk assessment framework, the closure decision is not made on the basis of a determination that the matter warrants closure or that there is no ongoing risk, but rather on the basis of 'current competing priorities'. In our submission we argue that this issue presents one of the greatest challenges for NSW in achieving a strong child protection system.

Against this background, we have supported an initial trial of a structured decision making assessment tool which DoCS has suggested may assist in determining the relative risks of certain matters over others. However, we note evidence put to the commission indicating that an early evaluation of this tool in Queensland suggests that overall it did not promote consistency in decision-making.

To assist DoCS' assessment practices, we have also argued for a shift towards intelligence driven child protection practice. We refer to DoCS' own data which indicates that 11% of sibling groups generate close to 50% of the total reports received by the department.

We argue that in order to develop intelligence based practice, the department would need to provide its frontline staff with the capacity to run reports which identify families subject to multiple reports. A further prerequisite for the development of more intelligence based practice would involve providing frontline staff with the reporting tools that provide real time, consolidated child protection family history reports.

We also note that it is important to recognise that possessing the necessary information technology capacity represents only one component of developing intelligence driven practice.

Other components include:

- a sound intelligence policy framework
- structural and governance arrangements capable of driving DoCS' intelligence practices, particularly at the corporate and local Community Service Centre levels
- skilled staff at the corporate and local level dedicated to use and develop the department's intelligence practices.

Early intervention and prevention services

In our submission we acknowledged that — even if DoCS is able to strengthen their assessment practices and adopt sophisticated intelligence based practices — they will still not be able to meet demand. We therefore support the need to expand service capacity.

Our work has highlighted a number of cases in which families have been referred to Brighter Futures — DoCS' major early intervention and prevention program — but were rejected on the basis that their presenting risks were too serious. However when these cases were referred back to DoCS' child protection staff, they were closed on the basis of competing priorities.

Young people at risk

In our submission we also made a number of general observations about the challenge of meeting the needs of young people at risk. In particular, we referred to the need:

- to provide early intervention in the lives of vulnerable children to put them in a better position to navigate adolescence
- for an overarching policy position, and related practice, for young people at risk
- for adequate services for these young people in areas such as accommodation, mental health and substance abuse.

We support the trend towards a coordinated, multi-agency approach for responding to young people at risk and their families, and recognise the important role that schools can potentially play in identifying and supporting vulnerable young people.

For at risk young people in out-of-home care, additional supports may be needed for the children and their carers in the often difficult period leading up to and during adolescence.

For at risk young people before the Children's Court on criminal matters, we have supported giving the court the power to require a report from DoCS on the care and protection issues of these young people. We have also supported the need to strengthen the availability of accommodation options for young people accused of committing offences.

Child protection issues in Aboriginal communities

In our submission we discussed issues such as:

- Aboriginal children and young people in out-of-home care
- the practical application of the Aboriginal child placement principle
- cultural support case planning
- enhancing the capacity of Aboriginal organisations
- attracting and retaining suitable carers for Aboriginal children
- Aboriginal participation in care and protection decisions.

Aboriginal children make up over 30% of children in out-of-home care, so there is a need to:

- expand the Aboriginal out-of-home care sector
- strengthen the role of the Aboriginal Child, Family and Community Care State Secretariat (AbSec) as the peak body
- increase the number of Aboriginal carers
- promote cooperative arrangements between well established non-Aboriginal service providers, DoCS and AbSec to help build the capacity of the Aboriginal out-of-home care sector
- explore the development of flexible accommodation models, particularly models that may help to keep Aboriginal children close to their families and communities.

We also canvassed the 'building blocks' that we believe need to be in place for progress to be made in responding to child abuse and neglect within Aboriginal communities. These building blocks include:

- building partnerships with community to address child protection issues
- frameworks to guide planning and service delivery
- building an evidence base
- workforce development measures to enhance frontline capacity.

Children in out-of-home care

In our submission we:

- canvassed a number of issues relating to the delivery of out-of-home care services in general
- provided some broad observations about practice issues relating to DoCS' care placements
- summarised the key findings from specific out-of-home care reviews and inquiries conducted by the Ombudsman over the past five years
- discussed some of the key issues that need to be considered if there is to be a significant expansion in the non-government sector providing out-of-home care services
- commented on issues such as recruiting sufficient numbers of carers, better supporting children leaving care, and improving arrangements for children with a disability who are voluntarily placed in care.

Privacy and the exchange of information

This submission outlines problems associated with the current privacy laws that inhibit the effective exchange of information between agencies about child protection matters. We proposed a specific legislative solution that would enable the ready flow of information between agencies to promote the safety, welfare and wellbeing of children and young people.

Interagency cooperation

In this submission we argued that it is important to understand the different dimensions of interagency practice if we are to improve service delivery. Good interagency practice should operate on both case management and systemic levels.

Case management

Joint agency discussions are critical for individuals or families with complex needs to ensure a planned, coordinated and high quality agency response.

One of the major challenges is to identify those cases that require a jointly planned and coordinated response. If the net is cast too wide, significant resource problems may arise because of the potentially resource intensive nature of this kind of response.

Systemic

Agencies should continually review the strengths and weaknesses of local interagency practice to improve the way they work together.

Our submission mainly focused on local and regional interagency case management practices, but we also discussed some of the structural and governance arrangements required to drive interagency child protection work from both within and across agencies.

Children's Court

In this submission we made comments about:

- the need for greater use of alternative dispute resolution at the pre and post court stages
- concerns about contact orders
- the need to trial models that involve more meaningful participation by Aboriginal people in child protection matters, including genuine participation by Indigenous representatives in care and protection decisions
- the absence of systems for capturing accurate and reliable data about critical aspects of care proceedings and the impact this has on our capacity to make informed decisions about court related practices and outcomes
- the handling of significant care and protection issues involving juveniles appearing in the criminal jurisdiction of the Children's Court.

The role of oversight agencies

We made two submissions on this topic — one discussed our broad oversight role in the child protection field and the other responded to specific concerns raised by DoCS about aspects of our oversight.

A national child protection framework

In May 2008, the Federal Government released a discussion paper on establishing a national child protection framework. Our submission on this discussion paper is available on our website.

We strongly support the key child protection themes emphasised in the discussion paper. These include:

- a stronger prevention focus
- better collaboration between services
- improving responses for children in care and young people leaving care
- improving responses to Indigenous children
- attracting and retaining the right workforce
- improving child protection systems.

However, we have argued that the areas of education and disability should also be included within a national child protection framework.

Child protection investigations

In 2007–2008, we started 15 new child protection investigations (not including employment-related child protection investigations) about seven matters and finalised 10 investigations of seven matters. A number of matters involved the investigation of multiple service providers, so the number of investigations is greater than the number of matters. We also monitored the implementation of recommendations we have previously made to agencies as a result of our earlier investigations.

Our investigation work has continued to highlight the critical importance of effective liaison and communication — both between and within agencies which are part of the state's child protection system. In a number of cases, we identified communication failures within health services — including mental health and early childhood services — that contributed to inadequate assessments of risks to children. We also continued to see examples of health services making unfounded assumptions that DoCS would provide services to certain children who were at risk.

Some of our investigations have also identified concerns about the adequacy of responses to chronic neglect of children, including the failure to give certain matters sufficient priority. Through our work we have been able to assist agencies in improving their ability to respond to child protection issues. See case study 8 for an example.

Case study 8

This year we finalised an investigation into the conduct of DoCS and an area health service (AHS) in relation to a baby who died and an older sibling.

The baby died in the family home at the age of five weeks and police contacted DoCS to report concerns about neglect of the baby's sibling. There had been three previous reports made by the hospital where both the baby and the older sibling were born.

The first report had been made following the birth of the older sibling. Concerns were raised about the mother's lack of antenatal care and problems with her capacity to parent. The second report was made after the birth of the second child in response to the mother discharging herself and the child, against medical advice. A nurse midwife subsequently visited the family home and observed that the house was filthy and unhygienic. This led to a third report to DoCS on the basis of the nurse's concerns about the mother's capacity to care for both children.

The nurse midwife also referred the family to an early childhood service, noting that an urgent home visit was required and advising that the matter had been reported to DoCS.

An early childhood nurse visited the family 10 days after the referral. The condition of the house remained unchanged and the baby had severe nappy rash. In her record of the visit, she noted that the family was known to DoCS but there were no child protection concerns and closed the case. She made no arrangements to provide feedback to the midwife who had made the urgent referral. We were also concerned that the early childhood service had assessed that there was no risk of harm to the baby and assumed that DoCS would be following up on the matter.

The DoCS Helpline transferred the hospital reports about the new baby to a Community Services Centre (CSC) for further assessment, noting that assessment and support to the family was urgently needed.

We found that the CSC took no action to assess the risks to the children until after police told DoCS the baby had died. Caseworkers removed the baby's three year old sibling on the same day. Subsequent assessment showed the child had severe health and developmental problems.

In response to this and similar investigations, the AHS has comprehensively reviewed their child protection policy and procedures and provided training to their staff. There is now a new child protection service structure within the AHS that will improve the level of expertise and leadership at a senior level. These measures are designed to significantly improve their capacity to respond to child protection issues in the future.

DoCS also told us that they were acting to ensure that all staff at the CSC received training on the department's neglect policy.

Case study 9

A father complained that DoCS had improperly taken his children from their paternal grandmother's house and placed them with their mother.

The mother of the children had previously taken them to New Zealand to live, against their father's wishes. In response, the father took court action under the Hague Convention seeking the children's return to Australia. He was successful in obtaining a court order that required the children to be returned to Australia so the Australian Family Court could decide which parent they should live with and make other related orders about their lives.

The children's paternal grandmother went to New Zealand to chaperone them back to Australia. For the next few days, they lived with their father and grandmother at her home.

The mother arrived in Australia the day after the children. She immediately contacted DoCS, seeking assistance to have the children returned to her.

While the mother had been in New Zealand and the father in Australia, she had obtained a 'protection order' against him. When she returned to Australia, she had the order registered in NSW so that it operated like a NSW apprehended violence order. This happened on a Friday afternoon and had the effect of prohibiting the father from having contact with his children until such time as he could obtain family court orders permitting him to live with, or contact, them.

On the Saturday morning, police went to the grandmother's house to advise the father of the order. He agreed to stay with a friend until Monday, when he could start Family Court proceedings. The police believed the children were safe at their grandmother's house and that it would be unlawful to remove them.

Later that morning, DoCS workers forcibly took the children from their grandmother's house to their mother — even though the paperwork shows that the workers did not believe the children were at risk of harm living with their grandmother. DoCS then lost contact with the mother and children.

The father asked DoCS why they took the children and where they were, but DoCS did not know. He had the matter urgently listed at the Family Court. The judge was extremely concerned about DoCS' actions, particularly as the mother and children were missing. DoCS was unable to provide an adequate explanation for removing the children. The court made interim parenting orders, placed the children on the Airport Watch list, and made recovery orders allowing federal police to locate them.

When the father complained to us, we decided to investigate. We found that DoCS had made two separate errors. The first was believing that the mother had some kind of court direction from New Zealand that required the children to live with her, when she did not. The second error was the belief that such a court direction gave DoCS the legal authority to forcibly remove the children and return them to their mother. This was not the case. DoCS has no role to play in enforcing such court orders. They can only remove children if, as provided under s.43 of the *Children and Young People (Care and Protection) Act 1998*, there are identified serious and immediate risks of harm. DoCS also did not take into account the fact that the mother had previously taken her children to New Zealand without their father's consent.

In response to our recommendations, the Minister and DoCS have accepted the errors made and provided a formal apology to the father and grandmother. They also made an ex-gratia payment to cover the cost involved in restoring the children to their grandmother. DoCs also intend to use this matter as a case study for staff training.

This year we also investigated a matter that showed what can happen if child protection agencies are unclear about their specific statutory role and responsibilities in a situation involving family breakdown and possible family law proceedings (see case study 9).

Handling complaints and inquiries

As in previous years, the highest proportion of complaints we received this year involving children and young people were about child protection services. In 2007–2008, 51% of the formal complaints we received were about DoCS' child protection services and 40% about out-of-home care services provided or funded by DoCS (see figure 20).

For child protection services, the most common complaints were about the adequacy of DoCS' casework, in response to risk of harm reports about children and young people. These concerns primarily relate to DoCS' decisions about whether or not to intervene following a risk of harm report, and the adequacy of DoCS' investigation, assessment of, and decisions in response to allegations that a child or young person has been abused or neglected.

Other issues that were the subject of complaint included DoCS' handling of complaints about its activities and the professional conduct of staff.

For out-of-home care services, the most common complaints were about the adequacy of services' assessment, planning and provision of services relating to meeting the needs of children and young people in out-of-home care. Particular issues of this kind included the appropriateness of placements for children and young people; the supports provided to children in care and their carers; decisions to move children between care placements; and arrangements for contact between children in care and their families. Other issues that were the subject of complaint included the quality of 'customer' service provided by service staff, the responses of services to complaints about children in care, and payment of allowances and fees to foster parents to support children in care.

Case study 10 is an example of one complaint we resolved this year that shows how vital it is for foster carers to be given up-to-date and accurate information about the children they foster.

Sometimes, we are able to resolve complaints by acting as an independent mediator or by making inquiries directly with a service. Case studies 11 and 12 are examples of matters that were able to be dealt with to the satisfaction of both parties without the need for a formal investigation.

Figure 19 — Outcomes of formal complaints finalised in 2007–2008 about agencies providing child and family services

- Referred to agency concerned or other body for investigation (1) **0.2%**
- Direct investigation (10) **2.2%**
- Service improvement comments or suggestions to agency (13) **2.8%**
- Complaint outside jurisdiction (22) **4.8%**
- Complaint declined at outset (40) **8.7%**
- Complaint resolved after inquiries, including local resolution by the agency concerned (182) **39.5%**
- Complaint declined after inquiries (193) **41.9%**

Reviews of children and young people in care

Supporting carers of Aboriginal children

Last year we started a project to better understand issues affecting carers of Aboriginal children and the adequacy of the services and supports to help them provide quality care. We completed this project during 2007–2008. Our report, *Supporting the carers of Aboriginal children*, noted issues based on interviews with service providers and feedback from face-to-face surveys of 100 Aboriginal and non-Aboriginal carers of Aboriginal children in care.

As more than 30% of all children and young people living in out-of-home care in NSW are Aboriginal, many of the issues in our report are likely to apply to children in out-of-home care generally. In our report, we made detailed observations about key areas such as:

- supports for carers
- consultation processes around placement of Aboriginal children
- cultural support planning
- health and education
- data collection.

We gave our final report to DoCS in April this year. However, given that the Wood Inquiry is examining a number of the issues canvassed in our report, we recommended that DoCS provides us with their response for addressing these issues within two months of the Wood Inquiry reporting its findings.

For more details about this review, see page 49 in Chapter 1: Community engagement.

Case study 10

A woman complained that DoCS had made arrangements for her to care for her 14 year old nephew under a kinship placement without telling her about his sexualised behaviour. After he was placed with her, he allegedly sexually assaulted the woman's six year old daughter.

The woman was distraught and demanded answers from DoCS, which initially were not forthcoming. However, they did refer the matter for a JIRT investigation which found there was insufficient evidence to prosecute the boy. The woman sought DoCS' assistance for counselling for her daughter, but was informed that she was not traumatised and did not need this.

The boy was moved from his aunt. A short time later, she saw him with a group of unsupervised younger children at a local pool. She contacted our office as she was concerned her nephew still posed a risk to young children.

We made inquiries and found that the local CSC had not provided the information about the boy's behavioural traits to the aunt. They had also not developed a structured case plan or any real assistance for the boy.

As a result of our involvement, DoCS conducted a comprehensive assessment of the boy. They found he had a disability which, in part, led to his behavioural traits. Because of his age and behaviour, they considered he could not be placed in another foster home so DoCS placed him in a refuge and provided intense supervision and counselling.

DoCS also provided the complainant with counselling and support. Her nephew's behaviour has improved and they appear to be re-establishing their relationship.

Figure 20 — Number of formal and informal matters received in 2007–2008 about agencies providing child and family services — by agency category

As a formal or informal complaint may involve concerns about multiple community services program areas, there are more complaints by program area than the 501 formal and 983 informal matters received in 2007–2008.

Agency category	Formal	Informal	Total
DoCS			
Child protection services	412	737	1,149
Out-of-home care services	333	463	796
Children's services	7	10	17
Family support services	0	6	6
Adoption	3	6	9
Sub total	**755**	**1,222**	**1,977**
DADHC			
Out-of-home care services	0	5	5
Sub total	**0**	**5**	**5**
Other government agencies			
Child protection services	14	3	17
Out-of-home care services	0	1	1
Children's services	2	1	3
Family support services	0	0	0
Adoption	0	0	0
Sub total	**16**	**5**	**21**
Non-government funded or licensed services			
Child protection services	13	14	27
Out-of-home care services	39	28	67
Children's services	9	10	19
Family support services	7	1	8
Adoption	0	0	0
Sub total	**68**	**53**	**121**
Other (general inquiries)	0	54	54
Agency unknown	0	39	39
Sub total	**0**	**93**	**93**
Total	**839**	**1,378**	**2,217**

Case study 11

We received information that a 15 year old boy had been exited unreasonably from a Supported Accommodation Assistance Program (SAAP) funded refuge late in the afternoon with no referrals to other services.

During our inquiries, the refuge questioned whether we had jurisdiction over the complaint because the young man had been accommodated as a 'respite client' and they did not receive any government funding for providing such a service. They defined 'respite clients' as those who need a break from their family situations but can return home afterwards.

In this matter, the young man did not return to his family home and it did not appear that staff knew where he was going when he left.

We believed the process of exiting the young man had not been in line with the agency's own policies and procedures.

Following our involvement, the agency decided to review their policies and procedures for respite clients, their intake and exit procedures, and the documentation required during a client's stay.

We are monitoring the review and will assess the outcome.

Children and young people aged 10 to 14 years in out-of-home care

This year we started a review of 36 children and young people aged between 10 and 14 in out-of-home care. The children had orders made in 2005–2006, allocating all or some aspects of parental responsibility to the Minister for Community Services. Each review involves examining the child's DoCS or service file, as well as interviewing their DoCS caseworker, carer and any other relevant service providers.

Our aim is to identify the common issues and needs of these children, and whether or not current practice is meeting those needs. We are particularly interested in:

- the children's health and educational needs and whether these needs are being adequately identified and responded to
- whether the children, and their carers, are given the opportunity to participate in case planning and reviews
- service delivery to the children, particularly for those who have complex needs
- specific case work practice and management issues.

A report on the results of our review for each child will be provided to DoCS and other service providers. In 2008–2009, an overarching report will also be prepared which outlines systemic issues which come to light from this work.

Children under the age of five in out-of-home care

Last year we started a review of a group of 50 children under five years of age in out-of-home care. We completed this review during 2007–2008 and provided DoCS and industry bodies with a report detailing our observations.

We found that significant improvements had been made in systems and practice for children in this age group since our last review in 2002. We also found several areas that still needed to be improved, including the following:

- Insufficient attention was paid to children's health and developmental needs when they entered care.

- Adoption practice for children who enter the statutory care system was not effective.
- Placement reviews were not occurring consistently or regularly for all children, particularly for those in kinship care.
- Statutory requirements for providing information and documentation to carers were often not met.
- There was limited consultation between child protection and out-of-home care teams within DoCS and difficulties or delays in transferring cases.

As a result of our recommendations, DoCS is developing initiatives to improve policy and practice to support very young children in care. They will advise us on progress and results of this work during 2008–2009.

Case study 12

A young woman who was accessing an early intervention program alleged that staff threatened to make a risk of harm report to DoCS if she left her child with the child's father while she was away for ten days. She was very distressed by this and complained that her attempts to resolve the situation with the service were unsuccessful due to poor complaint-handling processes and poor communication.

The young woman also alleged that the service had contacted her counsellor without her consent. This she also found very distressing.

Since raising these issues with the service, the young woman felt that she could not return to access the support she needed. She was then notified that her file was closed due to the difficulty the service had contacting her.

In this case we felt that the best approach would be to try to repair the relationship between the complainant and the service. We facilitated a conciliation meeting and were able to resolve the issues to the complainant's satisfaction. The service made a commitment that the young woman could contact them again if she needed support in the future.

Young people in statutory care living in SAAP services

Last year we reported on our review 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 Supported Accommodation Assistance Program (SAAP). The review highlighted the need for DoCS to finalise their policy on young people living in SAAP services. In February, DoCS told us that they anticipated the finalisation of a protocol between the Department and the Youth Accommodation Association of NSW by July 2008.

Guidelines for dealing with youth complaints

Last year we developed guidelines for dealing with youth complaints and training for our staff to improve service delivery to young complainants. Following the success of these internal guidelines, we decided to develop a version for external agencies and services that have contact with young people. Several agencies — including the Children's Guardian, Commission for Children and Young People, the NSW Youth Advisory Council and the National Children's & Youth Law Centre (NCYLC) — encouraged us to develop these guidelines.

The guidelines have now been distributed to over 3,000 oversight bodies, government agencies and community services across the country. Their aim is to:

- enhance the abilities of agencies to effectively communicate with young people
- assist young people to feel a part of the complaint process
- improve the handling of youth complaints
- complement and strengthen agencies' existing complaint procedures.

The Director of the NCYLC stated *"This guide is a landmark publication — a clear and practical aid that should be required reading for any government or community agency that makes decisions that impact on children and young people. The office of the NSW Ombudsman is to be congratulated."*

After our initial distribution of the guidelines, we received another 2,000 requests for copies from juvenile justice officers, police, high schools, universities, TAFE colleges, health services, councils and DoCS Community Service Centres.

Our youth liaison officer (YLO) was also invited to Melbourne to train staff at the Public Transport Ombudsman (Victoria) on the guidelines. Our complaint officers can now refer agencies to these guidelines when we oversee their handling of youth complaints.

Reviewable deaths of children

The Ombudsman's statutory responsibilities include reviewing the deaths of certain children, including:

- 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.

The objective of our reviews is to identify any shortcomings in agencies' policies, systems and practices and make recommendations to prevent and reduce the risk of deaths in future. We scrutinise records and information from various government agencies, including the State Coroner and NSW Health, and non-government agencies that provide services to children.

An advisory committee contributes to our review function. In 2007–2008 the committee met twice. There is a list of committee members in Appendix M.

Our annual report

We table a report to Parliament each year about our work reviewing child deaths in the previous calendar year. In the past four years, we have reviewed the deaths of 496 children. In December 2007 we released our fourth report, *Report of Reviewable Deaths in 2006 Volume 2: Child deaths*, which is available on our website. It covers the circumstances of 123 children who died in 2006.

Most recently, we have focused on how the child protection system responds to risk factors we have consistently identified since 2003. These factors include parental substance abuse, parental mental health problems, domestic violence and neglect.

In many cases, we found that agencies identified children at risk and responded appropriately.

However we also found some cases where risk was either not identified or was identified but not reported to DoCS. We also have significant concerns about the number of reports that do not receive the recommended level of assessment and are closed by local DoCS offices because of competing priorities. Some of our reviews found inadequate risk assessment and a lack of effective liaison and information exchange between agencies. There was also sometimes a lack of effective discharge planning for babies born in hospital to substance-using mothers.

The deaths in 2007 that we reviewed

In 2007 we reviewed the deaths of 169 children. If we identify concerns in particular reviews, we report these to agencies or service providers. We may also initiate preliminary inquiries or, where appropriate, investigate the conduct of agencies. We took action in relation to 37 of the 169 deaths (22%), including seven matters that we investigated and five where we made preliminary inquiries. In 26 cases, we prepared reports for agencies about the issues we identified.

Deaths of children not known to DoCS

In 2007, we initiated a group review of children who died between 2003 and 2007 and who had no, or no recent, child protection history. By definition, most of the children whose deaths are reviewable each year will be children or siblings of children who were reported to DoCS at some time in the three years before their death. Each year, however, some children whose families are not known to the department die in suspicious circumstances or in circumstances of abuse or neglect.

Between 2003 and 2007, 48 children who were not known to DoCS died in these circumstances. Our aim is to find out the demographic profile of these children and their families and to address key questions — such as whether there are any notable differences in demographic profile and circumstances of death between the children not known to DoCS and those who were. This information could then help us identify and respond to risk.

We have engaged the National Centre for Classification in Health to conduct a literature review relating to fatal abuse and neglect, including the manner of death and associated risk factors. We will include the results of this work in our *Report of Reviewable Deaths in 2007*. This report will be tabled in Parliament and available publicly in early 2009.

Mandatory reporting of domestic violence incidents

According to DoCS, mandatory reporters were responsible for approximately three quarters of all child-at-risk reports made in 2006–2007. The single biggest reporting group is the NSW Police Force (NSWPF), with domestic violence the most frequently reported risk factor identified in these reports. The operation of the current mandatory reporting system is a key consideration for the Wood Inquiry.

NSWPF policy requires police to immediately notify DoCS when a child has been present at a domestic violence incident. This requirement goes beyond legislative provisions for mandatory reporting and does not provide for professional judgement about whether a child is at risk. At a public forum conducted by the Wood Inquiry, the NSWPF commented that this approach was designed to ensure no child 'missed out' and to remove subjectivity from reporting.

In the context of ever increasing numbers of child-at-risk reports being made, we have suggested the NSWPF needs to consider moving towards a system in which police use a standard risk assessment to decide if a mandatory report is warranted. This will require individual police officers to have a clear set of risk indicators and use a greater level of discretion.

There are a number of current initiatives that should help improve reporting — including joint work between DoCS and the NSWPF to improve the quality of information communicated between them, finalisation of a DoCS /NSWPF memorandum of understanding, and the use of a standardised Helpline 'intake' form for faxing risk of harm reports.

A cross agency reference group has also been set up to develop a shared risk assessment tool to guide agencies in responding to domestic violence incidents. This group includes members from the NSWPF, DoCS, NSW Health and the Attorney General's Department. We have held several meetings this year with a number of these agencies to discuss the tool and how police report domestic violence matters to DoCS.

Employment-related child protection

Our child protection division oversees investigations of allegations against employees that involve abusive behaviours towards children, and scrutinises the systems employers have in place to prevent child abuse in the work environment. Heads of government and some non-government agencies are required to notify us of 'reportable allegations' and convictions against persons they employ or engage within 30 days of becoming aware of them. Reportable allegations include alleged sexual offences, sexual misconduct, physical assault, ill-treatment, neglect, conduct causing psychological harm or misconduct that may involve reportable conduct against a child.

Figure 21 — Number of formal notifications received and finalised — five year comparison

	03/04	04/05	05/06	06/07	07/08
Received	1,620	1,815	1,786	1,995	1,850
Finalised	1,908	1,760	1,541	1,749	1,921

In 2007–2008, we received 1,850 notifications of reportable allegations and finalised 1,921. Notifications decreased by 7.3% on the previous year (see figure 21). The most significant decrease (30%) came from our largest notifier, the Department of Education and Training (DET). They attribute this decrease to the class or kind determination and to training initiatives for sector, regional and school heads, education students in NSW universities and casual employees via a new online training program. Our records confirm a significant drop in the notification of reportable allegations involving DET casual teachers. We commend the DET for these initiatives to prevent reportable conduct.

Children and the internet

We are currently undertaking a project, funded by the Department of Immigration and Citizenship, on the vulnerabilities of young people online — including grooming for sex offences, recruitment by violent extremist groups, and involvement in sites encouraging self harm and anorexia.

Assessing and managing risk

To help develop a tool that agencies can use to decide what action to take at the end of an investigation to minimise future risks, we have researched the risk assessment tools used in the forensic arena. Key distinctions with our work include the variability of workplace environments, the limited access of agencies to critical information about the personal background of employees, and the differing standards of proof. Any risk assessment model developed in the civil arena must address these distinctions. We plan to start an in-depth longitudinal study of risk factors in various work environments, with an initial focus on the distinctive pattern of grooming and sexual misconduct in the school environment.

Repeat offenders

We have started an analysis of our data holdings on repeat offending in the workplace. Of the 1,921 notifications finalised this year, 449 involved employees who had been the subject of at least one previous reportable allegation. Of these, 348 were within the previous two years. A comprehensive analysis of repeat offending variables over time — including nature of employment, allegation type, findings and risk management strategies used — will provide insight into best practice and further inform our risk management advice to agencies.

Receiving fewer notifications enabled us to increase our scrutiny of high risk notifications. This year we monitored 16% more of these notifications than the previous year. It has also enabled us to increase our project-based activity and develop best practice guidance for agencies in key areas. Our project work has included scoping the development of a risk assessment tool that will assist agencies to manage employees who have engaged in reportable conduct, analysing our data holdings on repeat offenders in the workplace, and exploring the vulnerabilities of young people online. Our oversight work has highlighted these as challenging areas confronting agencies in preventing and responding to reportable allegations.

We also completed a review of our child protection guidelines and incorporated updated information on areas such as interviewing children, conduct causing psychological harm to children and grooming behaviour. Additionally, we are organising a child protection symposium to be held in May 2009. The specific focus will be the response of employers to reportable allegations and we will bring together child protection experts, practitioners and investigators to share their experience and knowledge.

Inquiries and complaints

The majority of the 695 inquiry calls we received in 2007–2008 were from agencies with jurisdictional queries or requests for guidance with their investigations of reportable allegations. We also received a number of inquiries from people who were the subject of reportable allegations. Of these, the majority were resolved by providing information — although a number proceeded to informal inquiries following a complaint from the caller. Informal resolution avoids a lengthy investigation and provides a quick outcome for complainants. We also receive a small number of complaints each year, usually from employees against whom allegations have been made or families of alleged victims.

Although handling inquiries is a relatively small part of our work, case study 13 demonstrates the value of using informal techniques to resolve even complex and sensitive matters.

Figure 22 — Number of formal notifications received by agency — two year comparison

Agency	06/07	07/08
Department of Education and Training	819	628
Department of Community Services	469	575
Substitute residential care	255	195
Catholic systemic and independent schools	109	133
Department of Juvenile Justice	91	74
Independent schools	56	77
Child care centres	77	60
Department of Health	27	29
Councils	24	16
Family day care	13	17
Department of Ageing, Disability and Home Care	27	9
Other public authority — not local government	13	22
Department of Corrective Services	13	14
Department of Sport and Recreation	1	0
Other prescribed bodies	1	0
Agency outside our jurisdiction	0	1
Total	**1,995**	**1,850**

Case study 13

We received an inquiry from the partner of an adult Aboriginal male (the complainant) who alleged he had been sexually assaulted as a child by a priest, currently employed by a designated agency. We had been notified of this matter, but had not received the agency's investigation report. The agency had reportedly told the complainant the allegations could not be sustained because of insufficient evidence. The agency told the complainant that we had a role in monitoring the investigation and provided the contact details of our case officer. The partner called us because of the complainant's distress about the agency's finding and their poor communication with him during the investigation — including misinformation about police involvement. We accepted the oral complaint and the complainant eventually consented to our making further inquiries.

The complainant had not been adequately informed about the progress of the investigation, so we consulted with the agency about the information needs of alleged victims in these matters. We also criticised the agency's misinformation to the complainant about the involvement of the police. He had signed a statement he believed gave his consent for police to investigate, when in fact it waived this option. Further, when we received the agency's investigation report we assessed it as flawed. We believed a better quality investigation could have obtained sufficient evidence to sustain sexual abuse. We asked the agency to undertake further lines of inquiry that we had identified and report the results to us.

The complainant told us he had a criminal history and a drug and alcohol addiction, which he attributed to the alleged sexual abuse by the priest. Although he had been stable for some time, his distress over the initial investigation findings resulted in him abusing alcohol again and being imprisoned. He was reluctant to approach police about his allegations as he thought his history would diminish his credibility. Our Aboriginal Unit made contact with the complainant and arranged for a Joint Investigation Response Team (JIRT) officer to take a statement from him. We also liaised with the complainant's partner and drug and alcohol counsellor to support him when making his statement.

The agency conducted further inquiries and uncovered additional evidence that sustained the allegations. The complainant decided not to pursue criminal action because the sustained outcome provided him with the resolution he had been seeking. The agency, which had provided counselling and other support to the man throughout, continued to support him. He and his partner thanked us for our involvement indicating they could start to move on from the effects of the childhood abuse.

Case study 14

We were notified of the alleged neglect of supervision of a 12 year old child with disabilities that resulted in him absconding twice from his Department of Ageing, Disability and Home Care (DADHC) residential facility, giving rise to serious risks to the child. On the first occasion, the child's whereabouts were unknown for over an hour until he was returned to the facility by police. The child absconded again the same day and hitchhiked with a passing stranger. His whereabouts were unknown for two hours.

We were satisfied with DADHC's response to the reportable allegations, but considered it important to ensure that systemic concerns about the client assessment process and management of security within the centre were properly addressed. An independent investigator had appropriately identified the concerns and made recommendations to address them. However, DADHC had not advised us whether or not they would implement them. We suggested to DADHC that the investigator's recommendations were sound and should be adopted, and issued a formal request for information about how DADHC intended to address the systemic concerns. DADHC agreed to implement the investigator's recommendations and we monitored this. The strategies, now fully implemented, will improve the safety of children at the residential facility.

Case study 16

Allegations against a teacher of sexual misconduct towards a 16 year old female with intellectual and developmental vulnerabilities were sustained and notified to the CCYP under Category One. We assessed the investigation action as satisfactory. However, the teacher subsequently requested a review and the agency withdrew the CCYP notification. We did not support this, as in our view there was evidence the teacher had engaged in grooming behaviour with the girl and no new evidence had been presented to alter the original finding. We were concerned that information about the alleged sexual misconduct would not inform any future risk assessment if the teacher applied to work with children in other agencies. We asked the agency to provide the CCYP with all relevant information about the matter and discuss the appropriateness of the CCYP withdrawal. As a result, the CCYP reviewed the investigation documents and agreed with our view and the agency reinstated the CYCP notification. Since that time, three further allegations of a similar nature have been made against the teacher and he has been placed on alternative duties pending investigation.

Case study 15

Twelve reportable allegations, including physical assaults resulting in bruising and welting, were made over three years against a foster carer of a seven year old girl. None were notified to us when they arose. Despite the number of reports that were sustained, the girl and her brother remained in the placement because the agency assessed that she did not present as frightened. We wrote to the agency and expressed concern that they had not considered the child's or the carer's history, and had not provided us with information about risk management strategies to prevent further abuse of the children. The agency completed a risk assessment and an alternative placement was found for the girl. However, the agency considered there were no risks to her brother and he stayed in the placement. We obtained a copy of the boy's case plan and inquired about supports for him and the carer. We are currently following up the outcome of carer training and reassessment to ensure that any risks to the boy are managed.

Case study 17

A non-government school investigated allegations that a teacher used inappropriate language and made a sexually inappropriate comment to a student. They sustained the allegations as sexual misconduct and notified the teacher to the CCYP under Category One. We did not agree that the teacher's actions, although inappropriate, met the threshold of reportable conduct. We asked the agency to review their finding and CCYP notification. They amended their finding to 'not reportable conduct' and withdrew the teacher's CCYP notification.

Case study 18

A foster care agency sustained three allegations of neglect against a foster carer and notified him to the CCYP under Category One. Our assessment identified a deficient and flawed investigation, including a denial of procedural fairness to the carer. We asked the agency to undertake further inquires and provide us with additional information to support their findings. After receiving the further information, we still felt the findings were not supported by the evidence. We outlined our reasons and requested a review. The agency amended their three sustained findings to 'not sustained', 'false' and 'not reportable conduct' and arranged for the Category One CCYP notification to be amended to a Category Two.

Assessing notifications

We assess the adequacy of agency investigations of reportable allegations to make sure that:

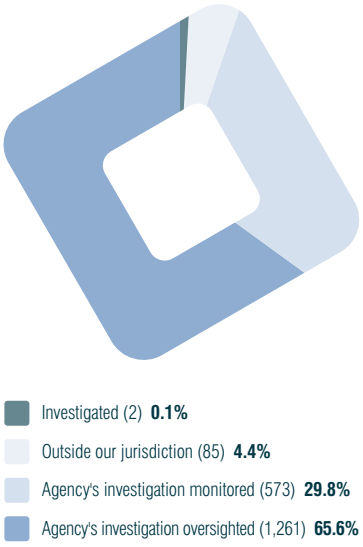
- risks to children have been appropriately addressed
- procedural fairness has been afforded to employees
- systemic concerns about agencies' child protection systems are identified and remedied.

Of the 1,921 notifications finalised during the year, 87% were finalised as satisfactory — 15% of these only after our significant intervention. In the 13% of matters finalised as unsatisfactory, we provided detailed feedback to inform future investigations by those agencies.

If it is in the public interest to remedy agency deficiencies, we may ask for further information, suggest additional lines of inquiry or request a review of the finding. If it appears that risks to children have not been addressed, or an employee has been denied procedural fairness, we will attempt to mitigate this. This reflects our balanced approach to child protection — ensuring employees are treated in a fair and just manner as well as minimising risks to children.

We also take further action if a notification highlights systemic issues that have not been adequately addressed by an agency (see case study 14).

Figure 23 — Action taken on formal child protection notifications finalised in 2007–2008



Addressing risks to children

Case studies 15 and 16 outline two different examples of addressing risks to children.

Ensuring procedural fairness for employees

Case studies 17 and 18 outline two different examples of ensuring procedural fairness for employees.

Monitoring agency investigations

One of our strategies for minimising deficient investigations by agencies is to use our s.25E monitoring powers under the Ombudsman Act. These enable us to have more direct input into an agency's investigation — from the initial planning and risk identification stage through to the completion of the matter.

The high volume of notifications means we are not able to scrutinise all investigations to this degree, so we focus our resources on the highest risk notifications.

The types of matters typically monitored from the outset involve alleged sexual offences (29%), sexual misconduct (28%) or serious physical assault (38%) of a child. Examples of investigations we monitored during the year are included in case studies 19 and 20.

Case study 19

A high school teacher had a sexual relationship with a 12 year old student over a three year period and was grooming other young students for sexual abuse. The investigation was lengthy and complex due to police involvement, the refusal of the teacher to cooperate with the investigation, and some reluctance by the alleged victim to be formally interviewed. The teacher was on alternative duties to mitigate risks to other students, but there was evidence he may have been grooming other children over the internet. To manage risk to children while ensuring procedural fairness to the employee, we worked closely with the agency to improve timeliness without compromising the quality of the investigation. Ultimately the agency sustained the allegations and placed the teacher on the list of people never to be employed in NSW government schools.

Case study 20

A foster carer sexually abused his 13 year old foster child daily for a year. The child made a clear disclosure after leaving the placement and JIRT investigated. We sought immediate advice about risks to another child who was still in the placement — and who had severe disabilities and a history of being sexually abused. A risk assessment was done and the child was removed. JIRT discontinued their investigation after the alleged victim withdrew her cooperation, but we monitored the investigation by the substitute residential care agency. This involved identifying additional avenues of inquiry and ongoing liaison. The allegations were sustained and the carer de-authorised. We were concerned that the carer's wife retained her authorisation, even though she lived with her husband who had been de-authorised. After making further inquiries of the agency, we were advised both carers would be de-authorised.

Investigating

We work with agencies to improve their investigative skills so they can conduct satisfactory investigations of reportable conduct. This means that we only occasionally directly investigate using formal powers. We generally use these powers to address systemic issues if our attempts to work with an agency have not brought about desired changes or it is in the public interest to do so.

This year, we finalised five direct investigations involving five separate agencies. These agencies complied with all the 37 recommendations we made. For example, significant improvements in child protection were achieved in two substitute residential care agencies we investigated. One had been providing care to children with disabilities and at the end of our investigation the head of the agency acknowledged they were not sufficiently qualified or equipped and withdrew their service to children. The head of the agency undertook to inform us immediately if they decide to provide services to children in future and, if they do, they will implement a number of strategies we identified to ensure risks to children would be minimised.

The other agency is one of our largest notifiers and has undergone rapid growth in a short period of time. Our investigation found that their systems had not kept pace with their growth and required significant overhaul. As a result of full compliance with our recommendations, the agency has revised their child protection policies, provided widespread child protection training to their staff, improved their compliance with employment screening and notification responsibilities, and raised the standard of their investigations into reportable allegations. All of these measures will improve the safety of children in the agency's care.

In another investigation completed this year, we made ten provisional recommendations for systemic change within a large designated agency. The agency is in the process of responding to our recommendations. We also started two other systemic investigations. One is focused on the probity checking systems of a large substitute residential care agency, and the other is investigating the specific and systemic issues arising out of an agency's handling of a reportable allegation. In this case, it was alleged the agency 'covered up' indecent assault allegations against an employee and failed to notify our office.

'I found the audit process most useful, for clarifying issues that clouded previous communications, and improving our policies which can only result in better care for the young people we serve.'

The CPD staff 'who conducted the audit did so in a most professional and non-threatening manner and we found their suggestions very useful. Thank you for the support your office gives us in this work.'

'With the Director… and relevant staff, I appreciate the time and care with which the [audit] report has been prepared and am pleased to receive the audit information. I welcome the opportunity the report provides to review process and practice to ensure that we maintain standards.'

Auditing

Section 25B of the Ombudsman Act requires us to scrutinise the systems agencies have in place for preventing and responding to reportable allegations. Auditing agencies is one way we do this.

We conducted 16 agency audits in 2007–2008, twice as many as last year. These audits fell into two categories — 'class or kind' and systemic audits.

Agencies with a class or kind determination with us have already demonstrated they have good systems in place for preventing and responding to certain kinds of reportable allegations. Our audits of these agencies therefore specifically focus on compliance with the determination.

- Our initial audit of the Department of Community Services' (DoCS) class or kind exemptions concluded they have sound systems in place for investigating exempted matters to a satisfactory standard. We considered excluding other conduct from notification, but were unable to progress this due to delays by DoCS in completing investigations of higher-risk allegations.
- Our audit of the Department of Education and Training (DET) concluded that exempted matters had been handled appropriately and there had been a marked improvement in the handling of 'local management' matters since we raised concerns about these in last year's report. As a result, we provided an extended class or kind determination to DET. This means that in future only allegations of serious reportable conduct will be notified to the Ombudsman.
- We also audited and extended the same class or kind determination to the eleven Catholic Dioceses in NSW as they have demonstrated good practice in preventing and responding to reportable allegations.

When auditing an agency's child protection systems, we review policies and other documents, interview stakeholders, inspect premises and visit a number of sites in large agencies. We specifically focus on agencies that care for highly vulnerable children (see case study 21) or respond to information suggesting the agency's systems could place children at risk (see case study 22).

The 'class or kind' and systemic audits include a thorough review process and a detailed report with findings and recommendations for improvement. Some agencies are initially apprehensive about being audited by the Ombudsman. However the process is consultative and feedback from agencies has confirmed that they see it as valuable.

Case study 21

We received information from DoCS about systemic child protection concerns in a remote independent boarding school for Aboriginal children. Numerous allegations of physical abuse and neglect had not been notified to us and there were concerns about the agency's understanding of their child protection responsibilities. We liaised with DoCS and our Aboriginal Unit to ensure we approached the head of agency in a culturally sensitive manner. We travelled to the school to meet employees and gauge their understanding of the reporting obligations and, as a result of this visit, decided to audit the agency.

We reviewed the agency's policies, which were outdated and contained no reference to the Ombudsman's jurisdiction. When we revisited the school, we interviewed the head of agency who had a good understanding of reporting responsibilities to DoCS and the police — but limited understanding of the role of the Ombudsman. We therefore took the opportunity during our site visit to provide a briefing on the Ombudsman's child protection jurisdiction and what this meant for the agency. This was well-received. The two visits to this remote school enabled us to provide information to the head of agency about the school's legislative obligations and establish a relationship that will help them comply with their reporting responsibilities in future.

Case study 22

We received concerning information from former employees of an agency providing substitute residential care to high-needs children. These concerns included inadequate supervision and safety practices within the agency and a culture that discouraged employees from reporting misconduct. We audited the agency and found they had no child protection policy or code of conduct and many of their existing policies contained incorrect, outdated or incomplete information. We reviewed relevant files at the agency's premises and identified poor records management as systemic. A significant concern was that we were unable to locate records of the Prohibited Employment Declarations and Working with Children Checks for most employees. Interviews with employees identified a lack of understanding about the agency's responsibilities under Part 3A of the Ombudsman Act. We asked for records of reportable allegations and were told the agency had never notified the Ombudsman, which we knew to be incorrect. We made a number of recommendations to the agency to improve their systems and will monitor their compliance with our recommendations.

During the audit, we were alerted to the poor standard of care being provided to a 14 year old male resident with multiple disabilities, including autistic tendencies. We interviewed employees and the child's family and were informed about inadequate supervision and safety practices, poor case management, and low standards of hygiene and medical care for the boy. We also identified a lack of induction, training and support for employees. We recommended the service immediately assess the safety issues at the home and implement strategies to mitigate risks to the boy and employees. We further recommended the service consult with DoCS about the boy's safety and care needs and the difficulties they were experiencing meeting them. We began inquiries into DoCS' case management and decision-making for the child. The child has since been placed in the care of another service and DADHC has become involved with his care.

Engaging with agencies

Education and information sharing are critical if we are to meet our objective of helping agencies to improve their systems for preventing child abuse. We work with agencies on a number of levels and this includes:

- hosting industry forums that bring together disparate agencies to discuss common practice issues and share information
- providing training or briefing sessions on child protection responsibilities and/or topical issues
- holding liaison meetings with the larger agencies in our jurisdiction to address systemic issues in a consultative manner
- holding case conferences with agencies we oversee and third party agencies such as the NSWPF, DoCS and the CCYP.

This year we presented over 40 education and awareness briefings or forums to more than 100 agencies across industry sectors, reaching more than 1,000 individual stakeholders.

In cooperation with NSW Health, we began a two year program for health services in NSW which included a combination of strategies to bring about major systemic improvement in work related child protection practices. This year, for example, we:

- Hosted two health forums, attended by eight separate area health services. At each forum we presented an analysis of reportable investigations from the health sector to encourage discussion about key issues. A guest speaker on 'Decision Making and Risk Assessment in Reportable Allegations' at the second forum was well-received.
- Used discussions at these forums to inform our planning for audits of area health services (AHSs) in NSW during 2008–2009. We did two audits this year (North Coast Area Health Service and South Eastern Sydney and Illawarra Area Health Service), and identified policy development areas and organisational changes that would enable an integration of general child protection issues and the management of reportable allegations. A further seven audits are scheduled.
- Conducted joint training with NSW Health's Employment Screening and Review Unit (ESRU) in all AHSs — with early signs suggesting increased competence in managing reportable allegations and convictions. The ESRU has played a key role in facilitating cooperation between the AHSs and our office and improving child protection systems within health facilities.

Agency liaison

We encourage agencies to meet with us to discuss policy issues and complex cases. Examples of the meetings we have held this year are outlined below:

- We had productive meetings with senior staff of the Department of Community Services to address our concerns about significant delays in finalising their investigations. In the last quarter, DoCS trebled their investigation finalisation rate of the previous quarter and provided other information that had been outstanding for some time. If this improved performance is maintained, we will consider extending our class or kind determination.
- We held meetings with the NSWPF about their investigation of historical sexual assault allegations against a casual teacher. The allegations had been notified to us by the teacher's employer, but they were unable to investigate pending the outcome of the criminal investigation. In the meantime, the teacher was not offered teaching duties because of the serious nature of the allegations. The time lapse since the alleged conduct, and the many vulnerabilities of the alleged victim, impacted on the progress of the police investigation. The agency had concerns about their inability to progress employment-related decisions and we discussed these with the police. Our police division also became involved to help ensure the criminal investigation was progressed and to minimise

procedural fairness concerns for the teacher. At the end of the police investigation, we guided the agency to obtain police documentation via a freedom of information request and this expedited their own investigation. This was a positive outcome for all parties involved.

- Over the year we contacted those NSW public authorities with whom we have had limited contact to gauge their awareness of child protection reporting responsibilities. Initial responses indicated a number of public authorities, some with significant contact with children, had inadequate understanding of reportable allegations and the requirement to report them to the Ombudsman. This is mainly due to the attrition of key staff with whom we engaged early in our jurisdiction. We have started addressing this through policy reviews and planned agency visits and audits. We have given detailed feedback to a number of key public authorities on aspects of their child protection policies that need amending or updating. We will also host the first of our new biannual public authorities forums in the last half of 2008.

Case conferences

A large number of the investigations we monitor are highly complex and we will often organise case conferences with agencies to guide them through difficult processes. This is generally at the agency's request or because we have identified that they would benefit from such a conference. The following are some examples of case conferences held this year:

- An agency notified us of serious historical sexual assault allegations that had been investigated by an independent investigator. We assessed the investigation report as seriously flawed. We met with the agency and outlined a number of concerns, suggested further inquiries, and provided advice on how to avoid similar problems in future. The agency acted on the advice and undertook to consult with us early in the course of future complex investigations. Soon after, the agency asked for a case conference to help them plan their investigation of historical sexual assault allegations against another employee. We met and talked through the relevant issues with the agency and the assigned investigator, agreed on the appropriate course of action, and continued to liaise closely throughout the investigation. Following further inquiries about the first matter, we suggested the agency conduct an audit of specified archived files. They were initially reluctant to do this, but agreed after further discussion. During the audit, the agency identified another sexual assault allegation that had not been investigated and notified it to us. We are currently monitoring their progress.
- An agency asked for a case conference about a complex investigation of historical child sexual assault and grooming allegations against one of their employees. It involved numerous alleged victims and conduct alleged to have occurred over a five year period in the 1990's. The agency had obtained overwhelming evidence of grooming behaviour, and sufficient evidence to sustain the indecent assault allegations. An independent investigator had recommended findings to this effect, which would have significant consequences for the employee. The agency wanted to make sure they had been procedurally fair to the employee before they finalised the investigation. We met with the agency and discussed their concerns about the employee's response to the preliminary findings. We also provided guidance to ensure the employee was given a fair opportunity to respond to the allegations and that concerns raised by the employee were given due consideration. The agency formally wrote to thank us for the case conference and the 'valuable advice [we] offered' which enabled the agency to finalise their investigation.

Figure 24 — What the notifications were about — breakdown of notifications received, by allegation

Figure 25 — Who the notifications were about — breakdown of notifications received, by sex of the alleged offender

Issue	Female	Male	Unknown	Total
Physical assault	573	482	36	1,091
Sexual offences	31	128	8	167
Neglect	126	49	8	183
Sexual misconduct	23	98	4	125
Behaviour causing psychological harm	47	29	3	79
Outside our jurisdiction	21	53	8	82
Misconduct — that may involve reportable conduct	19	56	1	76
Ill-treatment	31	13	0	44
Other matters	0	2	1	3
Total notifications received	**871**	**910**	**69**	**1,850**

Case study 23

We were notified that a male youth worker at a substitute residential care agency had allegedly formed an inappropriate relationship with a young male client. The child had a history of sexualised behaviour and was considered vulnerable to abuse. The agency made a preliminary finding that the allegation was false, based largely on the child's denial that anything untoward had occurred. We consulted the agency about our view that there was evidence the employee had engaged in a pattern of conduct consistent with grooming the boy — including daily mobile phone contact with him, giving him personal information, offering him accommodation, inviting him to his home and socialising with him. These acts constituted breaches of the agency's code of conduct and were corroborated by a number of witnesses. The agency undertook to review their finding, and soon after police informed the agency that they had charged the employee with aggravated sexual assault of the child. The grooming behaviours of the employee — that had not been identified and addressed by the agency — had escalated to sexual abuse.

Case study 24

We were notified of allegations that a trainee teacher had formed an inappropriate relationship with a 10 year old boy he met through his casual employment. The teacher's conduct included favouring the boy, visiting his home, inviting the boy to his own home, asking the boy's mother to leave him in his care, persisting with this request when the mother refused, and writing an intimate letter to the boy. The letter included personal information about the teacher, encouraged the boy to remain in contact with him, provided his email address and invited the child to his home. The boy's mother gave evidence her son had frequently asked that the teacher be invited to their house and that the teacher had taken a lot of photos of the boy. The boy had cried when he learned he would not see the teacher anymore, demonstrating an apparent emotional attachment that concerned his mother. The agency noted the teacher had admitted and explained the conduct and concluded the behaviour was the result of naivety. We did not agree and advised the agency we considered there was some evidence the teacher had been grooming the boy. The agency did take steps to ensure the teacher was not employed at the child's school and counselled him about appropriate conduct with students. However they took no further action and did not make a CCYP notification. Four months later, the teacher was arrested and charged with child pornography offences including production, dissemination and possession. The teacher pleaded guilty and will be prohibited from working with children. It was fortunate the mother of the boy in this matter had been alert to grooming behaviour, exercised protective strategies and reported her concerns.

Trends and patterns

Our analysis of trends, identification of systemic issues in the workplace and research into emerging issues enables us to keep ourselves and agencies well informed about practice issues (see figure 24 and 25).

Update on grooming behaviour

Our last six annual reports have provided progressive updates on our study of grooming behaviour in the workplace. Grooming allegations remain little understood by some agencies and poorly investigated by others. Some agencies readily identify grooming behaviours and take appropriate action when allegations are made. Others treat conduct that is consistent with grooming as misconduct if there is no direct evidence that the conduct was aimed at sexually abusing children. This has implications for the NSW workplace child protection system as misconduct that is deemed 'not reportable' is not notifiable to the Commission for Children and Young People (CCYP).

Although the definition of grooming behaviour in our guidelines and the CCYP's includes conduct 'aimed at engaging … a child as a precursor to sexual abuse', there is no requirement that such an intention be 'proved'. Grooming is an escalating process. Our objective is to improve the ability of agencies to identify grooming conduct early and interrupt the process before there is 'proof' of an intention to sexually abuse a child.

If there is some evidence of conduct consistent with a pattern of grooming behaviour, agencies should be implementing risk management strategies to prevent the conduct from continuing and escalating (see case studies 23 and 24). We are conveying this message to agencies through our forums and briefings, as well as on a case by case basis.

Psychological harm

Grooming can take place in the absence of a consciously formed intention on the part of the perpetrator to sexually abuse a child. Many perpetrators of grooming are situational offenders. Although aware their conduct breaches child protection policies and codes of conduct, they may not have formed a conscious understanding of their motives or the impact of their behaviour. This does not lessen the risk of sexual abuse of a child, nor the harm suffered by the victims of grooming.

Notifications to us increasingly reflect that conduct consistent with grooming behaviour can cause serious psychological harm to a child, whether or not the grooming escalates to a sexual offence. A common component of the grooming process is isolation of an already vulnerable child from their family and social network — often to the extent that the child relies exclusively on the groomer for emotional and other support. The child is led to believe a special relationship exists with the groomer, and the child's trust and affection is garnered. This 'special relationship' becomes meaningful to the child and can inform their sense of self. The process also often involves treating the child like an adult, including confiding personal information and discussing inappropriate topics. These factors of isolation, dependence and distorted boundaries combine to make the child highly vulnerable not only to sexual abuse but to psychological harm, particularly when the perpetrator's 'affection' is withdrawn (see case study 25).

Case study 25

Allegations of sexual misconduct (grooming) were sustained in relation to a female teacher found to have formed an inappropriate relationship with a vulnerable male student. The teacher entered into a sexual relationship with the student when he turned eighteen, which was not a sexual offence. However, the agency clearly established the teacher had groomed the student for the sexual relationship in the year before his eighteenth birthday. The boy had formed a close and dependent relationship with the teacher during the grooming process. This included the teacher spending time alone with him at school, frequently contacting him by telephone, socialising with him outside of school, and being his confidante during difficulties with his family. The teacher was aware the boy was suicidal and did not seek appropriate support for him. When the teacher ended the sexual relationship and withdrew her support, the student was particularly vulnerable to psychological harm and manifested his hurt and confusion through violence aimed at the teacher. His subsequent actions resulted in an apprehended violence order (AVO) against him. The boy breached the AVO and is now in gaol as a result of further threatening the teacher. The teacher is no longer working with children and will be risk assessed if she applies for child-related employment in NSW in the future. However the victim in this matter has suffered psychological harm, obtained a criminal record, and spent a portion of his early adulthood in prison — all causally linked to the abuse of the teacher who had groomed him as a vulnerable child.

Preserving evidence

Securing the integrity of evidence can pose difficulties for agencies if reportable conduct is alleged to have occurred outside the work environment. Employers have little control over the evidence in these circumstances, but need to try to minimise risks to the evidence if possible. This is particularly difficult when employers are faced with reportable allegations involving the use of technology and conduct that may be the subject of a criminal investigation.

For example, an independent school received information one of their teachers was accessing child pornography on his school-issued laptop. The school seized the teacher's laptop for forensic testing and confronted the teacher. The teacher reportedly admitted he had accessed child pornography on his personal laptop, but denied he had done so on his school computer. In response to the reported admission, the agency suspended the teacher and asked him to leave the school premises. Only then did the school contact the police and our office.

Case study 26

In 2005, the DET's employee performance and conduct unit (EPaC) became aware a teacher had engaged in a sexual relationship with a 17 year old student in the 1980's. The conduct was investigated at the time and the teacher was charged with breaching the *Teaching Service Act 1980*, cautioned and reprimanded. His assurance that his conduct would not occur again resulted in his continuing employment as a teacher. EPaC reviewed the investigation and although they had concerns about the department's action earlier, were not able to intervene any further. In 2007 the DET notified us that the teacher was allegedly in a sexual relationship with an 18 year old woman that had started when she was his 17 year old student. Notwithstanding the earlier incident, the teacher was assessed as a low risk to students and continued teaching based on an apparent absence of concerning conduct in the intervening years.

We contacted the DET to discuss our concerns with this decision. The DET then obtained strong evidence that the teacher had groomed the student and sexually assaulted her before she turned 18. They informed the police and placed the teacher on alternative duties. Soon after, the teacher was charged with sexual assault, special care and was dismissed from teaching. (Section 73 of the *Crimes Act 1900* renders sexual intercourse with a person who is under his or her special care and who is of or above the age of 16 years and under the age of 17 years a sexual offence. A 'special care' relationship includes that between a teacher and a pupil). It was only after the teacher's dismissal that DET became aware of other unreported conduct that was alleged to have occurred from the 1980's–2007 and had not been adequately risk assessed at the time. This included the teacher allegedly intimidating, stalking and indecently assaulting female students, accessing pornography on a work computer, and making sexually inappropriate comments about females. One of the alleged victims continues to suffer psychological trauma including self blame as a result of the alleged abuse, and has been unable to continue her studies. She is fearful that the teacher will continue to stalk and intimidate her, despite an apprehended violence order.

When police executed a search warrant on the teacher's home, a flatmate informed them the teacher had left home with his laptop. The teacher refused to surrender the laptop and it was never located. Potential evidence of the teacher's conduct — or connections to other people who may have accessed, possessed or distributed child pornography — was lost. This matter highlights the importance of careful planning, alerting the appropriate authorities to criminal allegations before taking any investigative action, and assessing risks beyond those in the immediate workplace environment. We obtained copies of the school's child protection policies and guidelines for responding to reportable allegations and provided guidance on improving these documents and future practice.

Assisting agencies to keep their policies and procedures in line with advancing technology has been a key focus of our work over the past few years. Technology plays an increasingly significant role in many of the more serious reportable allegations agencies are asked to investigate. The updated guidelines we are issuing later this year will include supplementary material to help agencies respond to such matters. Meanwhile, we continue to advise agencies to contact the police immediately if there is reason to believe that a criminal offence has taken place, and be guided by the police to preserve evidence and the integrity of any criminal investigation.

Investigating historical allegations

Ten percent of notifications closed this year involved historical allegations — that is, allegations against current employees involving conduct that allegedly occurred more than 12 months before being reported. Of those, 26% involved conduct that allegedly occurred more than ten years before notification — and 88% of these involved alleged sexual offences.

Investigating historical allegations against current employees is difficult. Often agencies are required to investigate conduct that allegedly occurred before the person was an employee, and often in a home or different work environment some years before. However, the real risk the employee may pose to children currently under their authority supports Parliament's stated legislative intention that historical allegations must be notified to us and investigated.

Most employers respond appropriately to historical allegations. Good practice has been increasingly demonstrated by many non-government organisations, which typically have scope to take decisive action to minimise risks to both children and the employee. Most agencies exhaust all avenues of investigative inquiry before drawing conclusions. Some employers are less rigorous in their responses to historic allegations against employees if there have been no other allegations made against them. Our data analysis and experience in these situations confirms that the simplistic and subjective risk assessment undertaken by some agencies has two major flaws. An absence of allegations or complaints against an employee cannot be equated to an absence of inappropriate and concerning conduct. Nor does an actual absence of concerning conduct over a period of years automatically reflect a low risk of re-offending. Case study 26 provides an example of this.

We recognise that differing legislative frameworks and other pressures affect the way agencies can risk manage these kinds of matters. However, there is a need for an appropriate response to ensure that children are protected when historical allegations are made. We will continue to monitor such matters.