



NSW Ombudsman

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Annual Report
2005–06

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25 October 2006

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

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

Dear Madam President and Mr Speaker

I am pleased to present our 31st annual report to the NSW Parliament.

This report contains an account of our work for the twelve months ending 30 June 2006 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*, *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 2006).

Yours sincerely



Bruce Barbour
Ombudsman

*This report is dedicated to the memory of our
colleague and good friend, Gaye Josephine.*

2 March 1947 – 11 July 2006

Ombudsman's message



This has once again been an active and productive year.

Increasingly, vulnerable members of our community rely on a safety-net of human services provided by a range of unrelated organisations. In my view, it is vital to have a strong watchdog that can comprehensively examine all the ways those services are delivered. We satisfy this need. We keep accountable the various groups and bodies — some governmental, some not — that provide these services.

Our broad jurisdiction and numerous functions require us to undertake a range of different, yet related, activities. We resolve complaints direct from the public and notifications from agencies, and systematically review the way some people have died. We keep under scrutiny the operation of new laws and teach organisations how to handle and learn from complaints about their work. We act as a go-between — an honest broker — to resolve previously intractable conflicts between citizens and agencies.

Like any effective watchdog agency, some of our activities draw criticism. This is the nature of our work. Our wide-ranging powers and jurisdiction have been of concern to some who believe it is better to have specialised watchdogs focused on individual agencies (for example, the police) or on groups of agencies providing similar services (for example, community services). But it is this very characteristic that gives us the unique capacity to identify issues of systemic failure that involve more than one agency, and find ways to fix those problems. Our ability to see the whole picture — to garner information from a range of sources and influence a range of players — is invaluable in producing success where there was failure.

Some of the projects we have been working on this year have focused on improving communication and cooperation between agencies. They include examining the joint police and DoCS response to women and children at risk of domestic violence, scrutinising interagency initiatives for dealing with issues such as youth crime and the needs of people with an intellectual disability who come into contact with the criminal justice system, and investigating how well NSW Health and other agencies work together to meet the medical needs of people with a disability living in residential care.

Our work is for the benefit of all who live in this State, not only the most vulnerable. Some of our most important work is aimed at preserving and promoting overall integrity in government. We scrutinise the way the public sector handles freedom of information applications and complaints about their work, from both the public and their own staff.

We aim to identify problems before they become a source of complaint. This means that we work to reduce the amount of reactive complaint work we do. The last five years has seen a steady increase in our formal complaint numbers, and this year they have exceeded 10,000 for the second year in a row. We have had no choice but to find ways to lessen the time we spend on less serious complaints and those where our capacity to help is limited. One of the projects we commenced this year focuses on developing strategies to reduce the resources we use in dealing with complainants behaving unreasonably.

As a final note, I would like to thank my staff for their enduring commitment, perseverance and hard work, and applaud their ability to pull together in times of professional and personal crisis. Sadly, this year we were faced with just such a crisis, with the sudden death of a good friend and colleague, Gaye Josephine, and I dedicate this report to her.

A handwritten signature in black ink that reads "B. Barbour". The signature is written in a cursive, flowing style.

Bruce Barbour
Ombudsman

Performance statement

Statement of corporate purpose

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
- the protection of rights
- the provision of quality services.

Our purpose

- 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.

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 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.

Goals

Purpose 1

- 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.

Purpose 2

- 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.

Purpose 3

- 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.

Purpose 4

- 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.

Outcomes in 2005–06

- Helped agencies remedy deficiencies by overseeing the quality of over 5,400 investigations, auditing 8,000 police records, and inspecting the records of 332 controlled operations.
- Directly investigated 66 matters and tabled 4 special reports to Parliament, making wide reaching recommendations to agencies, most of which have been accepted.
- Presented over 230 presentations and training sessions to more than 4,000 people.
- Our work led to improvements being made in areas such as the quality of land valuations, the relationship between police and Aboriginal communities, systems for the care and protection of children and people with a disability, and systems within correctional centres and juvenile justice centres.
- Revised our *Good Conduct and Administrative Practice Guidelines* and developed a range of other fact and information sheets on public administration.

- In almost 1,500 formal complaints we handled about the public sector, the agency concerned took action including changing their decision, making an apology, or admitting and correcting errors.
- Coordinated over 2,500 visits by official community visitors to more than 1,200 residential services in NSW.
- Conducted a number of comprehensive audits of agency systems for preventing reportable conduct and responding to reportable allegations against employees.
- Visited almost 60 regional towns and communities throughout NSW to observe correction and juvenile justice centres, audit agency systems, provide training and examine the quality of the services provided to Aboriginal communities.
- Delivered 15 training workshops on complaint-handling and negotiation skills for front line staff and how to deal with difficult complainants.
- Established a framework for managing unreasonable complainant conduct.

- Contributed to a number of inter-agency initiatives, such as the national *Whistling While They Work* project and the South West Pacific Ombudsman Institutional Strengthening project.
- Coordinated a meeting of the heads of all Australian police oversight agencies.
- Introduced a new statement of corporate purpose and new related business plans.
- Provided investigation training to staff of the Western Australian Ombudsman and Thailand Ombudsman.
- Participated in a scoping study for a 3 year AusAID project to support the National Ombudsman Commission of Indonesia.
- Shared our internal investigations training course resources with other Australasian and Pacific Ombudsman.

- Developed a corporate governance policy.
- Achieved re-certification under the AS7799 information security standard.
- Improved our energy management and environmental performance to meet the 4 star Australian building greenhouse rating.
- Our 2004–05 Annual Report won a bronze award at the Australasian Annual Report awards.
- Appointed a training officer to coordinate training for our staff in a variety of skills.
- Audited the operations of the child protection team and sought feedback from other agencies to identify improvements to the way that we work.
- Reviewed the structure, processes and staffing of the IT team.

Future plans

- Host the 6th National Investigations Symposium in November 2006.
- Monitor the progress of DoCS and DADHC in implementing our recommendations for improving the systems for the care and protection of children and the provision of services to people with a disability.
- Finalise our reviews of police pursuits and policing of domestic violence.
- Conduct forums and workshops with providers of community services and consumers of those services.

- Work with other Australian Ombudsman to evaluate whether the framework for managing unreasonable complainant conduct improves our interactions with complainants.
- Research the adequacy of complaint-handling systems in departments and authorities.
- Audit agencies in our police and child protection jurisdictions who are subject to 'class or kind' determinations.
- Finalise our guidelines for handling complaints made by young people.

- Contribute to a range of inter-agency initiatives.
- Provide technical consultancy services to the Indonesian Australian Ombudsman Linkages and Strengthening project.
- Provide advice and assistance to other watchdog agencies.
- Review our performance measures.

- Provide opportunities for staff to participate in training and cross-office projects.
- Implement a more responsive and flexible corporate team structure.
- Implement the recommendations of the child protection team information review.
- Integrate community services complaint processes into our office case management system.

About us

Who we are and what we do

The NSW Ombudsman is an independent and impartial watchdog. Our central goal is to keep government and some non-government organisations accountable to the NSW public by promoting good administrative conduct, fair decision-making and high standards of service delivery.

We are responsible for keeping the following types of organisations under scrutiny:

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

Our office was established by the *Ombudsman Act 1974*. We are independent of the government of the day and accountable to the public through the Parliament itself.

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.

Our approach is to be impartial and informal, and we aim for an outcome that is in the public interest. We investigate some more serious complaints, but in many cases we encourage the organisation being complained about to handle the matter themselves. We monitor their progress or provide advice and support where necessary.

We have one of the broadest jurisdictions of any watchdog agency in the Asia-Pacific region, and as well as continually looking for ways to improve our own practices, we strive to be a leading watchdog agency. We provide assistance, guidance and training to other watchdog agencies to help them continually improve their service delivery.

Our proactive work involves helping organisations prevent complaints arising by scrutinising the systems they have to provide services. We provide training and advice on how to effectively resolve and manage complaints that do arise. Our key focus is on helping organisations fix any problems with their performance that our work brings to light.

Other specific functions that we have relate to:

- the causes and patterns of deaths of certain children and people with a disability
- decisions made by public sector organisations 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.

Please see Appendix H for a full list of the legislation under which we have functions.

Our statutory officers



Bruce Barbour



Chris Wheeler



Steve Kinmond



Greg Andrews



Anne Barwick



Simon Cohen

Organisational chart



About us

How we operate

Our role and the way we do our work continues to expand and change. We are increasingly finding that our specialist functions are informing each other and enabling us to take a more holistic approach to the matters we deal with. Our extensive jurisdiction means we are able to develop a broad perspective on issues and work with a number of agencies to achieve more effective and thorough outcomes. In addition, our knowledge of best practice approaches enables us to make constructive recommendations to other organisations dealing with similar issues.

Because we have experienced a ten year growth in complaints, and have proportionately fewer resources, we have had to create efficiencies through staff specialisation. Our office is currently divided into five teams — the general, police and child protection teams, each headed by an Assistant Ombudsman, the community services division headed by a Deputy Ombudsman, and the corporate team, led by the Manager Corporate.

The police team has responsibility for work relating to NSW Police, and for reviewing certain legislation giving powers to police officers. 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. The child protection team handles notifications from organisations providing services to children of allegations of conduct by employees that could be

abusive to children. The general team is responsible for performing our other legislative functions, including handling inquiries and complaints about a wide range of public sector agencies, and reviewing legislation.

Our corporate team includes personnel, financial services, public relations and publications, information and records management, library services and information technology. They provide support to the core activities of the office, ensure a healthy, safe, creative and satisfying work environment and increase awareness of our role and functions.

Systems that encourage communication between our specialist teams have become increasingly important to our work. Regular information exchanges and open access to our case management systems enable staff to coordinate approaches to cross-jurisdictional issues. We have key specialist staff like our Aboriginal Complaints Unit and Youth Liaison Officer who work across the whole office. We rotate some staff between teams, initiate cross team working parties and investigations, and hold weekly meetings of our statutory officers to consider key issues and developments. We also facilitate agency and industry forums on particular areas of interest. We use the knowledge gained from these strategies to inform our responses to complaints and our general oversight tasks. Some examples of specific cross-jurisdictional initiatives and outcomes can be found in this report.

How we keep organisations accountable

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
- paid employees, contractors and thousands of volunteers of these organisations.

How we keep them accountable

We oversee (and sometimes investigate) organisations' investigations into allegations of conduct by an employee that could be abusive to children 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 to organisations in how to handle these kinds of allegations and convictions.

Agencies delivering public services

Who we scrutinise

We scrutinise:

- several hundred NSW public sector agencies including departments, statutory authorities, boards, government schools, 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 employees and complaints about the way agencies have handled disclosures.

We oversee NSW Police'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 of the Commissioner of Police in relation to the witness protection program.

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

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 family services for children and young people
- home and community care services
- services for people with a disability
- supported accommodation and assistance program services.

Note: Many of these services are provided by the Department of Community Services and the Department of Ageing, Disability and Home Care. 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 a community service.

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 receiving, or eligible to receive, community services.

Agencies conducting covert operations

Who we scrutinise

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

How we keep them accountable

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

Snapshot of our year

A variety of people contact us — members of the public, families of people who are receiving community services, members of Parliament, people who work in the public sector. They bring to our attention a broad range of concerns.

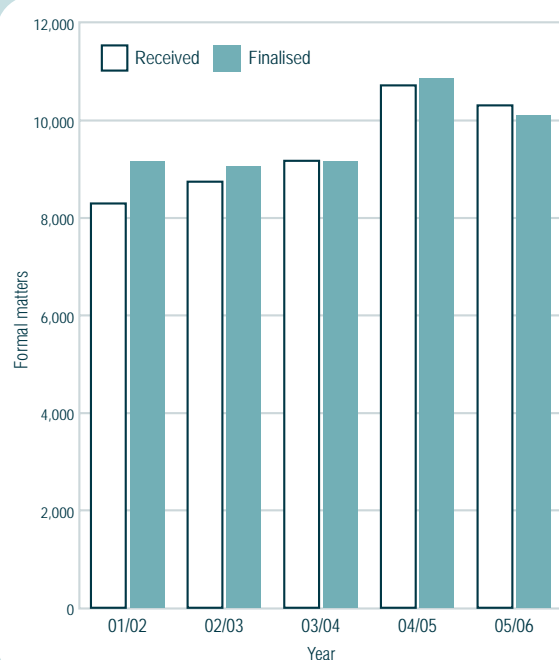
This year a total of 33,315 matters were brought to our attention. Of these, 10,304 were formal complaints and notifications, and 23,011 were informal complaints and inquiries.

As we have jurisdiction over a range of agencies, and specific functions under a number of pieces of legislation, we categorise matters to make sure we provide the most appropriate response. Figure 1 shows a breakdown of the matters we received this year into these subject categories.

This is the second year we have finalised more than 10,000 formal matters. See figure 2.

Formal matters received and finalised by our office fig 2

Year	01/02	02/03	03/04	04/05	05/06
Received	8,292	8,739	9,167	10,714	10,304
Finalised	9,164	9,052	9,159	10,866	10,096



Matters we received in 2005–06 fig 1

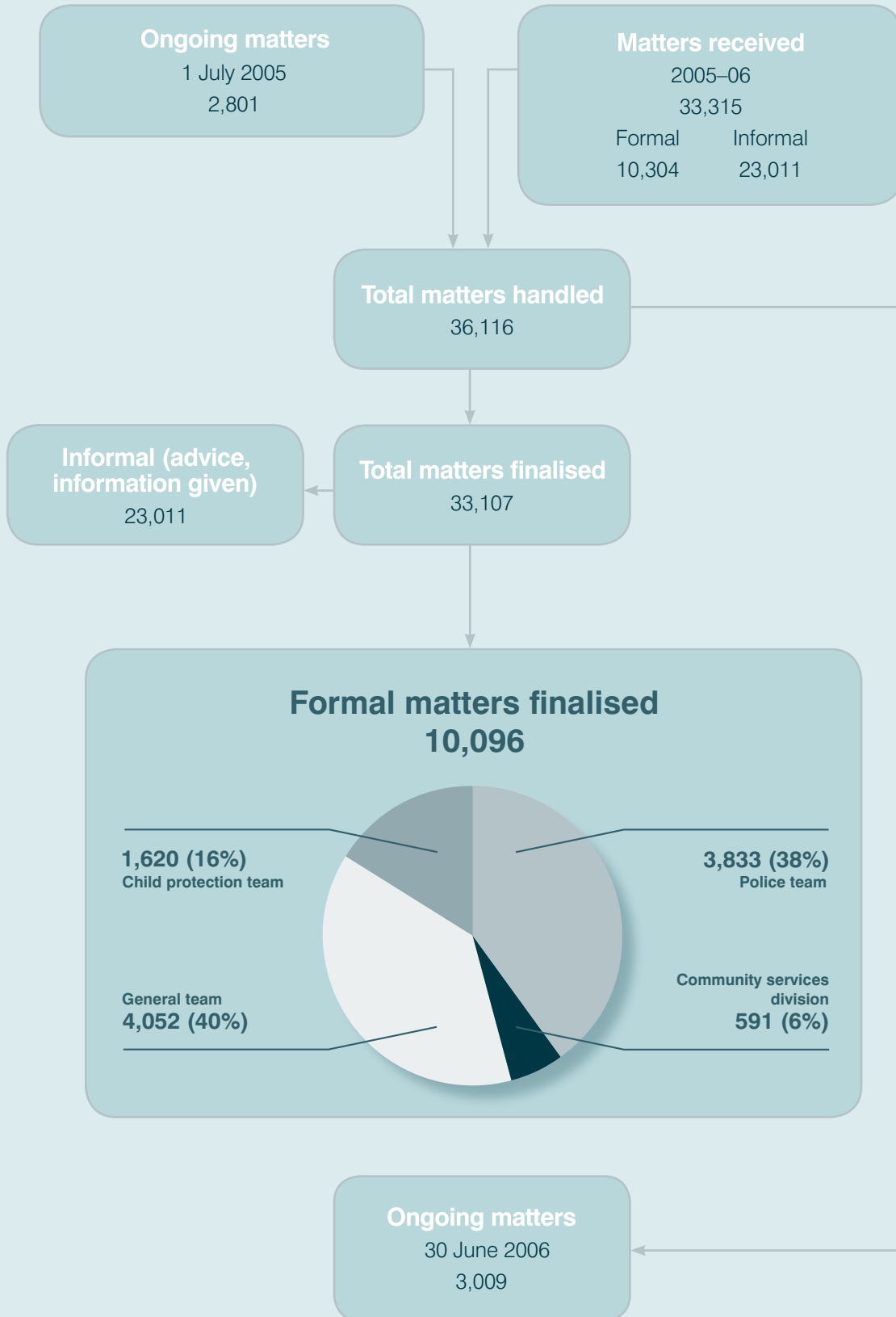
Subject area	Formal	Informal	Total
Police	3,753	3,121	6,874
Witness protection appeals and complaints, and controlled operations authorities	512	2	514
Departments and authorities*	1,329	3,625	4,954
Community services**	595	1,088	1,683
Local government	744	1,891	2,635
Correctional centres and Justice Health	852	3,460	4,312
Juvenile justice	41	257	298
Freedom of information	188	294	482
Employment-related child protection	1,865	824	2,689
Outside our jurisdiction*	425	5,750	6,175
Requests for information	0	2,699	2,699
Total matters received	10,304	23,011	33,315

* We sometimes receive written complaints about departments and authorities 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 departments and authorities. 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, and 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.

Matters we received and finalised in 2005–06

fig 3



Snapshot of our year

How we handle different types of matters

We make a distinction between ‘formal’ and ‘informal’ matters, and this determines the process we use to handle them. In most cases written complaints and notifications are considered to be formal, whereas complaints that are made over the telephone or in person are treated as informal. There are some minor exceptions to this — for example, some verbal complaints will be treated as formal if the complainant cannot reasonably be expected to make a complaint in writing.

Informal matters

We categorise as informal matters most telephone calls, visits to our office, and inquiries made to our staff when they are working out in the field. Usually we are 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 10,096 matters classified as ‘formal’. These matters can take anywhere from a few days to finalise — for example, by making a clarifying phone call to the agency — to a few months if, for example, we conduct 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 do 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 them. If we do use our coercive powers, we categorise the complaint as having been ‘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 66 matters this way (see figure 4)
- providing information or advice to the complainant
- making inquiries and finding no wrong conduct.

For complaints about police and child protection notifications from agencies, our primary role is to oversee the way these complaints are handled by the agencies concerned. We do have the power to investigate matters ourselves, but we do not do this very often. We finalise most of these matters by reviewing final investigation reports to assess the quality of the investigation. Figure 5 shows the areas that we handle most matters about.

We have achieved a number of significant outcomes in relation to the matters we handle. Figure 6 shows some results from our handling of complaints from the public. After our involvement, a number of agencies have tried to resolve the complaint, such as changing their decision or admitting and correcting mistakes.

Number of investigations finalised

fig 4

Year	01/02	02/03	03/04	04/05	05/06
Total	62	54	42	67	66

Formal matters finalised — by subject group

fig 5

Subject	04/05	05/06
Police	4,367	3,833
Witness protection appeals and complaints, and controlled operations authorities audited	422	512
Departments and authorities	1,386	1,317
Community services	683	586
Local government	833	720
Corrections and Justice Health	592	839
Juvenile justice	21	44
Freedom of information	182	198
Employment-related child protection	1,843	1,620
Agency outside our jurisdiction	537	427
Total matters finalised	10,866	10,096

Significant outcomes achieved in relation to complaints finalised by the general team

fig 6

Outcome	No.
The agency provided additional information	511
The agency provided reasons for decisions	296
The agency admitted and corrected errors	171
The agency provided another remedy	119
The agency reviewed matters and changed decisions	91
The agency mitigated consequences of decisions taken	81
The agency undertook case reviews	74
The agency reviewed internal processes	60
The agency changed policies or procedures	49
The agency gave apologies	45
The agency negotiated settlements	20
The agency gave monetary compensation	11
The agency took disciplinary action against staff	11
The agency trained staff	10
Legislative change initiated	3
Total outcomes	1,552

Taking the initiative: our proactive work

An important part of our work is to closely scrutinise agencies within our jurisdiction, identify areas for improvement, and persuade them to improve the way they work by implementing our recommended changes. This work — together with our work responding to individual complaints — gives us detailed information about the quality of services being provided to the public, particularly those that help some of the most vulnerable members of our society.

We have specific functions to review the circumstances of people in care and review the deaths of particular groups of people. This year we reviewed the deaths of 184 people who died in 2005. This included 54 people in DADHC operated or funded services, 13 who were in licensed boarding houses and 117 children. In a significant number of cases we found that the quality of the services being provided to the people who died could have been improved. We continue to work with key agencies such as DoCS and DADHC to prevent deaths in similar circumstances in the future.

In our police area, we use an 'audit' tool to examine how well less serious complaints about police are dealt with by local commanders, as these are not individually notified to our office.

Number of police records checked through an audit process

fig 7

Year	01/02	02/03	03/04	04/05	05/06
No.	2,623	7,701	7,529	7,627	8,000

We audit police records as part of our legislative reviews. This year we physically examined 8,000 police records — see figure 7.

We also use an audit tool to scrutinise the systems agencies have for protecting children and responding to reportable allegations against their employees. This year we chose to audit 10 agencies providing substitute residential care for children and child care centres because the children they look after are particularly vulnerable. Each year we also use audits to assess how well our 'class or kind' determinations are working — to make sure that those matters we permit agencies to handle themselves without notifying us are still being handled properly. This year we did 22 of these audits.

Every year our staff visit regional towns and communities to see how well the needs of the communities are being met and find out if we can help to improve things. This year we visited the premises of a range of agencies — including police stations, correctional centres, boarding houses and child care centres — and consulted with community groups and individuals in almost 60 regional towns.

We spent 148 person days visiting 27 correctional centres and made two visits to each of the eight juvenile justice centres in NSW. We also inspected court cell complexes at Lismore and Parramatta.

During the year we worked on a number of research projects on topics including the policing of domestic violence, care proceedings in the Children's Court, police pursuits and policing metropolitan communities. We are able to make recommendations to improve the systems reviewed at a whole-of-government level as well as to each of the many agencies who may be involved in these areas.

Part of being proactive also involves educating and training agencies about their responsibilities and how they can improve the way they handle complaints about their service and operations. In more recent years we have begun to educate the public about what to expect in service provision and how to make complaints about the services they receive.

Snapshot of our year

This year our staff made over 160 presentations and delivered over 70 training sessions to more than 4,000 staff of agencies and consumers of services. We also revised our *Good Conduct and Administrative Practice Guidelines*, and developed other fact and information sheets on various aspects of public administration — including the development of child protection policies, youth participation, transparency and accountability, and security of information.

Special reports to Parliament

In most cases we are able to persuade agencies to adopt our recommendations without needing to make our findings public. However occasionally it is in the public interest to report publicly our concerns about a particular issue or a particular agency. We have the power to make a special report to Parliament for this purpose.

Since 1 July 2005 we have tabled four special reports to Parliament on:

- improving the quality of land valuations issued by the Valuer General
- monitoring standards in boarding houses
- services for children with a disability and their families
- misconduct at the NSW Police College.

These reports are available on our website.

Legislative reviews

Since 1998, the NSW Parliament has given our office specific functions to keep under scrutiny the implementation of 20 pieces of legislation conferring additional powers on police, juvenile justice and correctional officers. These include laws relating to drug detection dogs, the collection and use of DNA samples, criminal infringement notices, the child protection register, and the new counter-terrorism laws.

Since 1 July 2005, our final reports on our review of the following Acts were tabled in Parliament:

- *Child Protection (Offenders Registration) Act 2000*
- *Crimes (Administration of Sentences) Amendment Act 2002* and *Summary Offences Amendment (Places of Detention) Act 2002*
- *Crimes Legislation Amendment (Penalty Notice Offences) Act 2002*
- *Police Powers (Drug Detection Dogs) Act 2001*
- *Police Powers (Drug Premises) Act 2001*
- *Police Powers (Internally Concealed Drugs) Act 2001*
- *Police Powers (Vehicles) Amendment Act 2001*.

We also provided our final reports on our review of the *Firearms Amendment (Public Safety) Act 2002* and the *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001* to the relevant Ministers. At the time of writing these reports have not been tabled.

1. Corporate governance

Our aim is to be an effective organisation — and one way to achieve this is by developing, implementing and maintaining a robust system of corporate governance. This also provides assurance to the Ombudsman, Parliament, government and the public that resources are being used effectively and our stated outcomes are being achieved.

As an independent and impartial oversight agency, we are responsible for ensuring that the organisations within our jurisdiction fulfil their functions properly. Our work is about promoting good administration and effective accountability, and we aim to work to the same standards that we promote.

We pride ourselves on the quality of our work and the standard of our service. This year we developed a governance framework that brings together the policies, systems and processes we have to promote accountability, transparency and ethical practices in order to identify how our office is managed, directed and controlled.

Statement of responsibility

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

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



Bruce Barbour
Ombudsman

Our corporate plan

Our new corporate plan came into operation on 1 July 2005. 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. The corporate plan sets out the direction for our office and outlines the goals and strategies that will support our vision. It consists of a statement of corporate purpose and the strategic plans for each of our business units. 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 business unit has developed their own business plan to align their activities with our overall strategic direction. These plans guide the day-to-day work of our staff.

Statement of corporate purpose

- Help organisations meet their obligations and responsibilities and promote and assist the improvement of their service delivery.
- Deal effectively and fairly with complaints and work with organisations to improve their complaint handling systems.
- Be a leading watchdog agency
- Be an effective organisation.

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). The PJC is made up of parliamentarians from different political parties. This ensures that we are accountable to Parliament — not to the government of the day — and is crucial to maintaining our independence.

In November 2005 the Ombudsman and other senior staff appeared before the PJC at our thirteenth general meeting. This meeting reviewed our 2004-05 annual report and discussed a number of aspects of our work including funding levels, an increase in complaints, and our functions under the new terrorism legislation. There is a detailed report on the meeting and a transcript of proceedings on the PJC site at www.parliament.nsw.gov.au.

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 Treasury. We are required to provide an annual report for our office, as well as a number of other annual reports relating to 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 also provide each complainant with our reasons for refusing to investigate or conciliate their complaint or for discontinuing an investigation. This is another important accountability mechanism and has helped us establish a public reputation for making fair and well-reasoned decisions.

The Ombudsman's performance statement

To retain the independence of the Ombudsman, the position is not responsible to an individual Minister. Although there is no formal one-on-one review of performance, the Ombudsman appears before the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission to answer questions about the performance of our office.

Monitoring performance

Performance indicators

Part of being an effective organisation is being able to monitor the quality, quantity, timeliness and impact of your work. As our work involves a wide range of jurisdictions and legislation, one of the challenges for us is to develop appropriate measures to capture the impact and effectiveness of what we do.

We have performance indicators relevant to specific areas of our work that are used to measure efficiency at corporate, team and individual staff levels. For example, key indicators for timeliness, resolution of complaints and percentage of recommendations implemented are included in this report.

We consistently review the way we do our work and use this information to improve our performance evaluation systems. Currently we are reviewing our performance indicators and plan to develop a set of indicators that may be used to inform procedural changes and give assurance to Parliament and the public that resources are being effectively used and we are achieving our stated outcomes.

Tracking performance and managing risk

We track our performance at two levels — in relation to individual files and in relation to our systems and structures for completing work. In particular, we look at timeliness and the quality of our decision-making. We have set performance benchmarks (provided throughout this report) for file turnaround times and we monitor our workflow to identify where there may be backlogs, delays or inefficiencies. We periodically review all files that have been open for more than six months and conduct internal audits of file handling.

In core business related activities, identifying and measuring risk and developing mitigation strategies is the responsibility of the relevant statutory officer. Work of individual staff is monitored through regular supervision sessions and providing feedback on their performance against team benchmarks. Regular meetings are held in specific function areas to monitor the progress and status of matters, identify significant matters, and address any identified risks in the handling of matters. Internal quality audits of complaint assessments and investigation oversight are completed each year and individual complaints or projects are identified for more intensive case management.

Team managers, office-wide committees, issues groups and core business units meet regularly to discuss current developments, share information, and reinforce new policies or management direction. The Ombudsman and the senior staff meet weekly

to review the progress of work, exchange information and discuss issues of concern. Annual planning days are held by each core business unit. They review the previous year's performance and identify strategies to support our corporate purposes in the coming year.

We also have programs to manage risk in specific areas such as information security, OH&S, 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. One area of risk identified this year was the likelihood of a pandemic flu (bird flu) outbreak, so we have been developing strategies to deal with this to be included in our business continuity plan.

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 have in place 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 where money, staff entitlements or our computer network could be compromised.

Although we received accreditation under the Australian information security standard AS7799 in December 2002, we have continued to improve our information security systems. We were accredited to the new standard (AS7799.2) in December 2005 and are now working towards accreditation under the international information security standard.

Internal structures and systems

During 2005-06 we made a range of structural changes to improve how we do our work, including:

- refining the outcome definitions used in our case management system to make them more consistent
- reviewing and amending the supervisory structure for processing FOI complaints
- altering internal structures to better manage legislative review projects and other research work
- reducing the size of our police complaint oversight teams to increase the supervision of more junior staff and free up senior investigators to focus more on the direct oversight of serious complaints
- reviewing the structure, processes and staffing mix of our information technology section and, as a result, improving service to our business areas
- refining the process for the intake of complaints about community services, resulting in an increasing number and proportion of complaints being resolved through Ombudsman action
- engaging an external contractor to help us to review the way we capture information and report on our work on child protection related matters
- implementing a number of new measures to better monitor high-risk child protection matters and track our decision-making in matters we decline
- specifying enhancements to Resolve, the main case management tool used throughout the office, in order to integrate our community service complaints.



We focus on ways to continually improve our work processes. We also promote collaborative solutions to issues impacting on us. Our IT and personnel staff meet to discuss priority issues and develop action plans for 2006–07.

We also created a number of new policies — including the corporate governance and salary packaging policies — and revised a number of policies — including our code of conduct, privacy management plan, total asset management framework and our risk assessment, use of communication and information technology devices, disclosure of information and media policies.

Balancing our books

Revenue

Most of our revenue comes from the government in the form of a consolidated fund appropriation. The government also makes provision for certain employee entitlements such as long service leave. There is a breakdown of revenue generated, including capital funding and acceptance of employee entitlements, in figure 8. This year we were provided with \$375,000 so we could review the implementation of new police powers.

We generated \$133,000 through the sale of publications, bank interest and fees for training courses for other public sector agencies. We also used \$48,000 of a transfer payment from the Department of Juvenile Justice for our review of the *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001*. See figure 9.

Total revenue

fig 8

Revenue*	
Government	
Recurrent appropriation	\$17,904,000
Capital appropriation	\$742,000
Acceptance of certain employee entitlements	\$409,000
Total government	\$19,055,000
From other sources	\$181,000
Total 2005–06	\$19,236,000

*Including capital funding and acceptance of employee entitlements

Revenue from other sources

fig 9

Revenue	
Workshops	\$60,000
Grants	\$48,000
Bank interest	\$44,000
Other revenue	\$15,000
Publication sales	\$14,000
Total 2005–06	\$181,000

Expenses

Most of our revenue is spent on employee-related expenses. These include salaries, superannuation entitlements, long service leave and payroll tax. This year we spent more than \$14.67 million — over 76% of our total expenditure — on employee-related expenses. The day-to-day running of our office costs over \$3.8 million a year. This includes rent, postage, telephone, stores, training, printing, travel and maintenance. See figure 10.

Total expenses

fig 10

Expenses	
Employee-related	\$14,675,000
Depreciation	\$706,000
Other	\$3,824,000
Total 2005–06	\$19,205,000

2. Our people

We have a committed team of 198 people working for our office on a full- or part-time basis. This equates to just over 172 full-time equivalent — see figure 11. These people 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 persuasive advocates for change.

Staff levels

fig 11

	01/02	02/03	03/04	04/05	05/06
Statutory officers	5	6	6	6	6
Investigative staff	98.2	139.5	149.5	132.8	138.4
Administrative staff	19.3	22.5	25	27.8	26.9
Trainees	0	0	0	0	1
Total	122.5	168	180.5	166.6	172.3

Figures are the full-time equivalent (FTE) staff number.

Human resources

Movements in wages or salaries

A 4% salary increase was paid to staff covered by the Crown Employees (Public Sector Conditions of Employment) Award 2002 from 1 July 2005.

Personnel policies and practices

Our staff are employed under the *Public Sector Management and Employment Act 2002*. This Act and associated regulations and the Crown Employees (Public Sector Conditions of Employment) Award 2002 set the working conditions of public sector staff, including those who work at our office. We therefore have little scope to set working conditions and entitlements for our staff. The Public Employment Office (PEO), a division of the Premier's Department, is the employer for this purpose and negotiates conditions and entitlements with the relevant unions.



Staff from our corporate team are responsible for providing support to the core activities of the office, increasing our productivity and accessibility, ensuring a healthy and safe work environment, and increasing awareness of our role and functions.

Our people

Our priority in 2005-06 was to start a comprehensive review of all our personnel related policies and systems to ensure that they support the achievement of purpose 4 of our new statement of corporate purpose. As part of this review, we finalised two policies — salary packaging and recording of time worked — and revised our conflict of interests, code of conduct, use of communication devices and consultative arrangement policies. We have also developed a draft personnel policy — with supporting policies on recruitment, induction and occupational health and safety — which will be finalised next year.

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 PEO and the relevant union and, if necessary, develop local policies. It includes management and staff representatives.

This year the JCC provided input on policy development and review, including the review of the

consultative arrangement policy. They also discussed a range of issues relating to working conditions and entitlements.

Training and development

This year our staff received training in a variety of skills — including investigation management, conflict resolution and negotiation, public speaking and presentations, writing, editing and proofreading, work and time management and various Microsoft applications. They attended courses and workshops on topics such as refocusing women's experience of violence, working with persistent complainants, credibility of children's evidence, corruption prevention, improving Aboriginal outcomes in the public sector, and giving advice to agencies who may have to deal with a protected disclosure.

We also support members of staff undertaking a variety of external courses — including postgraduate and undergraduate degrees and diplomas, TAFE courses and courses to obtain professional qualifications.



All new staff attend training in using our document management system. This year we conducted refresher courses for existing staff.



The IT team meet fortnightly to discuss relevant issues. They also use this forum to update colleagues on products, processes and system improvements.

Equal employment opportunity

We are committed to the principles of equal employment opportunity (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 12 and 13 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.

We achieved our targets for 2005-06, which included:

- increasing our representation of people with a disability
- offering flexible working conditions
- providing student placements and work experience opportunities
- providing developmental opportunities to EEO groups
- receiving a 100% response rate to our EEO survey.

We analysed the results of the climate survey conducted in June 2005 and, where necessary, reviewed and changed policies or practices and conducted training and information sessions. We also include EEO responsibilities in all our position descriptions and performance agreements.

In 2006-07 we will further develop our EEO program in line with the strategies outlined in our statement of corporate purpose. We will also continue to promote flexible work options to staff, have a consultative work environment, and provide opportunities for staff to participate in staff development and training activities.

Occupational health and safety

This year the government released *Working Together* — an occupational health and safety (OH&S) strategy to secure improvements in the public sector's health and safety performance, with a specific focus on injury management. This strategy commits public sector agencies to the following targets over the next 2-3 years:

- 40% reduction in workplace injuries
- 10% reduction in the proportion of injured employees still off work at 8, 12 and 26 weeks from the date of injury

Percentage of total staff by level

fig 12

Level	Total staff (no.)	Subgroup as a percent (%) of total staff at each level		Subgroup as an estimated percent (%) of total staff at each level				
		Men	Women	1	2	3	4	5
< \$32,606	2	0	100	0	0	0	0	0
\$32,606 - \$42,824	8	0	100	0	62.5	50	12.5	12.5
\$42,825 - \$47,876	12	25	75	0	66.7	41.7	8.3	0
\$47,877 - \$60,583	36	22.2	77.8	5.6	27.8	16.7	8.3	0
\$60,584 - \$78,344	101	26.7	73.3	1	21.8	16.8	5	2
\$78,345 - \$97,932	32	40.6	59.4	3.1	12.5	9.4	3.1	0
> \$97,932 (non SES)	2	50	50	0	0	0	50	0
> \$97,932 (SES)	5	80	20	0	0	0	20	0
Total	198	28.3	71.7	2	24.7	17.7	6.6	1.5

KEY

1. Aboriginal and Torres Strait Islander peoples
2. People from racial, ethnic, ethno-religious minority groups
3. People whose language first spoken as a child was not English
4. People with a disability
5. People with a disability requiring work-related adjustment

Percentage of total staff by employment basis

fig 13

Employment basis	Total staff (no.)	Subgroup as a percent (%) of total staff at each level		Subgroup as an estimated percent (%) of total staff in each employment category				
		Men	Women	1	2	3	4	5
Permanent Full-time	125	32.8	67.2	2.4	28	20	7.2	0.8
Permanent Part-time	39	7.7	92.3	0	23.1	17.9	5.1	5.1
Temporary Full-time	21	33.3	66.7	4.8	19	9.5	0	0
Temporary Part-time	5	0	100	0	20	20	0	0
Contract - SES	6	66.7	33.3	0	0	0	16.7	0
Contract - non SES	1	100	0	0	0	0	100	0
Training Positions	1	0	100	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	198	28.3	71.7	2	24.7	17.7	6.6	1.5

KEY

1. Aboriginal and Torres Strait Islander peoples
2. People from racial, ethnic, ethno-religious minority groups
3. People whose language first spoken as a child was not English
4. People with a disability
5. People with a disability requiring work-related adjustment

Our people

- 15% reduction in the average cost of claims
- 10% improvement in the percentage of injured workers who are placed in suitable duties within one week of the date that they become fit for suitable duties as specified on the medical certificate
- 90% of managers provided with appropriate information, instruction and training in their roles and responsibilities under their agency's OH&S and injury management system.

We are currently reviewing our programs to align them to this strategy. We have begun analysing claims and injury costs and have developed a training course for supervisors.

Other OH&S activities this year included providing a comprehensive training program for wardens to ensure they are equipped to handle emergency situations, holding emergency evacuation drills, reviewing the provision of first aid services and training staff for this role.

Staff trained in safety audits conducted workplace inspections, including ergonomic assessments of workstations and general hazard identification.

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.

- 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 to detect any potential problems.
- Flu shots — we organised flu shots for staff to reduce the taking of sick leave during the flu season.

Performance indicator Trends in the representation of EEO groups

EEO Group	Government target %	Ombudsman representation %			
		02/03	03/04	04/05	05/06
Women	50	72	73	72	72
Aboriginal and Torres Strait Islander peoples	2	2	1.5	2.1	2
People whose language first spoken as a child was not English	20	16	17	18	18
People with a disability	12	8	8	6	7
People with a disability requiring work-related adjustment	7	3	2.5	2.1	1.5

Performance indicator Trends in the distribution of EEO groups

EEO Group	Benchmark or target	Ombudsman				
		01/02	02/03	03/04	04/05	05/06
Women	100	90	86	89	88	89
Aboriginal and Torres Strait Islander peoples	100	n/a	n/a	n/a	n/a	n/a
People whose language first spoken as a child was not English	100	79	83	84	83	88
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

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.

We participate in the NSW Treasury Managed Fund, a self-insurance scheme for the NSW public sector. Our strategies for minimising our workers compensation claims include workplace inspections and providing a counselling service. This year eleven workers compensation claims were reported to the insurer.

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 try to reduce this impact — including energy management and waste reduction programs — and we 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

We developed a fleet improvement plan to ensure we meet public sector requirements set out in Premier's Memorandum 2005-03. Our plan identifies actions and policy changes required to improve our current fleet performance score and facilitate future planning.

Our current average fleet environmental score is 10.25 out of 20, which we aim to improve next year. We also aim to reduce our fleet greenhouse gas emissions by 15% by June 2007.

Performance indicator Petrol consumption

	95/96	03/04	04/05	05/06
Petrol (L)	4,296	6,277	5,326	5,159
Total GJ	147	215	182	176
Total cost (\$)	3,098	5,066	5,199	5,497
Distance travelled (km)	53,018	101,538	54,738	51,602
MJ/Distance travelled (km)/annum	2.77	2.11	3.33	3.42

Electricity consumption

We had an increase in energy use during 2005-06 as we replaced an old and inefficient air conditioning unit in our computer room with a bigger unit. We have identified ways to improve the performance of this unit, including purchasing better ceiling tiles that minimise cool air escaping into the ceiling cavity. We expect our electricity consumption to improve next year.

Future direction

We are committed to improving our environmental performance and will benchmark our performance annually against government and internal targets.

We will also continue our staff awareness program to ensure that all staff contribute to the achievement of these targets.

Performance indicator Energy consumption

	95/96	03/04	04/05	05/06
Electricity (kWh)	133,630	335,024	304,716	355,301
Kilowatts converted to gigajoules	481.07	1,206	1,097	1,279
Total cost (\$)	16,254	39,211	37,627	43,896
Occupancy (people)	69.7	180	187	187
Area (m ²)	1438	3,133	3,133	3,133
MJ/occupancy (people)/annum	6,872	6,700	5,866	6,840
MJ/Area (m ²)/annum	335	385	350	408
M ² /person	20.54	17.41	16.75	16.75

*There was an increase in energy usage compared to last year due to an upgrade of our server room air-conditioning unit. We are currently looking at ways of reducing energy usage in the server room.

Greenhouse performance

Australian building greenhouse rating (ABG rating)

We have a 3.5 star ABG rating and aim to be 4.5 stars by June 2007. We have been undertaking a range of energy efficient programs — including installing occupancy sensors and / or lightsave energy controllers throughout the office — and have implemented a program to educate staff on ways to conserve energy. As a result of these initiatives, we anticipate a reduction in our annual greenhouse gas emission of 28 tonnes by June 2007.

Waste reduction program

We are committed to the reduction 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 promote email as the preferred internal communication tool and encourage staff to print double-sided. We have an electronic record system allowing staff to access information such as policies, procedures and internal forms which reduces the need for paper copies. As publications are available to download from our website, we now print a smaller quantity of reports.

Resource recovery

We supply individual paper recycling bins at workstations and larger 240 litre bins are available throughout the office for secure destruction. All office waste paper, cardboard, glass, plastic and aluminium are collected for recycling. All our used toner cartridges, bottles, drums, inkjets and ribbons are recycled.

Using recycled material

We use 50% recycled content / 50% sustainably managed plantations copy paper and 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.

We are currently replacing carpet in our tenancy and are using carpet tiles with 65% recycled content.

Reducing water usage

The owners of our building have implemented a water saving strategy throughout the building.

3. Our relationships with others

Working with other organisations

Ombudsman offices here and overseas

We are a member of the International Ombudsman Institute (IOI) and participate in its activities through the Australasian and Pacific Regional Group (APOR). The Ombudsman is a Director of the IOI and the Regional Vice-President for the APOR. He travelled to Perth in April this year to attend the 23rd annual APOR meeting. In November last year, he attended the 9th Asian Ombudsman Association Conference in Hong Kong as a guest speaker, presenting papers on handling complaints from prisoners and measuring the effectiveness of Ombudsman offices.

During 2005-06:

- The Ombudsman met with Ombudsmen from Ireland, Vanuatu, Fiji and Pakistan to exchange information and ideas and discuss current issues.
- The Deputy Ombudsman met with the Ohio Ombudsman. He also visited the Western Australian Ombudsman to discuss issues relevant to both jurisdictions, and regularly meets with Deputy Ombudsmen from other Australian states.
- The manager of our corrections unit visited the Canadian Correctional Investigator and the UK's Prison and Probation Ombudsman to determine best practice in correctional oversight.
- Our staff met with the Victorian Ombudsman to gain new ideas about conducting outreach programs to young people and youth workers.



Bruce Barbour presented two papers at the 9th Asian Ombudsman Association conference in Hong Kong in November last year.

Our relationships with others



Members of the APOR group of the International Ombudsman Institute met in Perth this year.

As a leader in the field of accountable public administration, we are pleased to be able to provide guidance and training to other Ombudsman offices. For example, we continued our work with the Commonwealth Ombudsman on the South West Pacific Ombudsman Institutional Strengthening project.

This year we also:

- Finalised a two week training course in investigations and complaint-handling for our staff and provided other Australasian and Pacific Ombudsman with the materials in a format they could modify to suit their jurisdiction.
- Participated in training a delegation from the Ombudsman of Thailand in a two week course in complaint-handling, investigation and mediation skills. We provided the course on a fee-for-service basis as part of an AusAID support program.
- Provided training to 20 staff from the Western Australian Ombudsman on document and information management and planning major investigations.

We have also continued our involvement in the national research project *Whistling While They Work*. See chapter 13: Protected disclosures for more details.

Parliamentary groups

In October 2005, the Ombudsman delivered a paper on parliamentary oversight from the Ombudsman's perspective at the Australasian Study of Parliament Group's annual conference. The paper was well received and was later printed in the ASPG journal, the *Australasian Parliamentary Review*. The Deputy

Ombudsman presented a paper on whistleblowing legislation in NSW at the Parliamentary Committees of Anti-Corruption / Crime Bodies National Conference.

We also made a number of submissions to parliamentary reviews, including a submission to a ten year review of the police oversight system in NSW by the Committee on the Office of the Ombudsman and Police Integrity Commission.

Watchdog agencies

We continued our involvement this year with the Joint Initiatives Group (JIG). The Deputy Ombudsman held a JIG seminar on complaint-handling and privacy, and we were also involved in a seminar on promoting human rights issues through the media.

In December last year we hosted a meeting of the heads of all Australian police oversight agencies to discuss current issues and developments. This meeting generated renewed commitment by oversight agencies to work cooperatively, to ensure that knowledge and experience is shared, and to reduce any unnecessary duplication of our efforts.

After the meeting, key researchers from the oversight agencies got together to share experiences and ideas. Their discussions were very productive and covered topics such as the use of investigative powers to enhance research, using research to reshape policing practice, ethical issues, managing relations with police, and getting agencies to work together. These meetings will now be held on a regular basis.

The Assistant Ombudsman (Children and Young People) took part in a national reference group

to inform the format and content of a conference relating to the Senate Community Affairs References Committee Report: 'Protecting vulnerable children — a national challenge'.

Our staff also meet quarterly with:

- the Independent Commission Against Corruption (ICAC) and the Department of Local Government to coordinate initiatives relating to local government complaints
- the Police Integrity Commission to discuss issues and ensure there is no duplication in our oversight work.

Organisations in our jurisdiction

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

This year we held liaison meetings with senior staff from a number of agencies including the Department of Juvenile Justice, Department of Corrective Services, Department of Housing, NSW Police, Roads and Traffic Authority, Infringement Processing Bureau, Justice Health and RailCorp.

This year we provided training to 22 agencies — including the Department of Housing, Department of Ageing, Disability and Home Care (DADHC), and various councils and community services agencies — on complaint-handling and negotiation skills to enable their staff to better manage challenging customer situations and get more satisfaction from resolving complaints.

In addition this year:

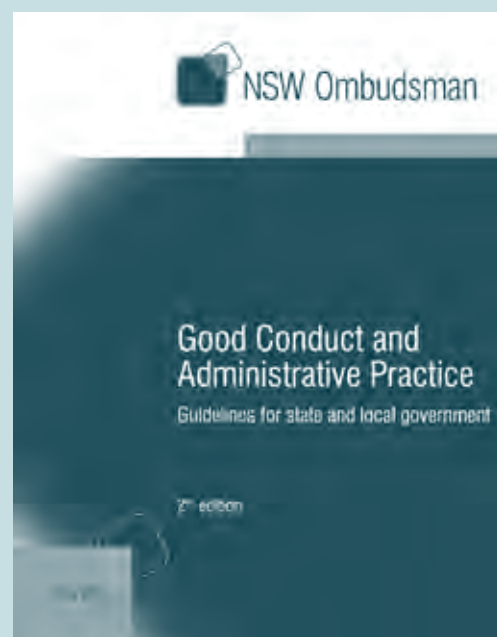
- We provided 14 workshops and 30 briefings to agencies in our jurisdiction to help them to meet their responsibilities under the Ombudsman Act
- We reviewed and amended our Good Conduct and Administrative Practice guidelines for state and local government, and provided the guidelines to most government authorities and all councils in NSW.
- Our child protection team visited rural and regional areas to run workshops for agencies working with children about our role, their responsibilities, and tips for making findings in investigations.
- We provided training to NSW Police investigators about common problems with NSW Police complaint investigation reports. We also contributed to police student training, and courses for police executive officers and crime managers.

- We worked with public sector agencies to raise awareness of the *Protected Disclosures Act 1994* and the obligations it places on agencies.
- The Deputy Ombudsman, in conjunction with the ICAC, ran a number of training sessions for managers, trainers and protected disclosures coordinators of public sector agencies.
- We supported the training initiatives of a number of government departments — including DADHC and the Department of Health — by providing training as part of their investigation training courses for managers.

Key stakeholders

Maintaining good relationships with stakeholders such as unions, peak bodies, interest groups and other government agencies is important to us. We regularly meet with, give presentations to and convene discussions with a range of organisations.

For example, our staff are members of the Health Policy Advisory Group, Child Death Advisory Committee, Disability Death Advisory Committee and Child Protection and Sex Crimes Squad Advisory Council. We attend meetings with the Legal Aid Commission, Residential Care Association, Homelessness Association, NSW Family Association, NSW Residential Care Association, Children's Guardian and the Deaf Society.



We provided a new edition of these guidelines to most government authorities and all councils in NSW.

Working with community groups

Aboriginal communities

This is the ten year anniversary of our Aboriginal complaints unit. This unit was originally set up to focus on relations between Aboriginal people and police but is increasingly informing other areas of our work.

Although measures to encourage police to deliver on their commitments to Aboriginal people remain central to the unit's work, their focus is expanding to include other NSW government agencies (such as community services, housing, juvenile justice and corrective services) and non-government community service providers. For example, after we found out that fines and large enforcement debts contributed to low numbers of licensed drivers in many isolated communities, we approached the State Debt Recovery Office and they agreed to implement a number of important changes.

Since 2002, we have been conducting a series of 'audits' in urban and country areas with significant Aboriginal communities. This has involved:

- reviewing projects and initiatives aimed at helping police and other services to work more effectively with local Aboriginal communities
- meeting with local police, other agencies and service providers and community leaders to discuss issues affecting Aboriginal communities and practical ways to improve outcomes
- rating the performance of local police against the six key objectives in the NSW Police *Aboriginal Strategic Direction*, and providing recommendations on how the command could perform better
- monitoring police compliance with our recommendations and the implementation of their Aboriginal policy objectives.

We explained our work in this area through a special report to Parliament in April 2005. This can be viewed on our website.

The unit's initiatives to improve police work with Aboriginal people will be discussed in further detail in chapter 4: Police.

These local area audits also enable Aboriginal communities to talk with us about issues relating to the work of other services and agencies.

A particular focus is on agencies providing out-of-home care, substitute residential care and child care services for Aboriginal people in regional areas, the systems they have to identify children and families at risk of serious neglect or abuse, and what they do to manage those at risk. This includes examining the adequacy of interagency arrangements for exchanging critically important information when a child or family are in danger and need help. This issue is discussed further in chapter 8: Community services.

Our work in the communities also includes examining the strategies used to keep Aboriginal people out of the criminal justice system. This includes coordinated programs for diverting offenders into drug and alcohol treatment, circle sentencing programs and community justice panels. We meet with community leaders, women's and men's cultural groups, and with other groups and individuals who play a significant role in keeping Aboriginal people out of jail. Our Aboriginal unit actively participates in the Ombudsman's outreach to prisons and juvenile justice centres across the state, focusing on those facilities with high numbers of Aboriginal detainees.

Our staff are frequently asked to give presentations to Aboriginal groups and Aboriginal service providers, and to lead workshops on ways to improve services, keep young people at school or in training, increase employment opportunities, reduce crime and other issues impacting on life in Aboriginal communities. Forums in Sydney, Mt Druitt, Newcastle, Ballina, Dapto, Campbelltown, Bankstown, Blacktown and Nowra have all provided valuable opportunities to reach out to key groups. We also attended the Aboriginal out-of-home care workers conference and the Aboriginal HACC workers conference, and were a sponsor of the Aboriginal agencies capacity building day.

The Offering was designed for the Ombudsman by Nathan Peckham, an Aboriginal artist from Dubbo and a direct descendant from the Tubbah Gah clan of the Wiradjuri Nation.

The footprints represent Ombudsman staff coming to meet the Aboriginal community. The circle is the 'meeting place' or 'fire', and represents the place for conciliation. The three 'seats' at the centre of the painting represent the Aboriginal community, government agencies and the Ombudsman. The three animals are offerings from each of the parties. These offerings represent what each party can trade. The pathways depict different options.



The Offering

Building community relationships

We have spent several years visiting regional areas and listening to the concerns of communities and the organisations that provide services to them. When specific issues arise, the relationships and knowledge that we have developed gives us the opportunity to make practical recommendations that suit the needs of the particular community that is affected. It is encouraging to see agencies recognise the value of our experience and draw on it to improve their own relationships within the community — with other agencies and with those people most in need of their help — and work more effectively. Here is just one example of the productive outcomes that we have been able to achieve this year, following an audit conducted by our Aboriginal complaints unit.

When we first visited the Bourke and Brewarrina area in 2004, it was clear that local police were dealing with one of the most challenging law enforcement environments in NSW. They faced high rates of youth crime and domestic violence, and their capacity to provide an adequate response was stretched to the limit. We identified that the police were responding to crime as it occurred, rather than using their resources to deal with problems strategically. We felt they should have been taking advantage of their contact with offenders and victims to try to identify and address the root causes of crime.

Since that time, the police have implemented a number of proactive measures. On our recommendation, the local commander appointed a domestic violence liaison officer (DVLO). The DVLO has trialled several programs to reduce the rate of domestic violence in the area, and has also improved the coordination of services for victims and offenders. She has helped the community to develop more trust in police, through her connections to the community and by proving her worth to local domestic violence services.

One initiative — the introduction of the routine electronic recording of victim statements — has so far resulted in an increase in guilty pleas to charges related to domestic violence, making the whole process much less stressful for the people concerned. The DVLO continues to track outcomes to assess how effective this strategy will be over time.

The command has also tried some different approaches to address youth-related crime, as well as having solid formal ties to a range of youth services. One initiative was to introduce a mobile Police and Community Youth Club (PCYC) as part of a more strategic response to youth crime.

These clubs enable police to provide activities such as sports for young people to participate in. As well as preventing them from engaging in criminal behaviour, PCYCs help young people to see police as a source of support. The static nature of the traditional PCYC means that young people in regional or disadvantaged areas rarely have the opportunity to attend one. The mobile PCYC is a novel way to overcome this. Now young people in places including Enngonia and some southern sector towns can access the club. We have heard encouraging reports about the popularity of the activities. One community member reported:

Kids are coming from all over Bourke to attend the mobile PCYC and it's packed every time we drive past.

In June 2006, the commander acknowledged the benefit of our previous work by asking us to provide concrete recommendations for further improvements and requesting that we return in the near future to audit additional initiatives. Among our new recommendations were that the command consider a more interventionist approach to domestic violence by trialling a domestic violence arrest team — a team of officers dedicated to arresting domestic violence offenders and serving apprehended violence orders.

Police in the Bourke and Brewarrina area face significant challenges, as it will take many years of demanding work to overcome the entrenched social problems that lead to family violence and youth crime. However we can confidently state that police are taking a positive lead role towards this goal by developing partnerships with other services and government agencies, and actively engaging Aboriginal community leaders. They are laying the foundations for long lasting change.

Our relationships with others



The winning design for our youth campaign competition.

Young people

Building relationships with youth services across NSW is a strong focus for our office. This year we visited the Far North Coast, Far South Coast, Goulburn / Yass, Far West NSW and the Riverina to meet with workers from local youth services, the Police Citizen's Youth Clubs, Police youth liaison officers, youth housing services and Juvenile Justice, as well as teachers and students in high schools. These visits helped to inform youth workers about what we do as well as provide us with valuable information about youth issues in these areas.

We gave presentations to the youth supported accommodation assistance program (SAAP) network and youth service networks to improve understanding of our role and the obligation on employers to notify us of allegations about employees behaving in ways that could be abusive to children. We provided further training and information to services identified as not being aware of their obligations.

We are also working with the BoysTown's Kids Help Line (KHL) to assist young people make complaints. We developed a memorandum of understanding which sets out the responsibilities and procedures for the Ombudsman and KHL counsellors to help a young person to make a complaint.

To improve our understanding of how and why young people contact our office, we conducted a snapshot survey of all inquiry callers over a three-week period. We found that 13.5% of inquiries were youth related and 51% of those inquiries were by young people.

The information from this survey has helped us improve our understanding of youth related inquiries and improve our planning for community education and other youth projects. We are also currently using information obtained from phone interviews and focus groups to develop new guidelines for our staff on dealing with youth complaints.

To improve awareness of and accessibility to our office, we developed and distributed new posters, stickers and youth complaint brochures to almost 3,000 youth related services across NSW. We had previously obtained feedback from young people on several draft designs. Their favourite design was by Amanda Fuller, a TAFE student who volunteered to help us to design a youth friendly poster and brochure.

The feedback so far has been very positive from both young people and workers. We have also submitted a number of articles to youth related publications and newsletters about the role of our office and various aspects of our work.



We work with staff from the Energy and Water Ombudsman to promote Ombudsman to young people.



Our youth liaison officer with young people from Pacific flava youth service at a youth week event.

Our relationships with others

People with a disability

To improve services for people with a disability we work cooperatively with DADHC, peak disability agencies and individual service providers.

We meet, liaise and consult regularly with these key agencies about systemic and specific issues affecting disability services. For example, we convene biannual 'round table' discussions with a range of peak bodies and advocacy groups to share information about service issues and trends, initiatives and the progress of developments in the disability sector, and our work in this area.

This year our round table discussions provided us with information that will help us to monitor DADHC's implementation of the NSW government's 10-year plan for changing and improving the way disability services are provided. This plan was released in May 2006.

Our staff and official community visitors have attended training courses about a range of service delivery issues concerning people with a disability including behaviour management, health and medication, and ways of communicating with people with a disability.

Disability Strategic Plan

Priority area for action	Goal	Strategy	Outcomes
Physical access	Ensuring that our office and any other locations we use are accessible to people with a disability.		<p>We provide toilet facilities for people with a disability on our public access floor.</p> <p>The building has wheelchair access (ramp and lift) and tactile ground surface indicators near all staircases, ramps and escalators.</p> <p>The tenant directory is a well-lit area with tenant details in a reasonably sized font. There are some details in Braille.</p>
Promoting positive community attitudes	Actively promote people with a disability as valuable members of the community.	Working in partnership with peak organisations to promote positive community attitudes.	<p>We promote people with a disability as valuable members of the community by including positive images of people with a disability and using appropriate language in our publications.</p> <p>We participated in community forums and gave speeches at conferences such as the Life Activities International Conference on Disability, the Ability Inc. Advocacy Service annual conference, the Professional Association of Nurses in Developmental Disability Areas annual conference, and the Multicultural Disability Advocacy Association forum.</p>
Staff training	Staff are trained and competent in providing services for people with a disability.	Conduct disability awareness training for staff.	As part of staff training on disability awareness we held a workshop on mental illness awareness.
Information about the services	Our office and the services we provide are accessible to people with a disability.		<p>We have our information brochure in accessible format including large print and Braille brochures, discs and audiotapes. We also have a Compic brochure for people with an intellectual disability.</p> <p>Accessibility is one of the key issues addressed in the review of our website. We have strategies in place to ensure that our new website complies with web accessibility guidelines.</p>
Employment in the public sector	To employ more staff who have a disability.		6.6% of our staff have a disability, with 1.5% requiring work related adjustments.
Complaints procedure	Our office and the services we provide are accessible to people with a disability.	Develop strategies to let people with a disability know about our compliments and complaints policy.	<p>We conducted 6 Rights Stuff workshops in metropolitan and regional areas for consumers of community services including people with a disability and their families.</p> <p>We have an internal compliments and complaints policy. We also inform people who use our services about how to make a complaint about us.</p> <p>We participated in consultations with people with a disability and their carers about their experiences in using community services including barriers to access.</p> <p>We gave special consideration to complaints by vulnerable members of the community, including people with a disability.</p>

Our relationships with others

People in regional areas

We visited regional NSW to provide training for agency staff, talk to and consult with community groups and senior managers in agencies, meet with local police, inspect correction and juvenile justice centres, audit the systems of various agencies within our jurisdiction, and attend community festivals and events. The map below shows the towns and regional areas we visited this year.

We also updated our 'community radio announcement' CD which includes five brief messages about child protection issues and our role in dealing with complaints about public agencies, police, councils and community services providers. We sent the CD to over 100 regional and rural AM, FM and public broadcasting stations.

Regional areas visited by Ombudsman staff



Our relationships with others

Ethnic Affairs Priority Statement — future plan

Key result area	Initiative	Time frame	Intended outcome
Planning	Review current Ethnic Affairs Priority Statement (EAPS) Implementation Plan and develop new three year plan for 2007-09.	Dec 2006	All team business plans include EAPS strategies.
	Regularly monitor office EAPS activities to ensure the implementation of EAPS.	Ongoing	Quarterly reporting of team business plans to Ombudsman.
	Develop proactive access strategies to target emerging and refugee communities.	Ongoing	At least one emerging community identified and access action plan developed.
Social justice	Establish and maintain close communication with key culturally and linguistically diverse (CALD) organisations and workers. Address any specific access issues identified.	Ongoing	Improved participation by CALD communities in our decision-making on access issues.
	Network with other complaint-handling bodies and key agencies relevant to CALD communities and explore joint projects to improve access to the NSW complaint system by CALD communities.	Ongoing	Improved access by CALD communities to NSW complaint system.
	Develop and implement effective communication strategies to raise awareness of the role of the office among CALD communities.	Ongoing	Improved awareness of the role of the Ombudsman.
	Consult with key CALD organisations and workers to identify any barriers to access and develop strategies to minimise the barriers.	Ongoing	Improved access by CALD communities to the Ombudsman.
	Implement any new strategies identified in our new three year EAPS plan.	Ongoing	Improved access by CALD communities to the Ombudsman.
Community harmony	Provide training on cross cultural issues and effective communication skills with CALD communities to our front line staff, their managers and other key staff.	Ongoing	Increased staff competence in service provision to CALD communities.
	Participate in cultural activities and festivals.	Ongoing	Improved community relations.
	Implement any new strategies identified in our new three year EAPS plan.	Ongoing	Improved community relations.

Culturally and linguistically diverse (CALD) communities

One of the strategies in our ethnic affairs priority statement action plan is to provide training to community workers on the role of the Ombudsman, our complaint process and alternative avenues for making a complaint.

This year we organised two workshops for over 80 community workers who provide face-to-face service to CALD communities, including refugee communities. These workshops raised awareness among community workers about our role and our expectations of agencies, and helped us learn about some of the issues faced by CALD communities.

The issue of young refugees being targeted by police and transit officers was raised regularly during discussions between our staff and youth workers and young people in 2005. As we were not receiving many formal complaints about this issue, we began to liaise with refugee services and communities to improve their awareness of our office. Our staff have met with refugees and workers from several migrant

resource centres and attended non-English speaking background (NESB) youth issues network meetings. They also recently spoke with over 20 newly arrived young people at the Auburn youth centre. These meetings have helped us understand some of the issues refugees have with NSW government agencies.

Our staff also participate in community festivals and migrant information days. For example this year we attended the Holroyd and Parramatta community information expo, the North Sydney migrant information day and the Harmony Day celebrations in Ashfield. We also distributed our general brochure in English and 16 community languages to all migrant resource centres, community information centres and libraries.

Action Plan for Women — progress report

Objective	Outcomes
Reduce violence against women	We have conducted audits of seven police local area commands regarding their work with Aboriginal communities. Police response to domestic violence and sexual violence is an important aspect of police efforts to work more effectively with Aboriginal victims, witnesses and offenders. Our audit reports include detailed feedback from Aboriginal residents and other sources about how well the command is targeting Aboriginal family violence and sexual abuse, and ideas for further improvement. In dealing with complaints, we are particularly concerned about the alleged failure by police to deal appropriately with domestic violence and sexual assault reports.
Promote safe and equitable workplaces that are responsive to all aspects of women's lives	We have adopted flexible working conditions including flexible working hours, part-time and job share arrangements, and leave for family responsibilities. We also promote a harassment-free workplace.
Maximise the interests of women	We participate in the NSW Spokeswoman Program. A morning tea was held in March 2006 to increase awareness of the Spokeswoman's program and to encourage networking between women across the office. The Spokeswoman has also conducted a survey within the office to identify any issues that female employees would like to have addressed.
Improve the access of women to educational and training opportunities	We have given women in our office educational and training opportunities to further their careers. We select and promote staff on merit.
Promote the position of women	We have a diverse and skilled workforce. Women make up 72% of total staff and about 48% of staff grade six or above. All but one of our team managers are women and one of our six statutory officers is a woman. We participate in activities celebrating International Women's Day and published fact sheets to inform women of our role and functions.

Women

During 2005-06 we initiated a major research project into the way police handle domestic violence issues — including how they are working with other government departments to help women and children at risk.

We are consulting with NSW Police, women's domestic violence court assistance schemes, regional violence prevention specialists and non-government organisations and services in metropolitan and regional NSW.

Among other things, the project is examining:

- issues identified by key stakeholders
- police domestic violence policies and operating procedures
- examples of best practice throughout NSW and in other jurisdictions.

The Ombudsman expects to report his findings and recommendations later in 2006.

We reviewed and redeveloped our fact sheet for women and distributed hundreds of these brochures — along with other key information about our office — to women in metropolitan, regional and rural areas during the International Women's Day Festival.

We also held a stall at the Young Women's Festival in Blacktown and ran a successful competition to raise awareness of our office.

People in residential care

There are more than 6,500 adults and children living in residential care in NSW. Many of these people are highly vulnerable — they rely heavily on their service provider for all aspects of their needs and often have limited family, social and community contacts. They also often have limited opportunities to access or contact our office.

The work of the official community visitors (OCVs) and community education officers is critical to improving access to our services for this group of people. This year our OCVs made more than 2,500 visits to residential services throughout the state, and identified and resolved service provision issues in consultation with people living in care and their families, advocates and other representatives.

We continue to work with the boarding house community — residents, proprietors and intermediaries — to explain their right to make complaints and positive ways to resolve them. This year we presented our Solving Problems — Right at Home training program to over 140 people living in boarding houses and disability residential services. This year we also reviewed the situations of a number of young people in out-of-home care who live in SAAP funded youth refuges and will be making recommendations about how their living circumstances can be improved. Please see chapter 8: Community services for more details.

Our relationships with others

People in correctional and juvenile justice centres

Although inmates of correctional centres and detainees in juvenile justice centres have telephone and postal access to our office to lodge complaints, our visits to these facilities are an important part of our work. We visit for two main reasons — to witness first hand the conditions in which people live (and implementation of the departmental policies and procedures governing the operations of the centres) and to give inmates and detainees an opportunity to raise concerns directly with our staff.

We increased our visits slightly this year, visiting 27 correctional centres over 48 days — this involved a total of 148 person days spent inspecting facilities and talking to inmates and staff. Each Juvenile Justice centre was visited twice. Staff from our Aboriginal Complaints Unit and our Youth Liaison Officer (YLO) also participated in some of these visits.

Older people

We participate in the activities organised by DADHC for Senior's Week. This year we produced 10,000 fridge magnets designed for older people, which were distributed in show bags at the Sydney Royal Easter Show.

We also provided information sessions to older people through existing networks such as the Family Law Reform Association, Seniors With a Goal, the senior's group at the Australian Chinese Community Association, and community based groups for retired people.

Speeches, presentations and training

This year our staff made over 160 speeches and presentations and delivered over 70 training sessions to more than 4,000 people — including staff of agencies providing services to the public and customers of those services.

A wide range of our staff were involved in these activities including the Ombudsman, Deputy and Assistant Ombudsman, team managers and training, youth liaison and investigation officers. They made presentations on a range of issues including the role of the Ombudsman, protected disclosures, conflicts of interest, access to information laws, the role of official community visitors, complaint-handling and alternative dispute resolution. Details of specific training programs are provided in other parts of this chapter.

This year we developed a new education strategy to inform people working with children and families about our role in community services. The aim of the project is to increase complaints from and / or about child and family services, particularly from areas where we typically do not receive many complaints. We will be presenting at conferences, providing information sessions, and developing pamphlets and information sheets to raise awareness of our role. This year we have consulted with eight peak agencies and conducted eight community education activities.



We provided a two week training course for staff from the Thailand Ombudsman in complaint-handling, investigation and mediation skills.

Our work with complainants

Handling complaints informally

The largest group of people we have contact with are complainants. This year we handled over 23,000 complaints informally and over 10,000 formally. 'Informal' complaints are mostly complaints that are made to our inquiry staff by telephone or in person at our office or on visits. We try to help all these complainants in some way. For example we may be able to explain something to them, give them information, provide advice on how to make their complaint to the agency concerned if the complaint to us is premature, refer them to a more appropriate agency or someone else who can help them, or explore other options with them. Sometimes, if the matter is within our jurisdiction and straightforward, we may be able to immediately contact the agency involved to try to resolve the complainant's concerns. If the matter is more serious or complex, we invite them to make a formal complaint for a detailed assessment.

Compliments and complaints

We take compliments and complaints about our work very seriously. Customer feedback helps us to identify the aspects of our service that we do well, the areas of our service that need improvement, and where expectations of our service exceed what we can reasonably deliver. This year we received 126 compliments through letters, faxes, emails and telephone calls about many aspects of our work — including the quality of our advice, the assistance we gave to customers, and the information provided to agencies within our jurisdiction.

We received 46 complaints about our work this year — only 0.1% of the 33,107 formal and informal matters we finalised this year. See figure 15.

If a complaint is justified, we will generally take some form of action to resolve it. During 2005-06, our responses to 17 complaints included apologising, giving greater priority to identified files and providing explanations. Please see figure 14.

Outcome of complaints about our office fig 14

Outcome	Total
Unjustified	26
Justified or partly justified	3
Some substance and resolved by remedial action	17
Total outcomes	46

Complaints about our office fig 15

Issue	Total
Bias / unfair treatment / tone	4
Confidentiality / privacy related	4
Delays	7
Denial of natural justice	0
Failure to deal appropriately with complaint	14
Lack of feedback / response	2
Limits to jurisdiction	2
Faulty procedures	7
Inaccurate information / wrong decision	4
Poor customer service	16
Corruption / conflict of interest	3
Other	2
Total issues	65
Total complaints	46
% of all matters finalised (formal and informal)	0.1%

Requests for reviews of our decisions

If we discontinue our involvement in 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 in more detail our decision-making process and the evidence and factors we took into account in making the decision. If they still request a review of our decision, a senior officer who was not involved with the original decision will review the decision and provide advice to the Ombudsman. The Ombudsman will review the matter and write to the complainant explaining the outcome.

Figure 16 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 17 shows that in 95% of cases the Ombudsman was of the view 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

Team	Target	05/06	04/05
Child protection team	<6.0%	5 (6.3%)	1 (1.2%)
Community services division	<6.0%	11 (1.9%)	10 (1.5%)
General team	< 6.0%	180 (5.1%)	195 (5.5%)
Police team	< 1.8%	62 (1.6%)	74 (1.7%)

Our relationships with others

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

fig 16

Subject	No. of requests	No. of formal complaints finalised	% 05/06	% 04/05
Child protection*	5	79	6.3%	1.2%
Community services	11	591	1.9%	1.5%
Corrections	9	883	1.0%	0.8%
Freedom of information	15	198	7.6%	2.2%
Local government	69	720	9.6%	11.3%
Other public sector agencies	85	1,317	6.5%	6.2%
Police**	62	3,833	1.6%	1.7%
Outside our jurisdiction	2	422	0.5%	1.1%
Total	258	8,043	3.2%	3.2%

* 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. This table shows that, of the 79 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 NSW Police to directly investigate each complaint, and our office plays an oversight role, the police team considers all requests to review the way a complaint about a police officer was handled as request to review our decision in relation to the NSW Police outcome. This table shows that, of the 3,833 complaints about police officers that we oversaw this year, 62 complainants asked for the outcome to be reviewed.

Outcome of reviews conducted

fig 17

Area	Original outcome affirmed		Resolved	Reopened	Total
	after reviewing the file only	after further telephone inquiries			
Child protection	4	0	0	1	5
Community services	9	2	0	0	11
Corrections	5	2	0	1	8
Freedom of information	12	4	0	0	16
Local government	37	26	0	4	67
Other public sector agencies	58	25	1	2	86
Police	37	0	4	0	41
Outside our jurisdiction	2	0	0	0	2
Total 2005–06	164	59	5	8	100%
% of total (05/06)	70%	25%	2%	3%	100%
% of total (04/05)	72%	24%	1%	3%	100%

As each review may take days or weeks to complete, some reviews may not be finalised the same year the request is received. This makes the total review finalised figure different from the total review request figure.

Educating the community about how to make a complaint

Our consumer education program — The Rights Stuff: Tips for Solving Problems and Making Complaints — helps community service users to understand complaint processes and how to effectively communicate their concerns to service providers. We ran six of these workshops in 2005-06, with over 120 participants. Most people who attended were people with a disability and their families, although this year we also opened the workshop to advocates and intermediaries.

This year our Youth Liaison Officer presented training to over 700 workers from 21 youth service networks, many individual youth services and three youth conferences about the Ombudsman's role, how they can help young people to make complaints, and how to raise systemic issues with our office.

We developed a new education strategy to inform those working with children and families about our role in community services. We will be presenting at conferences, providing information sessions,

distributing written resources and writing external articles to promote understanding of our role and how people can make complaints. So far we have consulted with eight peak agencies and conducted eight community education activities.

Dealing with unreasonable complainant conduct

A very small percentage of our complainants sometimes display unreasonable conduct. Such conduct can take up a disproportionate amount of our time and resources and cause stress for the staff and the complainants themselves. We have identified a number of unreasonable conduct categories, and have developed a framework of strategies for managing unreasonable complainant conduct. All Ombudsman offices in Australia have agreed to join with us to test the framework and work towards refining it over the next 18 months. As part of this project, we will be studying the effect the new strategies have on improving interactions with complainants across Ombudsman offices.

4. Police

Highlights

- We oversighted the investigation or resolution of 2,379 complaints by NSW Police and found that 90% of them were satisfactory. The deficiencies we did find in investigations were remedied by police in 92% of cases.
- Our audits and investigations have brought about significant improvements in NSW Police complaint-handling procedures, including improved timeliness in acting on referred complaints and better guidelines to minimise the risk of local commands dealing with complaints about serious police misconduct.
- The DPP and the Supreme Court have agreed to more rigorous systems for reporting adverse comments about police and suspected misconduct.
- Our visits to Aboriginal communities have found significant improvements in relationships between the communities and police as a result of our report on this issue last year.
- NSW Police have made positive changes in their policies and communication with a metropolitan community following our audit.
- Four of our reviews into legislation giving police new powers were tabled in Parliament. NSW Police have implemented, or are implementing, 73% of the recommendations we made in all our legislative reviews.

The police complaints system

The Ombudsman and the Police Integrity Commission (PIC) have an agreement that specifies how complaints about police officers should be handled. Under this agreement, the Ombudsman must be notified of all serious complaints. Figure 18 shows how this agreement works.

As with most other agencies, NSW Police investigate the majority of complaints about their own officers. We oversee the way these investigations are conducted to make sure they are adequate and fair.

Police complaints this year

This year we received 3,123 inquiries from members of the public where we gave advice or information about police complaints. For many of these inquiries, we either contacted the commander or put the complainant directly in contact with an officer who could resolve the matter. For others, we provided advice or assistance about making a complaint.

We also received 3,753 formal or written complaints. This includes complaints made to us directly, as well as complaints referred to us by NSW Police or the PIC. We finalised 3,833 complaints. Figure 19 shows the number of complaints we have received and finalised over the past five years.

Figure 20 shows the types of issues complained about this year. Appendix A breaks each issue down further. The number of allegations is larger than the number of complaints received because a complaint may contain more than one allegation about a single incident or may involve a series of separate incidents.

This year, 1,151 complaints were made by police (eg case study 1) and 2,602 by members of the public. See figure 21. An important aspect of the effectiveness of the complaints system is whether officers are reporting suspected misconduct by their colleagues. Recent years have seen a rising proportion of complaints being made by police officers. For these 'internal complaints', an effective investigation demonstrates a willingness by senior officers to deal with criminal conduct and other misconduct by police.

The police complaints system

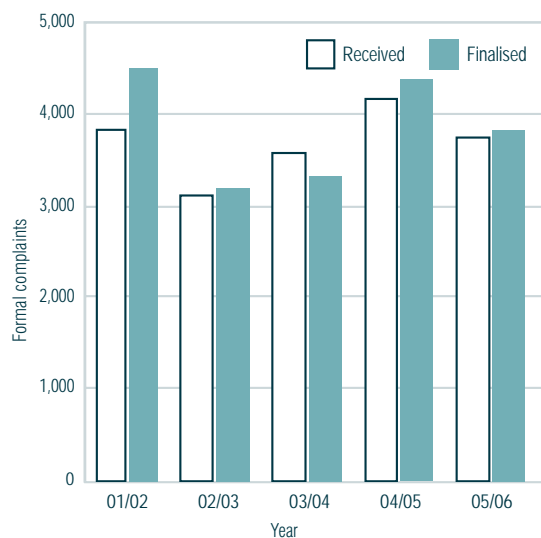
fig 18

Category of complaint	Description	How it is handled
Category 1 complaints — these must be notified to the Ombudsman and the PIC.	These are the most serious complaints, such as those involving allegations of perjury, interference with investigations, and involvement in the manufacture or supply of illegal drugs.	The PIC can decide to investigate the complaint or oversee the NSW Police investigation of the complaint. In practice, the PIC does this in only a small number of cases. For the vast majority of category 1 complaints, the police investigate and we oversee their investigation.
Category 2 complaints — these must be notified to the Ombudsman.	These are complaints about other serious matters and include complaints of criminal or corrupt conduct, improper arrest and detention, and police action or inaction resulting in death, injury or significant financial loss.	Investigated by the police with rigorous review by the Ombudsman.
Local management issues (LMIs)	These are less serious complaints, such as complaints about poor customer service and minor workplace issues.	Dealt with by local commanders. We examine the way these complaints are handled using tools such as audits.

Formal complaints about police received and finalised

fig 19

	01/02	02/03	03/04	04/05	05/06
Received	3,804	3,099	3,565	4,179	3,753
Finalised	4,501	3,204	3,316	4,367	3,833



CaseStudy1

A constable witnessed a serious assault by a senior constable on a man that the senior constable had apprehended. The senior constable had repeatedly hit the man on the head with a torch, causing two large wounds to his scalp that required stitching.

The constable reported what he had witnessed to his superior officers. The subsequent police investigation resulted in criminal charges against the senior constable, who was also suspended from duty.

Ultimately, the senior constable pleaded guilty to a charge of assault occasioning actual bodily harm and was sentenced to 400 hours of community service. The Commissioner subsequently ordered the senior constable's dismissal.

The constable who had reported the matter was formally recognised for his 'high level of integrity, honesty, and commitment to the ethos of the NSW Police code of conduct'.

What people complained about

fig 20

Type of allegation	No. of allegations
Criminal conduct	1,524
Assault	1,021
Investigator / prosecution misconduct	1,430
Stop / search / seize	509
Abuse / rudeness	534
Administrative wrong conduct	417
Breach of rights	566
Inadvertent wrong treatment	61
Information	1,051
Other misconduct	4,250
Total 2005–06	11,363

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

Who complained about the police?

fig 21

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

	01/02	02/03	03/04	04/05	05/06
Police	621	783	952	1,215	1,151
Public	3,183	2,316	2,613	2,964	2,602
Total	3,804	3,099	3,565	4,179	3,753

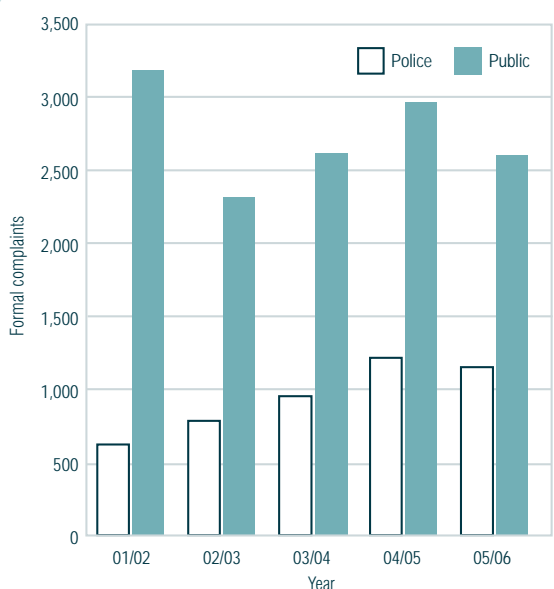


Figure 22 shows the type of action taken for complaints that were finalised this year. There were 2,131 complaints where the matter was investigated by police and oversights by us. We also reviewed the conciliation of 248 matters. We decided that 524 matters were local management issues for direct action by local police, without our oversight.

We decided that 930 complaints did not require any action. There are many reasons why a complaint might not require action. For example, there might be other ways to resolve the matter, such as court proceedings, or the incident may have happened too long ago.

This year more than half the investigations we oversights resulted in some form of management response. See figure 23. Figure 24 illustrates the types of management action taken.

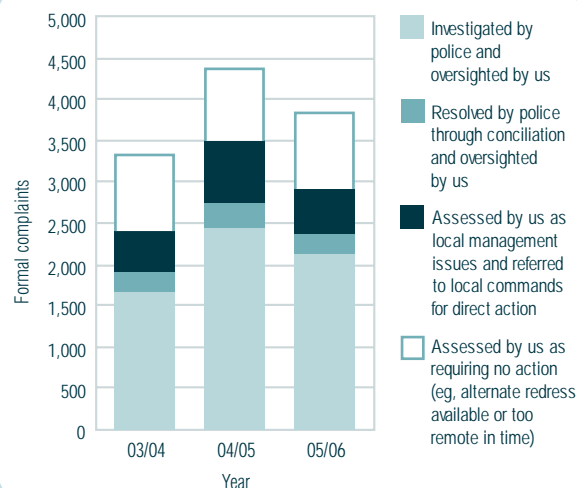
In some cases, an officer is charged during or at the end of an investigation. This year, 64 officers were charged. See figure 25. Charges included PCA and other driving related offences, assault (including sexual assault) and fraud. See figure 26.

Outcome

Action taken in response to complaints about police

fig 22

Action taken	03/04	04/05	05/06
Investigated by police and oversights by us	1,678	2,440	2,131
Resolved by police through conciliation and oversights by us	228	291	248
Assessed by us as local management issues and referred to local commands for direct action	491	768	524
Assessed by us as requiring no action (eg, alternate redress available or too remote in time)	919	868	930
Total	3,316	4,367	3,833



Action taken by NSW Police following complaint investigation

fig 23

	01/02	02/03	03/04	04/05	05/06
No management action taken	1,341	926	1,072	1,480	895
Management action taken	787	486	606	960	1,236
Total investigations completed	2,128	1,412	1,678	2,440	2,131

Enhancements to our complaints handling information system now permit reporting against every issue of a complaint, not only the primary issue. Any issue in a complaint which has resulted in management action is now able to be reported on.

Police officers criminally charged

fig 25

	01/02	02/03	03/04	04/05	05/06
No. of complaints leading to charges	71	61	54	78	65
No. of officers charged	73	62	52	81	64
Total charges laid	121	123	95	155	101
Officers charged following complaints by other officers	40(55%)	43(69%)	40(77%)	63(78%)	51(79%)

Common NSW Police management outcomes to complaints about police

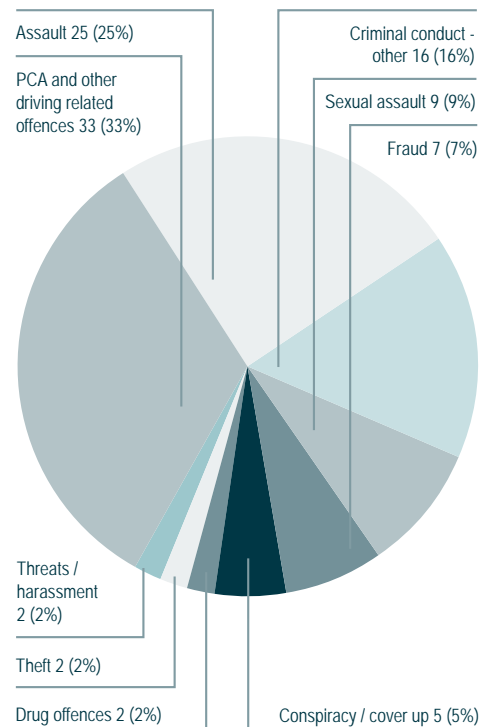
fig 24

Outcome	01/02	02/03	03/04	04/05	05/06
Management counselling	40%	36%	44%	42%	38%
Training – command	12%	10%	6%	6%	4%
Training – officer(s)	7%	7%	8%	7%	4%
Change in policy or procedure	9%	10%	6%	4%	7%
Supervision increased	6%	9%	7%	7%	4%
Performance agreement	n/a	n/a	9%	10%	8%

Types of charges

fig 26

Type of charge	Number of charges
PCA and other driving related offences	33
Assault	25
Criminal conduct – other	16
Sexual assault	9
Fraud	7
Conspiracy / cover up	5
Drug offences	2
Theft	2
Threats / harassment	2
Total	101



The quality of police investigations

The police investigate most of the complaints they receive and we review the way these investigations are conducted. This year we found that, in most cases, police conducted satisfactory complaint investigations. For an example of a case that was well investigated by police, see case study 2. However, sometimes we are not satisfied with the way police have handled the matter. There are a number of steps we can take in these situations, including asking police to reinvestigate the matter or to review the action taken.

Of the 2,379 complaints that were investigated and closed this year, 90% were satisfactory. However there were 242 where we found that the investigation itself and / or the action taken was unsatisfactory. Where we identified deficiencies in investigations, police acted to remedy 92% of these matters. For an example, see case study 3.

CaseStudy2

In late 2005, police shut down a party after it had been gatecrashed. Two officers initiated contact with two teenage girls from the party while patrolling the area in a marked highway patrol vehicle. The two girls got into the car and the officers drove them around. During the trip they stopped to pick up a third girl, a friend of one of the girls.

The mother of one of the girls made a complaint that the officers had taken the girls on a joyride and had driven at very high speeds. The mother also alleged that the officers had asked the girls to 'put on a show' for them.

When we reviewed the investigation, it was clear that considerable effort had been made to identify relevant issues and examine the available evidence thoroughly. For example, the investigator looked at the in-car-video system for possible footage of the incident and found that the relevant footage had been deleted. The investigation was also conducted relatively quickly.

The senior officer has been charged with driving at a speed or in a manner dangerous, and with modifying electronic data without authorisation. Both officers are being considered for dismissal.

Performance indicator

Percentage of our reports that made recommendations relating to law, policy or procedure

Target	2005-06
70%	75%

Performance indicator

Percentage of our recommendations implemented by NSW Police

Target	2005-06
80%	89%

Direct investigations

Occasionally we find that an investigation has been conducted so poorly that we need to directly investigate the complaint or the way police handled it. There are many factors we consider in deciding to conduct a direct investigation — including whether the matter raises issues of significant public interest and whether our involvement may result in a significantly better outcome. For example, this year we investigated an allegation that police had assaulted an Aboriginal man while arresting him (see case study 4), the way the police investigated allegations about officers receiving stolen alcohol (see case study 5), and allegations that police failed to respond to a '000' emergency call during the Macquarie Fields riots in 2005 (see case study 6).

During a direct investigation we can require police and other public sector agencies to provide us with information and documents. At the end of the investigation, we provide a report to NSW Police with our findings and recommendations. Although NSW Police are not obliged to comply with our recommendations, they implement the vast majority.

CaseStudy3

A man had an application for an apprehended personal violence order (APVO) made against him by a former colleague. The man did not turn up to the court hearing, so the court granted the APVO.

The man made a complaint that he had not received the court papers, which is why he did not turn up to court. Before the hearing, a senior constable signed an affidavit stating that he had served the court papers at the man's home. The complainant stated that this was impossible because he was at work that day.

Police investigated the complaint. The senior constable submitted in writing that his affidavit was correct. However, the investigator found the officer was at work the day he claimed to have served the papers, and the complainant was at work, not at home as the officer claimed.

The senior constable was interviewed and changed his story, saying that he had served the papers the following day, as supported by police records. He also said he was alone at the time.

The investigator found that, while the senior constable had put the wrong date in the affidavit, he had nevertheless served the court papers as claimed. The investigator recommended no action in relation to the matter.

When we reviewed the complaint, we had concerns about the way the investigation had been conducted and the conclusions reached. For example, there was evidence that the senior constable was working with another officer on the day that he supposedly served the court papers, not alone as he had stated. The investigator had failed to interview this other officer, even though her evidence was crucial. We also questioned why the investigator interviewed police before getting the complainant's version, and why he did not reinterview the complainant after the senior constable changed his story.

In our view, the evidence could be interpreted to suggest that the senior constable did not serve the court papers at all, and that he had tried to cover this up during the investigation. We asked NSW Police to reinvestigate the matter.

Their reinvestigation confirmed our view and found that the senior constable had not served the court papers. It also made other serious findings, including that the senior constable had created false records that he had served the papers the following day. NSW Police are considering whether to dismiss the senior constable and have sought advice from the DPP on possible criminal charges.

CaseStudy4

In November 2003, two officers stopped a young Aboriginal man who was drinking alcohol on a metropolitan railway platform while waiting for his train. While police were conducting radio checks on the man, he turned away to board his train. The senior officer sprayed the man with capsicum spray, forced him to sit on a platform bench, and sprayed him twice more. Police then told the man to get on the ground. When he failed to do so, the officers pulled him to his feet and the senior officer struck him on the lower leg with his baton several times.

The man was charged with drinking alcohol on railway land and resisting an officer in the execution of his duty. However the prosecutor reviewed the CCTV footage and, based on his concerns about the officers' behaviour, decided to withdraw the charges.

NSW Police investigated the incident and found the officers had acted reasonably because the man had made threats and was physically aggressive.

The senior officer suggested that he had been scared of being overpowered and injured. We decided to directly investigate the matter because we could not reconcile the finding with our own observations of the CCTV footage and the officers' statements. In our view, there was no evidence that the man had made threats or had acted aggressively. In fact, the officers' own statements suggested that the man had not made any threats of violence at all.

We found that the officers' use of force was excessive and in breach of NSW Police policies. The use of force was not in self-defence or in response to a violent confrontation, but rather to gain compliance. We recommended that NSW Police consider taking action against the officers.

NSW Police agreed with our findings, and the Commissioner issued the senior officer with a formal warning notice. We also recommended action in relation to the officer who had conducted the original investigation. As a result, he attended complaint investigation training.

CaseStudy5

A man who had been arrested for stealing alcohol from his employer claimed that he had sold some of the stolen alcohol to an officer from a highway patrol, and that this officer had in turn sold the alcohol to other highway patrol officers.

NSW Police investigated the allegations. The principal officer, who was the subject of the complaint, was interviewed first and denied the allegations. Other highway patrol officers were then required to provide reports about their knowledge of the matter, and all of them said they knew nothing about it. The investigator reported that there was insufficient evidence to indicate criminal conduct on the part of any officer, and his commander endorsed this report.

We had concerns about the adequacy of the investigation and asked for further information. After NSW Police supplied this information we were still concerned, so we decided to directly investigate the way the complaint had been investigated.

Our investigation involved a hearing at which we obtained evidence from a number of police officers, including the investigator and the commander. Both of these officers acknowledged that there had been a number of deficiencies in the handling of the complaint investigation.

While we were preparing our provisional statement on the inadequacy of the police investigation, further evidence supporting the allegations was identified. NSW Police conducted a reinvestigation of the matter, which involved

extensively interviewing all the highway patrol officers. We monitored some of these interviews.

The thoroughness of this reinvestigation stood in stark contrast to the original investigation.

The reinvestigation resulted in a finding that there was insufficient evidence to establish that officers from the highway patrol had received stolen alcohol. However, the conduct of one officer was referred to the DPP for consideration of a possible criminal charge of providing false evidence to the investigators. The DPP advised that there was insufficient evidence for such a charge.

We are finalising our report on the inadequacy of the original police investigation. There were a number of deficiencies including a failure to consider a range of possible investigative strategies, inappropriately interviewing the principal officer the subject of complaint before gathering other relevant evidence, and obtaining information from other highway patrol officers through written statements rather than interviews. We have proposed a number of recommendations to address the conduct of the officers involved in the investigation, and are awaiting the NSW Police response to those recommendations.

CaseStudy6

In our last annual report, we referred to a police investigation into the failure of officers to respond to a '000' emergency call during the Macquarie Fields riots. The call was from a young girl saying that her father was being assaulted. Since then, we have reported to the Commissioner and Minister on the unsatisfactory quality of the investigation — it was poorly planned and failed to consider all relevant issues and lines of inquiry. Most significantly, the investigation never adequately explored how senior police came to amend the usual procedures for responding

to emergency calls, and what the amended procedures were.

The Commissioner is considering our recommendation that an apology be made to the man who was assaulted and his family. At our suggestion, amendments have been made to the protocol for deviating from existing '000' procedures. This should ensure that police officers and other emergency personnel are notified of deviations, and that all '000' calls are dealt with properly.



Staff from our police team meet regularly to exchange information and discuss current policing and complaint-handling issues.

Conciliations

Sometimes we are notified of a complaint that we believe may best be resolved through conciliation. This involves all parties agreeing to sit down together and discuss the matter, with an independent person facilitating the discussion. The aim is to reach a

shared understanding of the issues in dispute and agree to concrete outcomes. Our independent role allows us to act as an 'honest broker' in these situations. For an example, see case study 7.

CaseStudy7

In 2005, the husband of a police officer asked us to help resolve ongoing issues that the officer had had with NSW Police.

The officer alleged in 2001 that a male officer had indecently assaulted her. Despite his admission that he had grabbed the inside of her leg, he was not seriously disciplined. The female officer was reprimanded for making the complaint.

In the meantime, she made more serious allegations that she had previously withheld because she had no confidence that her commander would take them seriously. These allegations were properly investigated. However the investigator found no evidence to support the allegations. He also questioned the officer's motives and recommended that she be reprimanded for failing to report the allegations earlier.

During the four years between her first allegation and her husband contacting us, NSW Police did not always keep the officer informed about the progress of the investigations. When we spoke to her, she was suffering a stress-related illness and

was on sick leave. She wanted to return to work, but could not work for NSW Police until she felt they had treated her fairly. We decided to attempt to conciliate the matter.

At the conciliation, NSW Police apologised for the inadequate way in which the officer's complaints had been investigated. They also agreed to provide her with a copy of the complaint investigation reports, which they had previously refused to give her.

The police station where she worked had a new commander. He invited her to morning tea, to meet the officers that she would be working with if she returned to work, and to learn more about the type of work she would be doing.

NSW Police also asked the DPP for advice about whether there was sufficient evidence to prosecute the male officer for indecent assault.

Although the DPP advised there was not enough evidence to charge the male officer, the complainant was satisfied because her allegations had finally been taken seriously. NSW Police are continuing to address the ongoing concerns of the officer.

Improving the police complaint-handling system

In this section we outline some of the work we have done to improve the police complaint-handling system.

Notifying complaints to our office

As a result of one of our regular audits into the handling of 'local management issues', we discovered that NSW Police were repeatedly failing to notify us of complaints that had been referred to them by the PIC, in breach of their legal obligation to do so. We decided to directly investigate the way that NSW Police managed all complaints referred to them by the PIC and our office.

Our investigation confirmed the results of our audit. We also found that there were often significant delays in the handling of complaints referred to NSW Police by our office and the PIC. There was also a tendency for police to 'downgrade' complaints that we had categorised as category 2 to the status of 'local management issues' without our knowledge.

These were trends that directly undermined the integrity of the police complaints system. We recommended that NSW Police centralise complaint notifications and that commanders be required to consult with us before downgrading complaint categories. We also recommended that NSW Police consult us about the development of policies and procedures in these areas.

NSW Police agreed to our recommendations, and our most recent audits have shown that referred complaints are being registered and assessed much more quickly.

Investigation of complaints about officers by police from other commands

As a result of a PIC report in 2000, a protocol was developed that required the most serious complaints to be investigated by commands external to the command where the alleged misconduct had occurred. This was to reduce the potential conflicts of interest that could occur when local police investigated complaints about officers within their own command.

Sometimes this is appropriate. However, having a complaint investigated by another command is resource intensive. If there is no conflict of interest, the expense and delay is an unnecessary burden to NSW Police. The delay may also cause needless anxiety for the complainant and the accused officer.

We have worked with the PIC and NSW Police for several years to find an alternative solution that would allow NSW Police to determine at the outset whether a complaint should be investigated by another command, rather than referring every serious complaint to another command.

This work has resulted in CARA — a complaint allocation risk assessment — which provides guidance on whether a complaint should be investigated by an external command.

This year CARA was trialled in two areas of NSW. We assessed the trial and found that CARA is generally effective. NSW Police have accepted our recommended improvements, including:

- referring all serious complaints about senior local police to other commands
- requiring local police to record their risk management strategies.

Visiting complaint management teams

As a result of our previous investigations into delayed complaint investigations, complaint management teams (CMTs) at each command monitor the progress of complaint investigations. The CMT usually includes the commander, the crime manager and an administrative officer.

In 2003 we began a program of visiting local area commands to observe CMT meetings and identify examples of good practice that other commands could learn from. After a year of these visits, we issued a discussion paper highlighting some examples of good practice.

In our experience, a well-run CMT:

- has a clear agenda
- monitors the progress of all complaint investigations
- does not spend too much time on minor matters
- looks at strategic ways to manage officers of concern, rather than narrowly focusing on individual complaints about them.

In the past year, we have visited 15 CMTs across NSW. Before our visit we examine our files on complaints within the command, so we can provide feedback to the CMT about the strengths and weaknesses of their complaint-handling performance and discuss officers who have significant complaint histories. After sitting in on the CMT meeting, we make suggestions about how to make future meetings more effective.

We will continue our visits over the coming year to assess whether the performance of CMTs is improving.

Lengthy complaint investigations

Lengthy complaint investigations can have a detrimental effect on both the complainant and the officer involved, and may reduce the community's confidence in the police complaints system.

For several years we have been conducting direct investigations into the timeliness of complaint investigations. These have been successful in helping police to pinpoint the common reasons for avoidable delay and take remedial measures.

NSW Police have now undertaken to:

- set a benchmark of having 70% of all complaints completed within 90 days
- incorporate complaint management key performance indicators in each commander's performance agreement, including one which measures the timeliness of complaint investigations
- increase the number of officers given training on how to investigate complaints.

We have also recently reached an agreement with NSW Police to trial a new way of managing lengthy investigations. Under this agreement, the Professional Standards Command has primary responsibility for managing the timeliness of investigations.

We will meet with the Professional Standards Command three times a year to review all delayed complaint investigations and to discuss trends in complaint management. We will also still, if necessary, directly investigate delayed complaint investigations.

Civil proceedings against police

Sometimes a person will seek damages for the alleged unreasonable or improper conduct of police officers. However the person suing may not make a complaint at the same time.

In 2003, we decided to make preliminary inquiries into how police were addressing allegations and findings of misconduct in civil proceedings. It is crucial that police examine all allegations of misconduct — whether or not they are made as part of a complaint — to help them identify risky behaviour and develop methods to prevent similar conduct from occurring again.

Such an analysis should also help to reduce the liability of NSW Police by minimising the likelihood that civil claims against police will be commenced or succeed.

In addition, we believe it is important for NSW Police to consider decisions by judges and magistrates that are critical of police conduct.

It was clear from our preliminary inquiries that this did not occur as a matter of course, so we decided to directly investigate the way NSW Police handled such matters. We required them to provide information that would allow us to audit civil proceedings against police in 2003-04.

Our final report emphasised that NSW Police should have reliable systems to identify any allegations of misconduct arising from civil proceedings, and that they should also investigate the officers the subjects of these allegations.

NSW Police have obtained legal advice on the issues raised in our final report. Because we have not yet achieved a satisfactory outcome, the Ombudsman has asked the Commissioner to personally consider the issue.

Concerns about police conduct by judges and prosecutors

Local commands have a rigorous system for reviewing failed prosecutions in local courts. This is to ensure that deficient investigation and prosecution practices can be rectified, and poor performance and misconduct identified and addressed. However this system did not extend to proceedings in the Supreme Court and District Court.

In 2005, we received a complaint arising from a finding of the District Court in 2001 that police officers had threatened an accused person to obtain admissions. The alleged threats were made in 1995, almost 10 years before we received the complaint. Another District Court judge had made different findings on the same evidence in 1997, and these findings had been accepted by the Court of Criminal Appeal.

Because the court hearings had resulted in different findings, and it was almost 10 years since the alleged police misconduct, we agreed with the NSW Police decision not to investigate the complaint.

However we were concerned that the adverse findings made about police officers in 2001 had not been investigated at that time. We raised this issue with the DPP and the Supreme and District Courts. As a result, the DPP has agreed to refer adverse comments on police conduct by judges, and concerns by DPP officers about police conduct, to NSW Police.

The Chief Justice of the Supreme Court has agreed to implement a scheme for reporting comments about police officers. We have asked that District Court judges be reminded of the options available to them to report adverse comments about police.

Information from phone taps

In last year's annual report, we described the problems we had faced in obtaining information about telephone intercepts (phone taps) relevant to police complaints and complaint investigations.

We are pleased to report that these problems have now been resolved. In 2005 we met with NSW Police and the Commonwealth Attorney-General's Department to discuss the issues involved. Since then, some critical developments have occurred.

- The Commonwealth legislation was amended to clarify that phone tap information can be used in the investigation of complaints of police misconduct.
- The Commonwealth Attorney-General's Department provided formal advice to NSW Police about when they can legitimately provide us with phone tap information.

NSW Police are developing guidelines for providing us with phone tap material in the context of police complaint notifications and investigations.

Advice on complaint management policies

We frequently provide advice to NSW Police about their policies and procedures for complaint-handling. In the past year, we have worked with NSW Police on:

- the appropriate use of an officer's complaint history during consideration of their possible promotion
- the development of internal grievance procedures to help senior police resolve conflicts and disputes early and prevent them escalating into formal complaints
- the establishment of procedures to manage complaints about members of the NSW Police Executive Service.

Deliberately false complaints

The *Police Act 1990* was amended in 2001 to make it an offence to deliberately make a false complaint about police. We have encouraged NSW Police to use this provision where appropriate. At our request a series of articles has appeared in the police newsletter, the *Police Weekly*, describing the successful prosecution of people who have made deliberately false complaints. We hope this will encourage commanders to identify other cases where prosecuting the complainant may be the appropriate course of action.

To maintain the integrity of the complaints system, we believe it is important to charge a person if there is strong evidence that they have deliberately made a false complaint to thwart police — see case study 8.

CaseStudy8

In 2005 a driver was stopped by a police officer for speeding and issued with a speeding fine. The officer also issued the man with a fine for not having a registration sticker for his trailer.

The driver made a complaint that the officer had stolen his registration sticker and treated him rudely. What the driver did not realise was that the entire incident was recorded on the police car's video and voice recording system.

The driver was interviewed and admitted that he had made false allegations about the police officer. He was charged with making a false complaint, pleaded guilty at court and was placed on a good behaviour bond. He was also ordered to pay over \$900 to cover the costs of investigating his complaint.

The driver has since apologised to the police officer for making the false complaint about him.

Profiling officers and local commands

Police complaints can be an indicator of risk in relation to both individual officers and local commands. Analysing complaints is an effective way of identifying and addressing potential trends and problems at an early stage.

Ombudsman profiles

We use information from our reviews of complaint investigations to create profiles of individual officers, complaint investigators and local commands. This information is useful in our discussions with commanders and in our oversight of individual complaints. See case study 9.

Officer risk assessment

For some time we have been working with the PIC to assist NSW Police to develop improved approaches to officer risk identification and management. This year we participated in the evaluation of a trial of a new risk assessment tool called ORA — officer risk assessment. Further evaluation is required to assess the worth of this initiative, and refine risk indicators. A group including NSW Police, the Police Association, the PIC and the Ombudsman will undertake this work.

CaseStudy9

We reviewed the investigation of a complaint that an officer had used excessive force. During that review, we found that the police investigator had himself attracted a number of complaints alleging assault and excessive force over a period of years.

While a number of these complaints were not found to be established, the fact that he continued to attract complaints about the same types of issues suggested that he posed some risk to NSW Police and the community. We asked NSW Police to consider this risk and whether the officer should be assigned to investigate complaints about assault, given his own complaint history.

NSW Police conducted a risk assessment and are monitoring the officer's behaviour closely. They also agreed not to assign him to investigate complaints about assault or excessive force.

Working with Aboriginal people

This year marks the tenth anniversary of the creation of our Aboriginal Complaints Unit (ACU). We have achieved significant outcomes for Aboriginal people through the ACU, particularly by resolving tensions, conflicts and disputes between police and Aboriginal communities.

For several years we have been scrutinising the way police relate to local Aboriginal communities across NSW. By 'auditing' the performance of local police commands, we have helped NSW Police to reinforce with their officers the importance and benefits of complying with the NSW Police policy relating to Aboriginal communities, the *Aboriginal Strategic Direction*.



Scott Campbell from our ACU (centre) with Uncle George Riley and June Cain from the Warren Local Aboriginal Land Council.



Laurel Russ from our ACU with Roy Leonard, police Aboriginal community liaison officer at Canobolas.



Our ACU staff (bottom row, 1st and 4th from left) with staff from other agencies at the Good Service forum in Newcastle this year.

Progress since our report to Parliament

In April 2005, we tabled a report to Parliament describing in detail our work with Aboriginal communities and police.

One of our recommendations was that police identify and share examples of best practice. Police commands that we visited for the first time this year were aware of the positive outcomes that had been achieved in other locations through good use of the *Aboriginal Strategic Direction*, and were actively exploring or implementing initiatives that were working well in other commands.

We also recommended that NSW Police improve their recruitment of Aboriginal officers. A taskforce has now been appointed to focus on this issue and has undertaken to implement various measures to increase the number of Aboriginal officers.

These include:

- working with local Aboriginal employment programs
- identifying and accessing state and federal funding to create Aboriginal traineeships
- giving potential Aboriginal recruits more options in relation to their training and work experience
- giving new Aboriginal officers more peer support and access to mentors
- ensuring that potential Aboriginal recruits are aware of the benefits of working with NSW Police, including the variety of roles and locations on offer.

We recommended that NSW Police emphasise how important it is for local police to have strong and meaningful partnerships with Aboriginal communities. We believe this is vital in reducing crime and improving the impact of social services. Since our report, several commanders have established formal partnerships with their local Aboriginal communities focusing on crime prevention and youth development initiatives. They also aim to bring together members of the Aboriginal community, police and service organisations to confront fundamental social problems.

Revisiting commands

This year we revisited seven commands that we first audited two years ago. We wanted to see if police were implementing the recommendations we had made and assess whether and how the community had changed.

We are pleased to say that we found significant improvements in all the commands that we revisited. It was particularly rewarding to see the stronger ties between police and Aboriginal communities. We believe this is a direct result of our work in this area. For an example, please see Building community relationships on page 28.

It's time to talk

By JANICE HARRIS

TWO years of failed attempts to bring the local Aboriginal community and police together to address issues facing both groups ended yesterday when almost 30 people attended a specially convened meeting at Orange Police Station.

In a last ditch effort to address concerns by the NSW

Ombudsman about the relationship between police and the Aboriginal community in Orange, Canobolas Local Area Commander Superintendent Mark Szalajko appealed to people to come forward and have their say.

Supt Szalajko and Aboriginal elder Gerald Power are hailing the forum as a great success.

"This is now a great way forward." Mr Power said.

Supt Szalajko said the attendance exceeded his expectations.

"It was very positive - we achieved our goal of getting people to come together," he said.

The new LACAC group of police and Aborigines will work closely with the Aboriginal Consultative Committee and will meet each month.

Central Western Daily, 5 July 2006, p1.

Specific projects

There are many policing issues that come to our attention through our complaint-handling work and our contact with police and members of the community. We sometimes decide to look at these issues in more detail as part of a specific project.

Domestic violence

This year we began a project to examine the effectiveness of the strategies used by NSW Police to address domestic violence.

As well as providing us with a general overview of domestic violence in NSW, this project has allowed us to focus on some specific aspects of the police response to domestic violence, including:

- critical issues, identified by experts and practitioners in the field, that police need to address
- compliance with policies and procedures
- operational constraints that may reduce the quality of the police response to domestic violence
- the benefits of the specialist position of domestic violence liaison officer
- the need for interagency cooperation.

We have also had an opportunity to examine how different government departments are working together to help children and families at risk. In particular, we are looking at whether police are notifying the Department of Community Services about domestic violence incidents involving children.

This project has involved extensive consultation with stakeholders such as women's domestic violence court assistance schemes, regional violence prevention specialists and the NSW women's refuge movement. We have also consulted with a range of specialist police throughout NSW.

Police pursuits

This project has involved closely examining the way police use and comply with their safe driving policy. This policy provides guidance on a range of safe driving issues, including police pursuits.

The impetus for this project was a complaint received in 2004, involving the police pursuit of a car being driven by a 13-year-old girl. The girl crashed the car into an oncoming truck and the car rolled for a considerable distance. She suffered serious injuries and spent over eight months in hospital.

When we reviewed the complaint, we had concerns about the way the pursuit had been conducted, and that other important aspects of the safe driving policy

had not been followed. Our preliminary inquiries indicated that these breaches might be occurring on a regular basis throughout NSW Police.

The project has involved a comprehensive review of police pursuits conducted over a twelve month period — including a review of complaints involving pursuits and the consideration of certain pursuit policies developed at the local level. We have recently provided NSW Police with our draft report.

Policing metropolitan communities

Another project we completed this year examined policing in a troubled metropolitan housing estate community.

The issue came to our attention through a complaint that young people on the estate were being targeted by police on the basis of their racial appearance. The estate community thought this was unfair and failed to deal adequately with the real problem — a gang that had 'taken over' the estate and was committing crimes and causing disturbances. The community believed the failure of police to deal with the gang indicated a disregard for their safety. This was causing a serious rift between police and the community, and hostility from young people towards police was leading to violence in some cases.

We decided to take a close look at the policing practices of the command and the way they related to the housing estate community, as well as the rest of the area that they were responsible for policing.

We found that there were two distinct communities that required significant police attention — the large local Muslim community and the housing estate. Although police had built strong relationships with the Muslim community, this was at the expense of their relationship with the estate community. We also found that the strategies police had to deal with the rise in crime at the estate were not being effectively communicated to the people living there.

We made several recommendations for change. For example, we recommended that after a significant police operation or traumatic criminal incident, police should hold a 'debriefing' with the estate community. We also recommended that the local youth liaison officer begin conducting activities for young people at the estate. At the suggestion of the community, we recommended police work with council and estate tenants to develop a formal crime prevention plan.

Local police have been receptive to our recommendations. We have contacted members of the estate community and have been advised that positive changes are occurring.

Reviewing new police powers

Since 1998, the NSW Parliament has asked us to conduct 17 reviews of new police powers. This has provided us with the opportunity to examine how police officers understand and use their new powers. This year we have been asked to conduct two further reviews.

Our approach

Generally the review provisions stipulate that we must 'keep under scrutiny' the operation of the powers. To do this, we conduct independent research and use a wide range of strategies to see whether police are using their powers effectively and fairly.

We analyse data held by police, directly observe police officers exercising the new powers, analyse complaints, conduct surveys and focus groups with stakeholders, undertake literature reviews, and review similar provisions in other jurisdictions. We also consult extensively with NSW Police at all ranks.

If we have evidence of a problem that can be fixed quickly, we usually recommend that police change their operational procedures immediately to solve the problem. If appropriate, we may also support NSW Police in seeking legislative amendments during the review period.

Results of our reviews

The aim of our recommendations is to ensure that legislation is workable for police and powers are exercised fairly. We focus on changing police practices to ensure more appropriate use of powers and the reasonable use of discretion by police officers.

Some of our reviews have strongly supported the new powers and have recommended legislative amendments to increase their effectiveness. For example, our review of the *Child Protection (Offenders Registration) Act 2000* supported amendments increasing the reporting requirements of registered people. We also made recommendations to increase the effectiveness of police monitoring of these people.

However, at other times, we have found evidence that Parliament needs to consider whether the legislation should remain in force. For example, our review of the *Police Powers (Internally Concealed Drugs) Act 2001* — which granted police the power to take medical images of suspected drug dealers — recommended that Parliament should consider repealing this legislation.

We have also recommended that Parliament consider redrafting or refining certain legislative provisions. For instance, our review of the *Police Powers (Drug*

Premises) Act 2001 recommended that the drug move-on provisions be replaced by clearer provisions.

This year we began systematically monitoring the progress of the implementation of the recommendations we made in our legislative review reports. So far, we have examined the implementation of 47 recommendations about police operational procedures and have found that NSW Police support the majority — 73% have been implemented or are in the process of being implemented. These findings are an encouraging sign of the success of our legislative review reports.

Please see figure 27 for an overview of the legislative review reports we tabled this year, as well as our current and future reviews.

Status of legislative reviews about police powers

fig 27

Status	Legislation	Brief description
Review reports tabled in Parliament 2005-06	<i>Police Powers (Drug Premises) Act 2001</i> — report tabled in September 2005.	Gives police powers to search suspected drug houses, and to move people on if police believe they are purchasing or supplying drugs.
	<i>Police Powers (Vehicles) Amendment Act 2001</i> — report tabled in November 2005.	Allows police to request identity information from passengers in vehicles in certain circumstances.
	<i>Crimes Legislation Amendment (Penalty Notice Offences) Act 2002</i> — report tabled in November 2005.	Allows police to trial the issue of 'on-the-spot' fines for specific criminal offences, such as shoplifting, and to take fingerprints in the field.
	<i>Child Protection (Offenders Registration) Act 2000</i> — report tabled in November 2005.	Allows police to keep a register of people living in the community who have committed offences against children.
	<i>Police Powers (Internally Concealed Drugs) Act 2001</i> — report tabled in November 2005.	Allows police to carry out internal searches using x-ray, CAT scans or magnetic resonance imaging on people suspected of swallowing or otherwise internally concealing a prohibited drug for the purposes of supply.
Review reports provided to the responsible Minister and not yet tabled	<i>Police Powers (Drug Detection Dogs) Act 2001</i> — report tabled in September 2006.	Regulates how police use drug detection dogs ('sniffer dogs') in the community.
	<i>Police Powers (Drug Detection in Border Areas Trial) Act 2003</i> — report provided to the Hon. John Watkins, then Minister for Police, and the Hon. Bob Debus, Attorney General, in January 2005.	Allowed police to trial check points in border areas for the deployment of drug detection dogs ('sniffer dogs').
Draft reports	<i>Firearms Amendment (Public Safety) Act 2002</i> — report provided to the Hon. Bob Debus, Attorney General, and the Hon. Carl Scully, Minister for Police, in April 2006.	Allows police to use dogs to detect firearms or explosives in a public place without a warrant.
	<i>Crimes (Forensic Procedures) Act 2000</i> — draft report provided to NSW Police and other agencies in March 2006.	Allows police to take DNA samples from volunteers and suspects.
Current reviews	<i>Justice Legislation Amendment (Non-association and Place Restriction) Act 2001</i> — draft report provided to NSW Police and other agencies in June 2006.	Allows police and courts to place restrictions on the places that a person can be in and the people they can associate with — when determining bail conditions, imposing a sentence or allowing parole.
	<i>Law Enforcement Legislation Amendment (Public Safety) Act 2005</i>	Introduced after the Cronulla riots. Allows police to prevent or control 'large scale public disorder' incidents.
	<i>Law Enforcement (Powers and Responsibilities) Act 2002</i> – Part 7 'Crime Scenes'.	Regulates police powers for setting up crime scenes.
	<i>Law Enforcement (Powers and Responsibilities) Act 2002</i> – Part 5, Division 3 'Notices to produce documents'.	Allows police to issue notices requiring financial institutions to produce information about their customers relevant to criminal investigations.
	<i>Law Enforcement (Powers and Responsibilities) Act 2002</i> – Part 4, Divisions 2 and 4 'Searches on arrest or in custody'.	Regulates the safeguards connected with searching people after they have been arrested or while they are in custody.
	<i>Terrorism (Police Powers) Act 2002</i> – Part 3.	Allows police and the Crime Commission to execute covert search warrants.
Future reviews (legislation has not commenced)	<i>Terrorism (Police Powers) Act 2002</i> – Part 2A.	Allows police to hold people suspected of involvement in terrorist-related activities in preventative detention.
	<i>Crimes Legislation Amendment Act 2002</i> .	Regulates the detention of people arrested during the execution of a search warrant.

5. Covert operations

Certain law enforcement agencies have the power to conduct covert operations — activities carried out during investigations that would otherwise be illegal. During these operations use is made of certain legislation such as the *Listening Devices Act 1984*, the *Telecommunications (Interception) (NSW) Act 1987* and the *Law Enforcement (Controlled Operations) Act 1997*.

Under these Acts NSW Police, the Crime Commission, the Independent Commission Against Corruption and the Police Integrity Commission have the power to intercept telephone conversations and plant devices to record conversations and track positions of objects. These NSW agencies and some Commonwealth agencies also have the power to carry out other operations that may involve committing breaches of the law, for example the possession of illicit drugs.

Because these kinds of operations involve significant intrusions into people's private lives, the agencies may only use these powers if they follow the approval procedures and accountability provisions set out in the relevant Act. We have a specialist unit within our office that monitors compliance with the accountability schemes set up for telephone intercepts and controlled operations, but not surveillance devices.

In 2004 the Commonwealth *Surveillance Devices Act 2004* implemented a model bill aimed in part to provide a framework for the regulation of the use of a broad range of surveillance devices including listening devices, optical surveillance devices, data surveillance devices and tracking devices. To address concerns about the potential abuse of the new powers — which

arguably give law enforcement agencies an unprecedented ability to monitor conversations and movements of members of the public — the Act requires the Commonwealth Ombudsman to inspect records relating to the use of these devices.

Although it was expected each state would enact legislation similar to the Commonwealth Act, in NSW a draft Bill to do this was only circulated for comment in July this year. This Bill seeks to expand the Ombudsman's monitoring role to cover surveillance devices.

Controlled operations

Controlled, or 'undercover', operations allow law enforcement agencies to infiltrate criminal groups — particularly those engaged in drug trafficking and organised crime — in order to obtain evidence of criminal activity or expose corrupt conduct.

The head of a law enforcement agency may approve controlled operations without consulting an external authority. To ensure accountability for these operations, the Ombudsman has a significant role in monitoring the approval process.

Agencies must notify us within 21 days of the authorisation of an operation, or the receipt by the head of an agency of a report at the completion of an operation. We are also required to inspect the records of each agency at least once a year to ensure they are notifying us of all operations. We have the power to make a special report to Parliament if we have concerns that we believe should be brought to the attention of the public.

6. Witness protection

...Covert operations continued

During 2005–06 we inspected the records of 509 controlled operations. The number of records we have inspected has increased by 300% since 1997.

We report on our work in this area in detail in a separate annual report which is available at our website and from our office. As well as reporting on compliance with the Act, we provide details about the types of criminal conduct targeted and the number of people authorised to undertake controlled operations.

A review of the Act was completed by the Ministry of Police and tabled in Parliament in June 2004. Some of its recommendations were implemented in the *Law Enforcement (Controlled Operations) Amendment Act 2006*, which was assented to on 11 April 2006 but at the time of writing is not yet in force. The amending Act made no changes to the inspection and monitoring role of the Ombudsman.

Telecommunication interceptions

We are responsible for ensuring agencies comply with their requirements for keeping records of telecommunication interceptions. For example, agencies must be able to provide documentation of warrants issued and a description of how the information gathered is used. They must also demonstrate all records are kept securely and destroyed once they are no longer required. We inspect each agency's records at least twice a year and report the results of our inspections to the Attorney General.

During the year, staff from our secure monitoring unit met with telecommunications interception inspectors from other jurisdictions to discuss common issues and concerns. For example, recent amendments to the Commonwealth *Telecommunications (Interception) Act 1979* gave agencies the power to conduct certain additional operations. While NSW agencies can already use these additional powers, the failure over recent years to amend the *Telecommunications (Interception) Act 1987* to mirror Commonwealth legislation means the Ombudsman is not currently monitoring the use of these powers.

The witness protection program

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

Appeals

The Act gives the NSW Commissioner of Police the power to refuse someone entry to, or remove them from, the program. The person may appeal this decision to the Ombudsman. The Ombudsman must determine an appeal within seven days and our decision overrides the Commissioner's. This year we heard one appeal from someone who had been refused entry to the program. After interviewing the applicant and reviewing their case file, we agreed with the Commissioner's finding that the circumstances did not warrant the applicant's inclusion on the program and dismissed the appeal.

Complaints

Witnesses have a right to complain to the Ombudsman about the conduct of police in relation to the operation of the program. Complaints usually relate to management practices and personality conflicts between participants and the officers responsible for their protection. Because of the need to maintain the ongoing relationship between the participants and their case officers, we try to use conciliation methods to resolve these complaints. Where complaints raise systemic issues, we have found that police typically respond positively to our suggestions for improving their systems. This process has contributed to a noticeable improvement in the management of the program and a related decrease in the number of complaints we receive. This year we dealt with only four complaints from participants on the program.

7. Departments and authorities

Highlights

- Of the 661 preliminary and formal investigations we conducted into complaints about departments and authorities, we achieved a total of 633 positive outcomes.
- The NSW government allocated \$12.9 million to enable the Valuer General to implement the major recommendations of our report on 'Improving the Quality of Land Valuations Issued by the Valuer General' following our major systemic investigation.
- As a result of our recommendations, RailCorp has restructured its complaint-handling systems, introduced a system that allows officers' complaints histories to be reviewed, amended a number of standard operating procedures, and formalised the procedures for the use of discretion by transit officers in relation to issuing infringement notices.
- As a result of our intervention, the State Debt Recovery Office has made a number of changes to its procedures, including increasing outreach programs to raise awareness of the Fine Enforcement Hardship Review Board and reviewing database input procedures to minimise identity error.

Introduction

In this chapter we discuss some of the issues arising from the complaints we received about NSW departments and statutory authorities during the year. We report on our specific work relating to police, corrections, local government and community services in other chapters.

During 2005-06 we received 1,329 complaints in writing (which we call 'formal' complaints) and 3,625 complaints over the telephone or in person (which we call 'informal' complaints). About a quarter of these complaints were from people who were concerned about issues affecting their property and homes. Many complaints were also from people who were concerned about the way their businesses and personal lives were being regulated, and about issues in relation to transport and utilities. See figure 28.

The number of formal complaints we received this year was similar to the amount received in 2004-05, however, the number of informal complaints we received dropped significantly this year. See figure 29. As in previous years, basic customer service issues and poor complaint handling were the subject of a large proportion of complaints. See figure 30. This year we finalised 655 complaints through preliminary or informal investigation, and 6 complaints by formally investigating the issue. See figure 31.



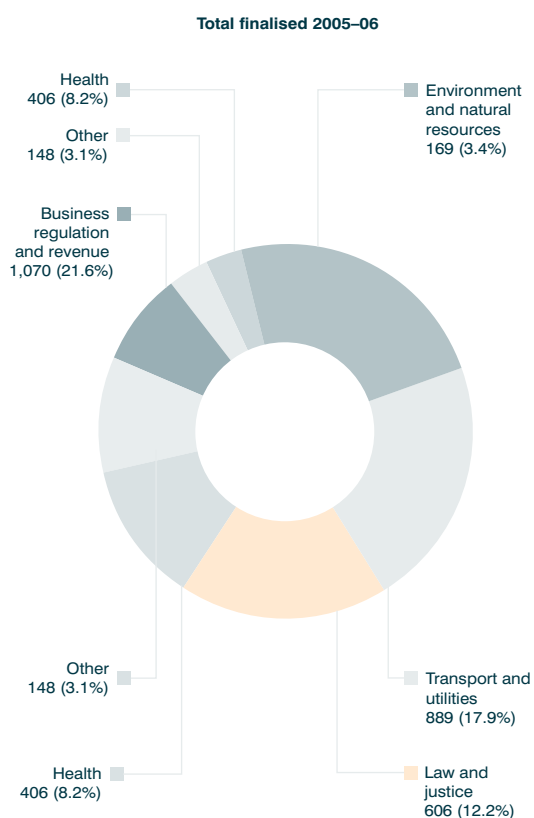
Staff from our general team handle complaints and inquiries about departments and authorities except NSW Police, DoCS, DADHC and those relating to child protection notifications.

Formal and informal complaints received — by agency category

fig 28

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

Category of agency	Total
Planning, property and housing	1,170
Business regulation and revenue	1,070
Transport and utilities	889
Law and justice	606
Education	496
Health	406
Environment and natural resources	169
Emergency services	56
Culture and recreation	44
Aboriginal Land Councils and services	24
Other	24
Total 2005–06	4,954

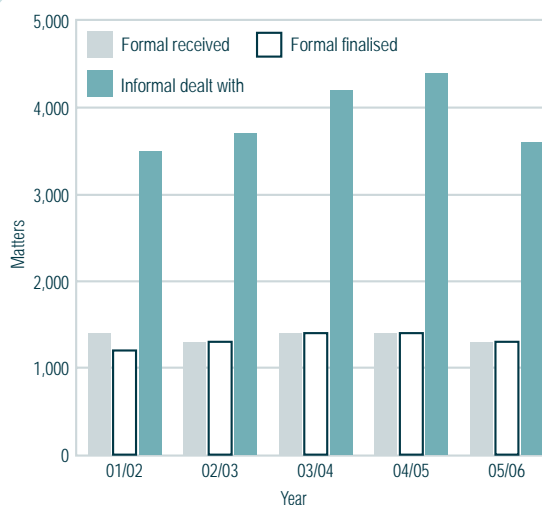


Five year comparison of matters received and finalised

fig 29

Matters	01/02	02/03	03/04	04/05	05/06
Formal received	1,140	1,280	1,390	1,355	1,329
Formal finalised	1,238	1,304	1,390	1,386	1,317
Informal dealt with	3,546	3,719	4,161	4,414	3,625

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



What people complained about

fig 30

This figure shows the complaints we received in 2005–06 about NSW public sector agencies other than those complaints concerning police, community services, councils, corrections and freedom of information, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Customer service	172	737	909
Complaint handling	229	437	666
Charges / fees	204	388	592
Enforcement	160	382	542
Object to decision	83	418	501
Approvals	104	267	371
Information	93	200	293
Policy / law	55	189	244
Contractual issues	62	174	236
Conduct outside jurisdiction	64	167	231
Other	27	111	138
Misconduct	39	59	98
Natural justice	17	52	69
Management	19	41	60
Child abuse related	1	3	4
Total 2005–06	1,329	3,625	4,954

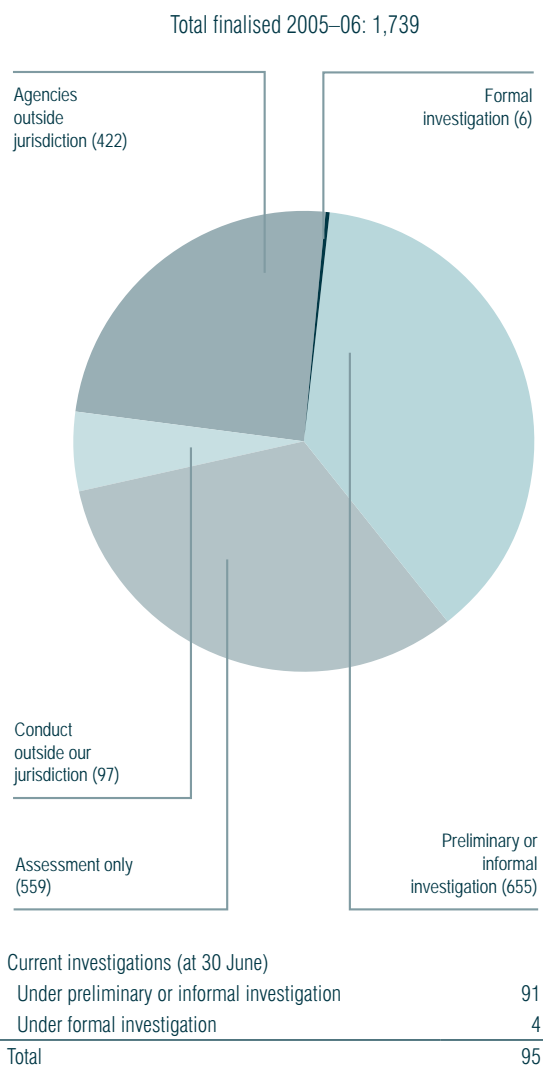
Performance indicator Time taken to assess complaints

Target	2005-06
90% within 48 hours	93% within 48 hours

Performance indicator Time taken to finalise complaints

Target	2005-06
Average: 7 weeks	Average: 5 Weeks

Formal complaints finalised fig 31



Resolving individual complaints

This year we dealt with complaints about 113 different departments and agencies in all. These included large organisations such as the Department of Housing, Department of Education and Training, Department of Primary Industries (see case study 10), Department of Health (see case study 11), Department of Lands (see case study 12) and agencies that have high public contact such as RailCorp (discussed below), the Department of Commerce and Office of State Revenue. We also dealt with complaints about a number of small authorities such as the Tow Truck Industry Council, Aboriginal land councils and the Zoological Parks Board. Please see Appendix C for a full list of agencies we received complaints about this year and how we dealt with these complaints.

Performance indicator Complaints resolved through the provision of advice or constructive action by a department or authority

Target	2005-06
65%	67%

A broad range of outcomes is achieved in relation to the complaints we handle. These include the relevant agency providing an apology or negotiating a settlement with the complainant, or changing their policies or original decision.

In many matters we handled this year, not only was the individual grievance resolved (eg case study 11) but our intervention led to important changes in agency policies and procedures (eg case study 10). For example in 2005-06, our involvement has led to changes in systems relating to:

- consultation with people who are going to be directly affected by a department's decision (see case study 12)
- the licensing of builders (see case study 13)
- land valuation (see Accuracy of land valuations below).

CaseStudy10

The owner of land subject to an open cut coal mining lease complained about the quality of the mining company's rehabilitation of his property, and that the Department of Primary Industries had failed to make sure his land was restored to its pre-mining condition.

We first addressed this complaint in 2001. The department gave us undertakings to fix the problem but in late 2004 the landowner told us there had been no progress with the rehabilitation.

Our inquiries — which included a site visit and meetings with the department and the landowner — suggested that the department had failed to ensure that the mining company prepared a detailed rehabilitation plan before it was granted the lease. This made it very difficult for the department to enforce rehabilitation requirements.

This case also highlighted other weaknesses in the process, including the inadequacy of rehabilitation security deposits and the lack of clarity about what constitutes approval for a rehabilitation plan.

We understand that the department recently proposed and obtained approval for significant amendments to the *Mining Act 1992*.

These amendments will:

- require lease title to include conditions necessary to protect the environment
- remove discretion to not impose conditions for rehabilitation
- require a rehabilitation security deposit to reflect the full cost of rehabilitating the title area and adjacent land
- clarify the Minister's powers
- make environmental reporting on mine sites a statutory requirement, rather than a title condition
- broaden powers that facilitate environmental audits on mine sites
- allow the Minister in certain circumstances to amend mining operations plans, title conditions and security deposit amounts
- make the development of closure plans (to facilitate rehabilitation and appropriate post-mining land use) a statutory requirement for mines about to close down
- extend the department's enforcement powers.

CaseStudy11

A doctor complained about the way NSW Health had handled complaints about him, some of which related to operations he performed before he went to work overseas for a time. When he returned to Australia, he found he had problems getting work in his local area because of his complaint history. We reviewed the department's files and met with both the previous and the current CEOs from the relevant Area Health Service (AHS). An investigation into the complaints had been begun, but was not completed because the doctor had gone overseas. Our subsequent inquiries into the original matters showed there was no compelling evidence of malpractice by the doctor.

When serious complaints are made about a professional person, a thorough investigation into the matter is very important. A finding of unprofessional conduct gives administrators a chance to take appropriate action. Just as importantly, an investigation can be an opportunity for a person to clear their name of any allegations. If the doctor had been guilty of malpractice or professional incompetence, the failure to identify and act on this could have had serious consequences, whether he was practising in Australia or overseas. Following our investigation, the AHS updated their records and apologised to the doctor.

The department is developing guidelines for rehabilitation approvals and proposing a compulsory independent audit of rehabilitation before final approval is granted. There will also be a new seven year window in which they can require further rehabilitation.

These initiatives addressed most of our concerns and removed the need for a formal investigation. Also, after negotiation, the complainant agreed to sell the affected land to the mining company.

CaseStudy12

We queried the Department of Lands about altering an inner city land boundary without notifying the person who owned the land next door — who had made a complaint to us. The alteration had allowed the complainant's neighbour to build right up to the boundary, leaving no space between the new building and the gutter of the complainant's house.

We found that the department may change the registered location of land boundaries merely by registering a plan made by a surveyor. In some cases, this can lead to a reduction in land area because the actual dimensions of an old suburban street block can be less than those on that block's last registered plan. When this occurs, all affected owners should be notified — something the department rarely does. The reduction should also be distributed fairly across all the properties in the block.

In this case, the neighbour on the other side of the development site had by chance learnt of the boundary alterations to her block (already approved by the department) and complained to the department. The department had then met with the developer, his surveyor, and the neighbour and agreed to a redistribution of the shortage. The person who had complained to us had not been invited to this meeting, and consequently had no opportunity to dispute the proportion allocated to her property. We thought this was also inappropriate.

We suggested that the department:

- apologise to our complainant for not involving her in the shortage redistribution meeting
- supply a registered plan showing the exact placement and measurement of all the complainant's boundaries
- change their procedures so that all landowners affected by a proposed boundary redetermination that causes a reduction in their land are informed before the survey is registered, and given the opportunity to object.

The department agreed to apologise and pay for a survey for the complainant and pursue systemic changes within the industry. In March they met with the Institution of Surveyors NSW and a member of the Law Society of NSW Property Law Committee about this issue. We will follow these developments.

CaseStudy13

The complainants contracted a building company to construct a new house in Dural. Before signing the contract, they asked the Office of Fair Trading (OFT) about the company's conduct and were told no penalties or insurance claims were recorded against them.

A few months into construction, the complainants had difficulties with the builder. The house was never finished and had multiple serious defects. The complainants successfully took their case to the Consumer Trader and Tenancy Tribunal, but could not enforce the judgment as the company had no assets. Although covered by homeowner warranty insurance, the complainants' payout did not meet the cost of rectifying and finishing the house.

The complainants discovered that the builder had been the director of two other building companies liquidated less than three years before, so they made a complaint to us about the OFT.

We found that the OFT had an inadequate system of checks for assessing licence applications. In this case staff had failed to perform the checks required, including whether the director had previously run any other companies.

After making further inquiries, we found the OFT had no criteria for assessing an applicant's overall fitness to hold a licence and there were no procedures to ensure information was exchanged between the OFT's insurance debt recovery and licensing sections.

We made a number of recommendations to the OFT, including the need to:

- develop guidelines for assessing the fitness of applicants to hold a licence
- place a warning on the public register about incomplete external insurance claim listings, and collect the missing information within four months
- improve the register by introducing more rigorous checks with other licensed entities
- pay compensation to the complainants.

OFT accepted our findings and recommendations and we are monitoring their implementation.

Accuracy of land valuations

In this year's state budget, the NSW Treasurer announced the government would increase stability in land values which would reduce fluctuations in land tax bills for property investors. From 2007, land tax will be calculated using the average land value over the previous three years. This decision implements one of the recommendations in our special report to Parliament in October 2005 on 'Improving the quality of land valuations issued by the Valuer General'.

The government has also announced funding of \$12.9 million with three years to increase resources for land valuations, reflecting another of the major recommendations in our report.

Our special report was triggered by our investigation into complaints that indicated a serious breakdown in the administration of the system of mass land valuation. This investigation involved reviewing the mass valuation system and the Valuer General's quality control process. Mass valuations are used throughout the world and can be an economic and logistical necessity. We found that the methods used in NSW to determine mass valuations were capable of producing estimates of value within a reasonable margin of error for the majority of properties. We were also satisfied the quality assurance framework — including the objection process — was reasonable. However we found the system had a number of serious weaknesses which produced unacceptable margins of error in some areas.

These weaknesses included:

- a deterioration in the quality of the baseline data
- inadequate time to undertake valuations and to implement quality assurance mechanisms
- inadequate monitoring of component and benchmark reviews and valuations outcomes
- poor quality control of objection processing.

We made 38 recommendations, primarily aimed at ensuring the accuracy of valuations and improving the handling of objections. Most of our recommendations have been implemented or are in the process of being implemented.

Transit officers

Last year we investigated RailCorp's policies and procedures for handling complaints about transit officers, and found that a majority of the RailCorp investigations we audited were fundamentally flawed. The disturbing implication was that some 600 officers with important law-enforcement powers and responsibilities were receiving considerably less rigorous scrutiny than the public had a right to expect.

This matter received significant press coverage after we included some of the details of our investigation in last year's annual report.

Since then, RailCorp has implemented a number of our recommendations. The reforms they have made include:

- restructuring their complaint-handling systems
- introducing a complaints management system that allows officers' complaints histories to be reviewed
- reviewing and amending a number of their standard operating procedures
- formalising the procedures for the use of discretion by transit officers about issuing infringement notices.

These reforms have been pleasing, but we have continued to receive some complaints about transit officers that suggest the need for external scrutiny remains vital. The conclusion we drew last year — that there was an urgent need for RailCorp's complaints handling system to be subject to rigorous and systemic external oversight — was underlined by a case we investigated this year.

In this case, a young man alleged he was handcuffed and knocked to the ground by transit officers at Sutherland station. He suffered serious leg injuries during the incident and, as a result, was off work for an extended period and unable to compete in sporting events.

A complaint was also made to RailCorp about the incident, and we asked for advice on the outcome of their investigation. When we wrote to RailCorp some months later about the matter, we were told arrangements were being made to interview the complainant. The complainant however told us he had received no communication from RailCorp. Our concerns about the timeliness and adequacy of RailCorp's investigation, and the contradictory advice about arrangements to interview the complainant, prompted us to formally investigate their handling of this complaint.

We found RailCorp's handling of this investigation to be very inadequate. As CCTV footage covering the incident was unclear, it was very important that the complainant and other witnesses were interviewed at the outset of the investigation. Several people had witnessed the incident, and one person had even taken photos with his mobile phone.

We found RailCorp had failed to:

- interview a number of witnesses to the incident and view the mobile phone footage
- examine the complaints histories of the involved officers at the start of the investigation

- interview the transit officers who were the subject of the complaint (instead, the transit officers were asked to respond to the complaint in writing — providing an opportunity for them to meet and manufacture a version of events)
- interview other transit officers who had witnessed the incident
- seek medical evidence as to whether the complainant's injury was from the alleged assault or an aggravation of an old injury.

RailCorp also stated that they had suspended the investigation for some time because the complainant had begun civil proceedings. We could find no documentation supporting this decision. More importantly, the fact RailCorp had to form a legal defence made it even more vital for them to properly investigate the facts of the incident. An agency should carefully weigh all relevant matters before suspending the investigation of serious incidents simply because the alleged victim is also seeking a civil remedy.

By the time we received the case review we had recommended, almost 18 months had passed since the alleged assault. The review found, on balance, that excessive force had been used when the complainant was brought to the ground after being handcuffed. Unfortunately, the length of time passed and other flaws in RailCorp's original handling of the matter contributed to the fact that no action could be taken against the officers involved. At the time of writing the civil action was unfinished.

Our suggestion that RailCorp be subject to oversight by a body such as our office has been received positively and negotiations about this are continuing.

Department of Housing

We were able to achieve a number of outcomes from the complaints we received about the Department of Housing this year, including changes to policies and procedures (see case study 14) and individual remedies for the complainants (see case study 15). We also suggested the department apologise to tenants in cases where, for example, administrative errors had been made. When it is impractical to fix or reverse errors, an apology can be a way for a department to acknowledge the disadvantage or distress their mistake has caused their clients. Case study 16 is an example of the department apologising to a client.

Problems experienced by the department's tenants — such as delays in essential house repairs, the disruptive behaviour of neighbours, rental disputes and threats of eviction — have an everyday immediacy that intensifies anxiety and frustration

in those affected. Because a significant number of tenants have a physical disability, mental illness or poor literacy levels, departmental staff can have major difficulties in communicating with these clients. This situation requires clearly written and readily understood procedures and solid training of staff to deal sensitively and effectively with all tenants. We welcome the department's efforts to liaise with other agencies that may also have disadvantaged tenants as their clients.

We have also found that poor record keeping by departmental staff has contributed to their problems with their clients. For example, in one case we discovered that a letter of complaint received by a Sydney office about maintenance matters was thrown away. Last year we sought and received assurances the department would issue directions to staff about improving document filing and record keeping. Unfortunately, more recent cases suggest that this problem is still an issue.

CaseStudy14

A woman claimed the department unfairly forced her family to move from one town to another after an incident with neighbours led to her being charged with assault. This appeared to be part of ongoing disturbances involving these departmental tenants.

The department told us their staff met the tenant and gave her two options:

- the department would apply to the Consumer Trader and Tenancy Tribunal for her immediate eviction, or
- because of the number of children affected by potential homelessness, the department would relocate the family to another town.

The department said the tenant agreed to the second option. Staff made notes of the conversation, but did not document the terms of the agreement and get the tenant to sign it. If this had been done, consent would have been confirmed and the subsequent dispute avoided.

On our suggestion, the department undertook to develop and use an agreement template for transfers in such situations in the future. The complainant, who had been moved months before the complaint was lodged, was notified of the outcome.

CaseStudy15

An elderly couple asked the department for safety handrails to be installed in their home. The man was deaf and his wife was deaf and blind. The woman had had several falls on stairs in the property, suffering a number of injuries.

A local doctor had written to the department asking that handrails be installed. The department told the couple they needed an assessment from an occupational therapist (OT) before installation could be approved. As there was a long waiting list for OTs, the couple would be without handrails for some time.

We discussed the matter with the department, who agreed to approve minor modifications on the basis of a medical certificate from any health professional. They have now amended their policy to reflect this decision.

CaseStudy16

We received a complaint that a tenant was wrongly sent a number of eviction notices. The tenant explained to us he had not paid rent for a period due to previous overpayments that had put him in significant credit. He said the department told him they would notify him when he needed to restart rental payments — but they did not do this. The department subsequently contacted the tenant and he made an arrangement to pay the rent owing.

Around this time, a staff member was asked to examine all rental arrears in the tenant's local office. This staff member, unaware of the arrangements in place, started the eviction process because of the tenant's rental arrears. The local office would not initially apologise, so we asked the Director General to review the matter. The Director General agreed with our suggestion and the department subsequently issued a written apology to the tenant for sending the eviction notices.

The fine enforcement system

On 15 May 2006 Infringement Processing Bureau (IPB) operations were integrated into the State Debt Recovery Office (SDRO). SDRO is now responsible for processing, collecting and enforcing all fines imposed in NSW by state and local government agencies. In the past, people have expressed their frustration to us about having to contact more than one agency for information about their fine. This integration should remove gaps in fine processing and enforcement operations and enable fine recipients to discuss their fine with one person — no matter what stage it has reached in the enforcement process.

Most of our contact with SDRO is by telephone. We find this an efficient means of obtaining information and resolving issues quickly. However, it is also valuable to meet with agencies, and we had three liaison meetings with SDRO during the year. We also visited their Maitland and Lithgow offices.

Some of the complaints we received raised systemic problems and required a more detailed response from SDRO. The suggestions we made to improve their systems were largely accepted and implemented. See case studies 17 and 18.

CaseStudy17

A man shared similar details to a fine defaulter and complained SDRO had mistaken his identity on two occasions. The SDRO had issued the complainant with an examination notice to confirm his identity after they had obtained his details from a telephone directory. The man called the SDRO to deny he was the fine defaulter, but SDRO still began enforcement action against him. He complained to SDRO, who admitted their error and told him they had stopped enforcement action. However in January 2006 the sheriff's office served a property seizure order on the man for the same unpaid fines.

The SDRO initially told us that the RTA wrongly merged the man and the fine defaulter's identities. After our intervention the SDRO agreed to:

- apologise to the complainant
- review procedures for issuing examination notices
- review the way staff record and format information on the SDRO database
- develop a case study based on this incident to train staff to avoid such errors in the future.

Performance indicator

Percentage of our reports to departments and authorities recommending changes to law, policy or procedures

Target	2005-06
90%	90%

Performance indicator

Percentage of recommendations to departments and authorities implemented

Target	2005-06
80%	97%

CaseStudy18

In September 2004 the Fine Enforcement Hardship Review Board was created to independently review SDRO decisions about requests for extensions for time to pay fines and applications to have fines waived. After reviewing a number of complaints from people with large debts from enforcement orders — who were often unemployed, in gaol, juveniles or living in Indigenous or remote communities — we asked the SDRO about the work of the board. They advised us that the board had only received a few applications. We also knew, from community consultations we conducted during the year, that people in remote areas and rural communities were not often aware of the board's existence.

We were concerned that not enough was being done to promote the board as an avenue for people whose time-to-pay application was refused or to identify their eligibility to have their debt waived.

As a result of our inquiries, SDRO expanded the board's personal hardship procedures to include obtaining evidence from a much wider group of advocates such as local land councils, community development and employment project (CDEP) administrators, neighbourhood centres and major charities. They also increased programs to raise awareness of the board by:

- conducting programs with local Aboriginal court and health services
- liaising with major charitable organisations
- attending monthly programs in correctional centres for inmates and staff
- providing fine enforcement information to TAFE driver education programs
- liaising with peak welfare organisations and advocacy groups.

SDRO also agreed to be more proactive in helping people with old and / or large debts by inviting them to apply for a new time-to-pay arrangement.

Policy work

This year we contributed to policy reform in a number of areas. We made a submission to the NSW government's 'Red Tape' review into the impact of regulation and other red tape on government agencies.

We also provided comments and feedback to the Department of Environment and Conservation (DEC) on their draft guidelines for assessing wilderness in NSW. For example, DEC was proposing to report on decisions about wilderness area classifications and types of submissions about areas to the government only, and providing a less comprehensive report to the public. We felt the public should be aware of all relevant information, and recommended DEC publish one report only. We also recommended the DEC prepare a policy on the treatment of public submissions. DEC has advised they will adopt these recommendations.

Regulating the taxi industry

For some time we have been monitoring the Ministry of Transport's regulation of the taxi industry — an issue we continue to receive complaints about. Since 1998 the Ministry has been reviewing and redeveloping draft service standards for the industry, but they have never been finalised.

We began inquiries into the delay in finalising these service standards in 2002. We have been told every year since then that the standards would be implemented that year, after consultation with the industry. In February 2006, the Ministry again advised they would implement the standards as soon as possible. In June 2006, they said they were reviewing the performance of two metropolitan networks to work out 'realistic and achievable service delivery and performance measures'.

While some of the interim service standards have been included as statutory conditions and criteria for authorisation as a network provider, it is now 13 years since legislation required the introduction of service standards. We have ongoing concerns about the continued delays in finalising these standards and the resources used in repeated consultations and reviews.

8. Community services

Highlights

- We resolved 48% of the 591 complaints we finalised this year about community services.
- We completed 13 investigations into the care and protection system for children and their families. Most of the recommendations from these investigations are being addressed as part of DoCS' reform initiatives.
- We tabled a special report to Parliament: *Services for children with a disability and their families: DADHC progress and future challenges*. DADHC has accepted our findings.
- We released a special report into DADHC's monitoring of boarding houses based on our inquiry.
- We completed our second reviewable deaths annual report that highlighted significant child protection and disability health issues.
- Official community visitors made 2,500 visits to 1,210 services.

Community services in NSW are primarily provided by the Department of Community Services (DoCS), the Department of Disability, Ageing and Home Care (DADHC), and numerous non-government agencies that are government funded, licensed or authorised. Much of our work focuses on DoCS and DADHC because of the central role these agencies have in the community services sector.

Services are provided to many thousands of people around the state, and include child protection and out-of-home care for children, services for people with a disability — such as accommodation and support services, respite care and in-home support — and accommodation and support services for homeless people.

Our role is to promote improvements in community services. We do this by:

- responding to complaints about community services from individuals
- reviewing the circumstances of people in care
- reviewing the deaths of people with disabilities in care and certain children
- monitoring the delivery of services and making recommendations for service improvement
- monitoring the responses of agencies to our recommendations.



Staff from our community services division meet regularly to exchange information and discuss current issues.

Complaints about community services

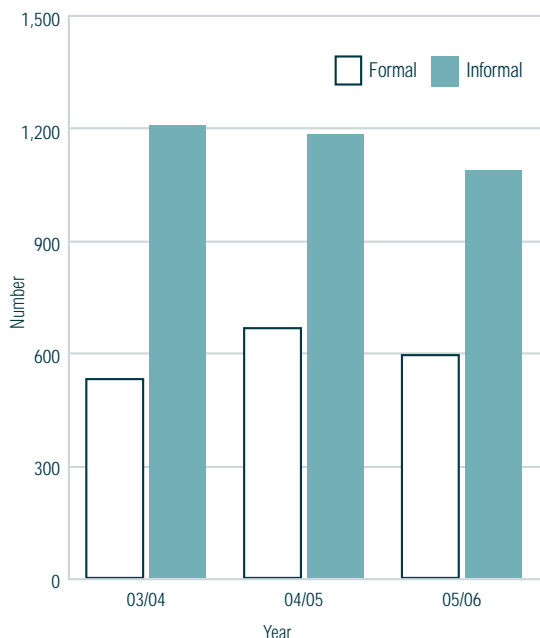
In 2005-06 we received 595 complaints about agencies providing community services, down from 667 in 2004-05. See figure 32. Just over half (56%) of these were about DoCS and another 17% were about DADHC. See figure 33. Figure 34 shows the number of complaints made about each type of service. Most complaints were about services providing child protection, followed by out-of-home care providers.

The most common complaints were about case management or decisions affecting people receiving a service, followed by poor quality services. See figure 35.

We finalised 591 complaints in 2005-06. We were able to resolve 283 (48%) of these — see figure 36.

Formal and informal matters received fig 32

	03/04	04/05	05/06
Formal	531	667	595
Informal	1,209	1,184	1,088
Total	1,740	1,851	1,683



Formal and informal matters received — by agency fig 33

Agency category	Formal	Informal	Total	%
DoCS				
Child protection services	153	395	548	33%
Out-of-home care services	148	208	356	21%
Other (incl. requests for assistance, licensing)	10	27	37	2%
Adoption	1	4	5	0%
Sub-total	312	634	946	56%
DADHC				
Disability accommodation and support services	85	73	158	9%
Home care service	17	54	71	4%
Policy and strategic services	25	29	54	3%
Sub-total	127	156	283	17%
Non-government funded or licensed services				
Disability services	71	65	136	8%
Out-of-home care services	21	16	37	2%
Home and community care services	21	22	43	3%
Supported accommodation and assistance program services	16	20	36	2%
Children's services	2	5	7	0%
Boarding houses	8	8	16	1%
General community services	10	9	19	1%
Family support services	0	2	2	0%
Other	7	27	34	2%
Sub-total	156	174	330	20%
Other (general inquiries)	0	124	124	7%
Total 2005-06	595	1,088	1,683	100%

Formal and informal matters received — by program area fig 34

Program area	Formal	Informal	Total	%
Child protection services	160	403	563	33.5%
Out-of-home care services	169	225	394	23.4%
Disability accommodation services	148	143	291	17.3%
Disability support services	71	94	165	9.8%
Aged services	8	27	35	2.1%
Childrens services	8	19	27	1.6%
Supported accommodation and assistance program services	17	21	38	2.3%
Adoption services	1	6	7	0.4%
General community services	11	17	28	1.7%
Family support services	2	9	11	0.7%
General inquiry	0	124	124	7.4%
Total complaints 2005–06	595	1,088	1,683	100%

What people complained about fig 35

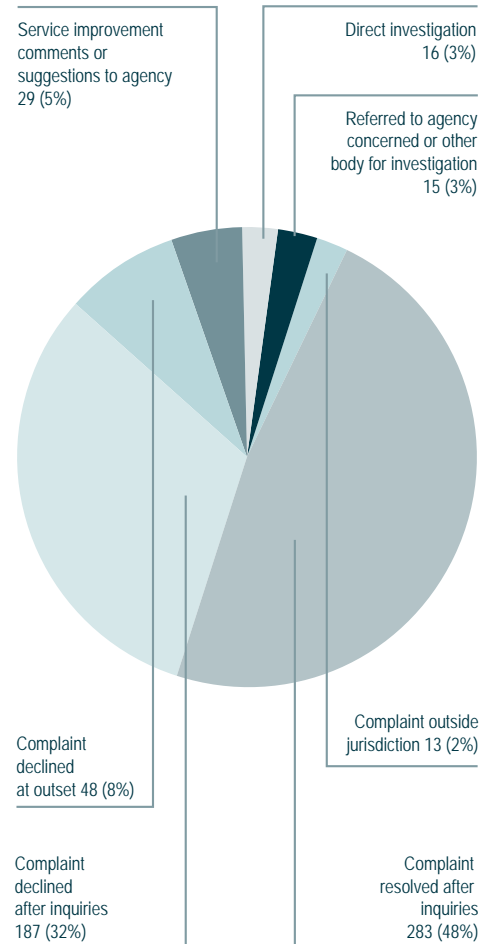
This figure shows the issues that were complained about in 2005–06. Please note that each complaint we received may have been about more than one issue.

Issue	Formal	Informal	Total
Case management / decisions	196	314	510
Poor quality services	172	137	309
Case planning and casework	107	152	259
Individual needs not met	95	94	189
Complaint-handling by services	89	95	184
Contact with family, friends	62	53	115
Service provider management	32	52	84
Access to or exit from services	47	31	78
Clients not involved in decisions	34	37	71
Non-provision of information	14	52	66
Inadequate service policies	14	48	62
Professional conduct of staff	25	29	54
Funding of services or providers	10	31	41
Other issues	8	7	15
Total 2005–06	905	1,132	2,037

Outcome fig 36

Outcomes of formal complaints finalised

Outcome	No.
Complaint resolved after inquiries, including local resolution by the agency concerned	283
Complaint declined after inquiries	187
Complaint declined at outset	48
Service improvement comments or suggestions to agency	29
Direct investigation	16
Referred to agency concerned or other body for investigation	15
Complaint outside jurisdiction	13
Total outcomes 2005–06	591



Performance indicator

Average time taken to assess and determine complaints

Target	2005-06
70% within 10 weeks	75% within 10 weeks

Performance indicator

Number and proportion of finalised complaints resolved and / or where services are improved

Target	2005-06
50% or more	328 (55%)

Services for children and families

DoCS and non-government agencies funded by DoCS are the main providers of community services to children and families in NSW. The services they provide include individual family support and assistance, community development and support programs, child protection, and services for children and young people in out-of-home care.

DoCS is in the third year of a five-year plan to improve the care and protection system in NSW. Key initiatives of the \$1.2 billion budget increase include the development and funding of early intervention programs, increasing the numbers of DoCS staff working in child protection and out-of-home care, providing more funding for services supporting children in need of care and protection, and improving the support provided to 'front line' DoCS workers. DoCS have also advised they are committed to making policies and procedures clearer and easier to access, providing better support and training, improving their electronic client database, and improving the handling of new risk of harm reports by the DoCS helpline. These initiatives are being implemented at a time when there is a rapidly increasing demand for all services provided by the department.

This year we released our second report about our work in relation to reviewable deaths — the *Report of Reviewable Deaths in 2004* (available on our website). This report, and issues arising from our investigation of agencies' responses to individual children at risk of harm, highlights how critically important it is that the DoCS reform agenda is effectively implemented. We are concerned by evidence that children continue to be reported to DoCS as being at high risk of harm, and the department has not acted to determine their safety.

Complaints

The care and protection system continues to be the most complained about area of community services provision. In 2005-06, 26% of formal complaints (153 of 595) were about DoCS' child protection services and 28% of formal complaints (169 of 595) were about

out-of-home care services either funded or provided by DoCS. See figure 33.

For child protection services, the most common complaints are about the adequacy of the DoCS response to risk of harm reports. This was also the case last year.

For example, people complained about:

- risk of harm reports getting lost in the system
- reports being closed without being investigated
- DoCS not intervening in cases of chronic neglect
- DoCS failing to act on requests for assistance to prevent children going into care
- poor cooperation and information sharing between DoCS and other agencies and professionals
- customer service issues such as DoCS not responding to phone calls, lack of feedback on investigation progress, and lack of feedback to mandatory reporters.

Contact between families and their children in care was the most common issue complained about by people receiving out-of-home care services. This included complaints about too little contact, too much contact, contact not being supported financially by DoCS, and the impact of contact on children. Other issues people complained about included:

- the adequacy of permanency planning for children placed in care
- the adequacy of support provided to young people who are leaving or who are no longer in statutory care (eg case study 19)
- the adequacy of support provided by the department to foster carers — including the level of casework support provided once children are placed, the adequacy of information provided to carers about the children placed in their care, and the adequacy of responses to carers' requests for assistance (eg case study 20)
- the adequacy of support for Aboriginal children placed with family and kin
- administrative issues including delays in transfers of files between DoCS offices, delays in the assessment of foster carers, and differential treatment and support of carers between DoCS offices.

CaseStudy19

A youth service that provides support to young people leaving statutory care complained to us that DoCS would no longer support a young person. The care order placing the young person under the parental responsibility of the Minister for Community Services was to expire when he turned 16. At the time we received the complaint, he had moved from accommodation provided by a non-government agency and was living in crisis youth refuge accommodation. The complainant said that the young person had to move to the refuge because DoCS stopped funding his placement with the non-government agency.

The youth service was concerned for the young person's safety and welfare because, in their assessment, he did not have the skills to live independently. They complained that DoCS had failed to properly plan and consult with the young person about his leaving state care and to provide adequate support and assistance. The service also complained that the department had put pressure on the young person to make a decision not to return to the Children's Court to review his care situation.

We facilitated a meeting with the relevant DoCS office and the youth service to try to resolve these issues as quickly as possible. The parties agreed that while DoCS would not seek a further care order from the Children's Court, they would continue to support the young person. As well, a DoCS caseworker would work closely with the youth service and the young person to ensure that he had appropriate accommodation and support — including financial assistance if he enrolled in a study course — until he was ready for independent living.

CaseStudy20

A foster carer complained to us that DoCS had reduced the support provided to a 17-year-old in her care. This teenager had significant learning difficulties. The carer had already complained to the department about the reduction of support, including the removal of reimbursement of travel costs and funding for one-on-one support relating to vocational goals. The carer said that DoCS had not responded to her complaint until she made a complaint to the Minister and, even then, all she was told by the department was that in their assessment the young person no longer needed the additional support.

The carer raised these issues with us. As the carer wanted to meet with departmental representatives to have her complaint heard, we referred the complaint to DoCS to try to resolve and then report back to us. The department met with the carer and agreed to pay her for outstanding allowances. They also agreed to continue to fund the young person's one-on-one support.

Our investigations

This year we conducted 37 investigations into various aspects of the care and protection system. We finalised 13 investigations and monitored recommendations arising from four investigations completed in 2004-05. We also closed our files for two investigations started the previous year. For one we made no adverse findings and for the other we discontinued the investigation. We did this because DoCS started a comprehensive risk assessment of the child involved after we began the investigation.

We initiated most of these investigations under our 'own motion' powers following our reviews of deaths of children. The investigations considered the adequacy of child protection services provided before the death of the child — or, after the child's death, to their siblings. All the children had been reported to DoCS. In some instances NSW Police, funded agencies, and / or area health services also knew of them or their families.

The children who died included a 3-year-old allegedly murdered by a family member, a five-week-old who drowned in a bath while his mother experienced a drug induced psychotic episode, an 18-month-old who died from non-accidental head injuries, and a six-month-old who was found to have methadone, amphetamines and benzodiazepines in his system.

When conducting these investigations we take into account the legislative responsibilities, policies and procedures of the agencies involved, and cross-agency guidelines — for example, the *NSW Interagency Guidelines for Child Protection Intervention*. We look at how services intervened with the family and whether this intervention was adequate, given the reported concerns and the roles and responsibilities of the different agencies.

Based on our work this year we continue to have serious concerns that some children who are at high risk of harm are not being allocated to a child protection caseworker for a full risk assessment.

For children who were subject to risk assessment, our investigations have identified the following deficiencies:

- Firstly, inadequacies in the way DoCS considered the information it already had about the family. If a child or children have already been removed from a family then it is critical that this is identified and considered when assessing risks to any new child born into the family. See case study 21.
- Secondly, inadequacies in the way information was gathered and analysed from other agencies. If DoCS caseworkers do not seek critical information from other agencies when they are assessing risk, they will make judgements about the child's safety that are not based on all relevant information. This can lead to poor decisions.
- Thirdly, risk assessments that were narrowly focused. If the focus of a risk assessment is on the last reported incident, and previous reports of risk are not taken into account, patterns of carer behaviour will not be identified and the impact of these patterns of behaviour on the child will not be adequately considered. This means that facts relevant to a child's safety and wellbeing will not be identified.
- Fourthly, cases allocated for risk assessment but no assessment was done. Casework may be provided in these situations but, if this casework is not informed by a comprehensive risk assessment, there is a danger that the focus of intervention will be the parent or carer's problems and the child's safety will be overlooked.

Last year we also reported that we were concerned that agencies who have some responsibility for child protection were not communicating effectively enough. This year's investigations continue to highlight problems with the exchange of information between DoCS and other agencies.

For example, we have found instances of:

- requests for information being sent by DoCS but not received by agencies

- reports by police and NSW Health to DoCS being lost in the system or significantly delayed because police and health documentation and reporting procedures had not been followed
- reports to DoCS made by mandated reporters that do not contain all the relevant information.

We have also identified instances where mandated reporters have failed to make risk of harm reports when they should have. This makes DoCS' job of assessing risk more difficult and, as we have found, has serious consequences for some children.

We have made a number of recommendations to DoCS arising from our investigations. Many of these recommendations have related to improving DoCS' approach to assessing risk to children once a child at risk report has been made, and ensuring responses to risk of harm provide adequate protective intervention. The DoCS reform agenda includes a commitment to undertake a 'quality review' of each community service centre in NSW over the next four years, as part of the department's broad framework for service improvement. DoCS is also in the process of finalising a review of the procedures that guide staff in undertaking secondary risk of harm assessment.

SAAP services for children and young people in statutory care

Services are funded under the Supported Accommodation Assistance Program (SAAP) to provide transitional accommodation and support. Peak agencies have expressed concern that SAAP youth services are required to make up deficiencies in the statutory care system. They have also expressed concern about young people being discharged from statutory care into youth SAAP services, as these services may not be well equipped to provide appropriate care and protection.

In August 2005 DoCS told us that there was no protocol between DoCS and SAAP services for dealing with children less than 16 years of age living in SAAP youth accommodation services. DoCS has now drafted a policy, which we are advised will come into effect in 2006-07.

In these circumstances, and given that DoCS is still developing this policy, we decided to examine the circumstances of children and young people who are under the parental responsibility of the Minister for Community Services and who are living in SAAP services. Among other things we wanted to know why these children and young people were living in SAAP services, and what plans were in place to help them either move to more appropriate accommodation or live independently.

CaseStudy21

A baby boy died at age five weeks from a serious but treatable illness. Twenty months before he was born, DoCS had removed another baby from his mother. The Children's Court determined that the first baby should not return to his mother's care. This baby had been born with health complications from his mother's drug use. DoCS' risk assessment for this baby identified serious concerns for his wellbeing and safety associated with the mother's long history of severe alcohol addiction and violent relationships.

The second baby was reported twice to DoCS before he was even born. The first of these reports indicated the presence of the same problems that had resulted in DoCS assuming his brother's care the previous year. However, this report was given a low urgency rating by the DoCS helpline and referred to a DoCS' office where it was closed without further assessment.

The second pre-natal report was made four days before the baby was born when an outreach nurse raised her concern that the boy's mother had not received antenatal care and was continuing to abuse drugs. The nurse also reported that the mother's parents were concerned for the baby's welfare.

Despite DoCS' previous involvement with the family, the Helpline also gave this report a low priority. Due to an administrative error the Helpline did not forward the report to the local DoCS office until three months after the baby was born.

During the five weeks of the baby's life, he was reported to DoCS on another four occasions by credible sources raising serious concerns for his welfare. These concerns related to his mother's intoxicated state while caring for him, domestic violence and itinerancy.

As a result of the last of these reports, DoCS decided to place the baby in temporary care until the mother found suitable accommodation. In assessing the safety of the baby and coming to this decision, DoCS did not consult with, or ask for information from, drug and alcohol services that knew the baby's mother.

We also found no evidence that the comprehensive risk assessment that had been undertaken for the baby's older sibling the previous year was taken into account when decisions were being made about the safety of the younger child.

The baby's mother agreed to certain informal undertakings requested by DoCS. These included temporarily placing him with relatives while she found accommodation and sought drug and alcohol counselling. When she found accommodation, she resumed the care of the baby without consulting DoCS. The department visited her and the baby and decided not to remove him. In our view, this decision failed to take into account the mother's very long history of severe alcohol addiction and afforded the baby little protection. The baby died two days after the visit.

In January 2006 we contacted all youth SAAP accommodation services. On the information these services provided it appeared that there were 21 children and young people under the parental responsibility of the Minister being supported by these services. We selected 15 of these and are comprehensively reviewing their circumstances. These reviews are currently underway.

Children's Court project

Reviewing child deaths involves considering the circumstances of the child before his or her death — including the adequacy of community services provided — and identifying issues and strategies that may prevent future deaths. As the NSW Children's Court plays a significant role in the child protection system, we decided to look more closely at how care proceedings operate.

Among other things, we wanted to find out:

- how quickly courts are dealing with care applications
- how consistent decisions relating to care applications are
- the effects of supervision orders on the lives of children
- the effects of restoration plans, and whether they achieve the goal of safely reuniting children with their natural parents.

We interviewed more than 50 people including NSW Children's Court Magistrates, various legal representatives, and staff from DoCS, the Family Court of Australia, the Australian Institute of Health and Welfare, SAAP agencies, the Intellectual Disability Rights Service and the NSW Foster Carers Association.

Although we have not finalised this report, our preliminary findings show a disturbing lack of statistics about care and protection matters in the Children's Court. It appears that nobody is collecting or analysing the relevant information. For example, there is no data available about how many orders are for long or short term removal of children or how many result in the restoration of children to their families. Because of this absence of data there is a significant gap in knowledge about the Children's Court, which is a key part of the care and protection system in NSW.

Services for people with a disability and older people

There are more than 3,000 organisations providing services for people with a disability and older people across NSW. The services are provided by DADHC and the wide range of non-government services that DADHC licenses or funds. They include:

- accommodation support services, including group home and large residential centres and support provided to people in their own homes
- licensed boarding houses for people with a disability
- community support services such as respite services, day programs, support for young school leavers with a disability, and advocacy services
- home and community care (HACC) services to support people to remain living in the community — such as home help, home nursing, respite, food services, home modifications and maintenance, and community transport.

DADHC is responsible for ensuring the provision of these services meets required standards. Last year we reported that DADHC was in the process of implementing a number of important changes intended to improve the quality of these services.

We are monitoring DADHC's progress in implementing reforms in relation to:

- the relocation of people from institutions to the community
- the improvement of conditions for residents in boarding houses
- the development of a service system to better support children with a disability and their families
- the development of a service system for people with an intellectual disability who may come into contact with the criminal justice system
- the development of a robust system for monitoring and improving the quality of services DADHC provides and funds.

In May 2006 the NSW Government released *Stronger Together*, a ten year plan for disability accommodation and support services. The plan represents a significant and welcome commitment to increase the capacity of the service system for people with a disability and their families, and improve service access and quality.

The implementation of the plan, both in the short and longer term, presents considerable challenges for DADHC. In view of its scope and the significant budget commitment for supporting its implementation, we will maintain a particular interest in the department's progress in implementing the plan.

Complaints

This year 26% of formal complaints (156 of 595) were about disability accommodation and support services. See figure 33.

The most common complaints about agencies providing accommodation services related to:

- alleged abuse and neglect of residents, and how such incidents were handled by the services (eg case study 22)
- management of individual support needs of residents, especially those relating to resident behaviour and the compatibility of residents (eg case study 23)
- risk management and occupational health and safety issues
- decision-making and delays by DADHC in relation to service funding
- consultation and decision-making in relation to managing vacancies and resident transfers.

People also complained to us about medication management, lack of interagency cooperation in relation to health needs and support for children with a disability, and retribution for complaining.

The most common complaints about agencies providing support services for people with a disability were about:

- problems accessing respite services, including the management of 'blocked' respite places
- poor service quality in day programs for people with a disability and HACC services for older people (eg case study 24)
- lack of access to home and community care services, including Home Care
- problems with the provision of support to people with a disability in contact with the criminal justice system.

CaseStudy22

We received a complaint about an alleged sexual assault involving two residents of a group home run by a non-government service. The alleged victim was a man with an intellectual disability. His brother complained to us about the way the service responded to the allegations, and about what he saw as their failure to ensure the safety of the residents.

Given the serious nature of the complaint, we arranged for an official community visitor to visit the group home. We also asked the service for detailed information about their response to the allegations of sexual assault and their policies and procedures. We also spoke with the legally appointed guardian of the alleged victim.

We found that the service had appropriately handled the allegations. They had also arranged counselling and training in relationships and sexuality for the complainant's brother and other residents of the house, and professional assessments of the residents' capacity to make informed decisions about their sexual activity.

During the course of our involvement, the complainant was appointed as his brother's legal guardian. This resolved certain ambiguities about his access to information. However, we found that the service did not have policies or procedures in place that were relevant to the issues raised in this complaint. It also appeared that they had not kept the complainant well informed about their actions in response to his allegations. We made a number of suggestions to the service for improving their systems in these areas.

As a result of the complaint and our action the service implemented:

- sexuality counselling and education for residents (conducted by a sexuality counsellor)
- staff training on sexuality issues for people with an intellectual disability
- training for families on the rights of residents with an intellectual disability to have sexual relations
- a review of supervision arrangements — direction issued to staff to increase supervision of residents — and had locks fitted to residents' bedroom doors
- a review of their policies and procedures.

CaseStudy23

A family contacted us within hours of learning that their adult son — who had autism and an intellectual disability — was being moved without notice from the group home where he had lived for the past seven years. The man's family strongly objected to the move, which was happening on the day the family complained to us.

We immediately contacted the service who told us that there had been a number of critical incidents of assault between residents in the group home, and the situation had reached a crisis. We were satisfied that the service was acting appropriately to ensure the immediate safety of all the residents by going ahead with the move that day.

However we were concerned about the reasons for the situation reaching a crisis, and how decisions about the man had not been communicated to his family. It was also unclear whether the man's health and safety needs would be adequately met in his new placement, how his needs would be met in the longer term, or how he and his family would be involved in future decisions and planning for his accommodation.

We facilitated a meeting between the service provider, the man's family and his doctor to resolve these issues. The service apologised to the man's family for the way the move had been managed, explained the reasons for its speed, and said that the new placement would be temporary until other more suitable accommodation could be found. Following discussions, all the parties agreed that it was not in the son's best interests for him to return to the group home. The service undertook to work closely with him and his family to find more suitable accommodation and this was done.

CaseStudy24

A complaint involving the installation of a stair-lift in the home of an elderly woman resulted in a change in the approach of a non-government home modification service.

The woman's husband had approached the service for assistance after she had a stroke. The service advised that the couple's home would need major structural alterations that would take some time. However the husband made his own inquiries and learned that a stair-lift could be installed sooner and cheaper, so his wife could come home without delay.

The husband obtained advice from an occupational therapist and went ahead with the installation. When he later approached the service for assistance with the costs, they refused because he had not obtained appropriate prior approval. He contacted our office after complaining to the service without success.

We established that the service's guidelines required the prior approval of projects before there could be payment assistance, so we met with them to discuss the matter and explore possible ways to resolve it.

As a result, the service agreed to accept a late application from the complainant — with support from an occupational therapist — and to consider the matter afresh against their usual criteria. They also accepted our suggestion that they incorporate in their guidelines some discretion to waive the requirement for prior approval in cases where the strict application of this requirement may result in hardship.

Our investigations

This year we finalised four investigations into services for people with a disability. Three had been started in 2004-05 and one in 2005-06. We also began two other investigations this year which have not yet been completed.

The four investigations we finalised this year were about:

- a non-government accommodation service's handling of occupational health and safety (OH&S) issues
- DADHC's handling of the health of a client at one of its centre-based respite services
- DADHC's placement and support of a client in a non-government accommodation service
- DADHC's response to issues identified after the death of a client at one of its accommodation services.

The first two of these investigations are discussed below. We made no adverse findings against DADHC in the other two matters.

We made a number of recommendations to DADHC in 2004-05 after finalising our investigations. These related to:

- improving the service system for people with an intellectual disability who may come into contact with the criminal justice system (discussed below)
- managing the program for aids and equipment for residents of DADHC accommodation services
- systems for handling allegations of assault of residents.

This year we have been monitoring DADHC's implementation of these recommendations.

Handling occupational health and safety (OH&S) issues

There is considerable debate and uncertainty in the disability service sector about how OH&S issues should be managed. This uncertainty is, at least in part, based on perceptions that the primacy of OH&S requirements to control risks is potentially at odds with requirements under the *Disability Services Act 1993* to support consumers to live in a way which is as similar as possible to that of other members of the general community. A number of complaints we receive relate to the handling of OH&S issues by community and disability service providers.

This year we completed an investigation into the handling of alleged OH&S risks by a non-government disability accommodation agency. This followed complaints that the service had banned a group of

parents and carers from entering the group home where their adult children lived, on the basis that the parents presented a risk to the health and safety of staff. The residents of the group home had significant intellectual and physical disabilities and the parents were acting as their decision-makers and advocates for their care.

We found that there had been a history of unresolved complaints about service provision to residents, which had led to conflict between the parents and agency staff. The agency's decision to ban the parents from the group home may not have been wrong — in the context of their obligations under OH&S legislation and advice provided to them by WorkCover NSW — but they did not take an individualised approach to assessing and managing the alleged risks, based on the needs of each of the residents.

Following our investigation, the agency took steps to improve their complaints, staff grievance and risk management systems. We also made a number of observations about WorkCover's role and highlighted the considerable potential for WorkCover to influence risk management practices in disability service settings. There are a number of current initiatives that may lead to improved assistance for disability services dealing with OH&S issues. These include resources developed by WorkCover and a jointly funded project between DADHC, WorkCover and ACROD NSW to develop resources and support for disability services around OH&S risk management. We will continue to monitor these developments.

Health care in a respite service

A critical incident in which a client collapsed in a DADHC respite unit prompted an internal review by the department, an independent inquiry and an investigation by our office.

Just before she was admitted for short term respite, the client's family told the respite unit that her health had deteriorated and her medication for bi-polar disorder had been altered in the preceding days. The family confirmed that she could still attend respite.

After her admission, the residential care workers became increasingly concerned about the woman and wanted her family to resume her care. They contacted the family, who asked that an ambulance be called, but staff did not do this until the woman collapsed later that day.

The hospital subsequently advised that the critical incident happened because of the client's multiple medical conditions, some of which developed during her stay in the respite unit.



Community service division managers participating in performance management training.

All three reviews and inquiries produced consistent findings and conclusions. These included a finding that although some DADHC staff had breached their duty of care to the client, an important mitigating factor was the absence of any departmental policy for managing the health care of clients in respite services.

DADHC responded by proposing to address these systemic deficiencies. They took action to ensure that clients are admitted to respite care with current medical information and respite staff know clearly when to call an ambulance. DADHC also extended their review of policies on managing health care for clients to cover respite clients.

People with an intellectual disability and the criminal justice system

This year we have continued monitoring DADHC's progress in improving interagency coordination for supporting people with an intellectual disability who are in contact with the criminal justice system. DADHC is the lead agency for the Senior Officers' Group (SOG) responsible for developing and implementing a strategic plan to achieve this goal. Last year we reported on our investigation that found that DADHC had failed in this role and, as a result, the SOG had failed to achieve its terms of reference.

After slow progress, the SOG finalised a new strategic plan in October 2005 which DADHC remains responsible for leading. The new plan represents a shift in direction. The focus had been on developing a whole-of-government approach, but the current focus is on implementing a collection of projects aimed at improving interagency practice in a number of discrete areas. These include court support for people with an intellectual disability, interagency case

management for people in the corrective services and juvenile justice systems on community-based orders, case management for people in frequent contact with police for minor offences, and the development of supported accommodation options for people leaving corrective services.

We have a number of concerns about the progress of this work, including the implementation of some projects and the capacity of the current approach for achieving the government's commitments in this area. We are currently awaiting formal advice from DADHC about progress and their actions in response to the concerns we have raised.

Services for children with a disability and their families

In May 2006 we tabled a special report to Parliament, *Services for children with a disability and their families: DADHC progress and future challenges*. This report followed our monitoring of DADHC's progress since our investigation two years ago, which found significant deficiencies in the way DADHC implemented their policy for supporting children and young people with a disability and their families.

In April 2004 we reported that DADHC's implementation of this policy had been ineffective and characterised by extensive failures — including a lack of guidance for staff, an inadequate operational framework to underpin the policy, and lack of clarity about the respective responsibilities of DADHC and DoCS. As a result, families seeking support to care for children with disabilities at home were faced with significant barriers to getting the support they needed to continue to do this. We also found that arrangements for supporting and monitoring children who had been voluntarily placed in care were deficient.

DADHC accepted our findings and promised to address the shortcomings we identified. They said they would do this by implementing an 'action plan' for improving services, with strategies for improving their organisational capacity and systems to support the delivery of quality services.

We closely monitored their progress and, in late 2005, DADHC gave us a report on an independent evaluation of the impact of their action plan.

DADHC has taken positive steps to begin addressing the issues we reported in 2004, and has made a commitment to continuous improvement. It is critical that this continues as some initiatives are still at an early stage of development, and there is little information available about when they will be fully operational. Many new support options are not yet readily available, including intensive family

support for children living at home and family-based accommodation options for those who are unable to remain at home. The long-term impact of the action plan on children and families needing support has not been evaluated.

The need for continued improvement in this area is critical. Families caring for a child with a disability may not have the time or resources to complain about a system that does not support them. It is therefore important that DADHC build on their systems for receiving feedback from families and evaluate whether the services they provide are supportive — and, if not, how they can be improved. We have recommended that DADHC provide clear and accessible information to the community on the ongoing development of their child and family programs and the results of the evaluation process.

Monitoring conditions in licensed boarding houses

In June 2006 we tabled a special report to Parliament about our inquiry into DADHC's monitoring of licensed boarding houses against the requirements of the *Youth and Community Services Act 1973* (YACS Act). There are 55 licensed boarding houses in NSW, with around 1,000 residents. People who live in licensed boarding houses are often highly vulnerable — most have an intellectual disability or a psychiatric illness or both, and many are elderly. Almost all rely on government benefits for income and most of the benefits are spent on board and lodging.

We found serious problems with the way boarding houses in NSW are licensed and monitored by DADHC, including:

- variable regional compliance with the department's policy for monitoring licensed boarding houses — with implications for resident health, safety and welfare
- limitations in the monitoring system because of uncertainty about the legal enforceability of some standards
- inadequate safeguards for protecting people with a disability who live in unlicensed boarding houses.

In response to our inquiry findings, DADHC acknowledged that there was scope to improve their monitoring of licensed boarding houses. They have taken steps to address the performance issues identified by our inquiry and prioritise completing their review of the YACS Act. We will continue to monitor DADHC's commitments and their progress with reviewing the YACS Act.

Access to health services for people with a disability in care

Our reviewable deaths annual report, tabled in Parliament in December 2005, highlighted some gaps in health service provision as well as concerns about the quality of care delivered by some health services to people with disabilities in care. As part of our work in this area, we met with numerous funded services who told us about the challenges they face in trying to support the health needs of the people living in their services. These challenges included extensive waiting lists for DADHC speech pathology services, difficulties accessing sufficient support in hospitals, and troubles locating health professionals with adequate knowledge of disabilities. Our review work also identified the limited provision of palliative care services to residents of licensed boarding houses, and raised questions about the use and adequacy of the boarding house reform program for meeting the health care needs of residents.

As a result, we made a number of recommendations including that:

- NSW Health evaluate the implementation of their *People with Disabilities: Responding to their needs during hospitalisation* policy directive
- DADHC and NSW Health coordinate their provision of palliative care for people with disabilities in care
- DADHC report on their review of a clinical nurse specialist model of health care case management.

We are continuing to monitor the progress of both agencies towards meeting our recommendations. Please see our *Report of Reviewable Deaths in 2004* for full details about our findings and recommendations.

This year we are examining in greater detail the interaction of people with disabilities in care with the health system in NSW. Our research project involves consulting with a wide range of service providers, peak agencies and official community visitors across the state. We will report our findings and any recommendations arising from this work in our reviewable deaths annual report later in 2006.

Services for people who are homeless

The Supported Accommodation Assistance Program (SAAP) is a jointly funded Commonwealth / State program that provides accommodation and support services for people who are homeless. In NSW, SAAP is administered by the Department of Community Services (DoCS) and delivered through

non-government, community-based organisations with some local government involvement.

This year we received a relatively small number of complaints about SAAP services — only 36 formal and informal complaints, 2% of all complaints received about community services. See figure 33. The majority of these complaints concerned inadequate case management and casework support for residents (20 of 36 complaints).

Monitoring access to SAAP services

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

The report made recommendations to DoCS and SAAP service providers aimed at ensuring the program maintained non-discriminatory and fair approaches to client eligibility and their access to and exit from the services.

This year, we continued to promote our findings and recommendations and monitor what SAAP service providers were doing to address the concerns we identified. We met with SAAP peak agencies on a number of occasions throughout the year.

A significant development has been the completion and trial of a client risk assessment tool funded by DoCS and developed by peak agencies. The aim was to produce a method for SAAP funded agencies to make informed decisions about a person's appropriateness for acceptance as a SAAP client. The tool was tested and evaluated and, in January this year, we received a final report that identified overall positive results. The tool is now being provided to services across NSW.

In May this year, DoCS gave us a progress report on their implementation of our recommendations. They advised that some recommendations had been acted upon — for example, they had published their *Good practice guidelines for DoCS funded services* which outline policies and practices relating to client eligibility and their access to and exit from services. Training on how to use these guidelines would be prioritised in all services. We have sought more information from DoCS on their implementation of number of other recommendations.

We also started a review this year of children in statutory care who were living in SAAP services. For details of this review, please see the section on services for children and families earlier in this chapter.

Policy work

This year we contributed to policy reform in a number of areas. We made submissions to DoCS' reviews of the *Children and Young Persons (Care and Protection) Act 1998* and the interagency guidelines for child protection intervention.

We also provided feedback to DADHC in relation to its progress in implementing systems for monitoring disability services, and comments on policies and procedures relating to care and support for people with disabilities.

Official community visitors



The Hon. John Della Bosca, Minister for Ageing and Disability Services, opening the annual official community visitors conference in June this year.

The Minister for Ageing and Disability Services and the Minister for Community Services appoint official community visitors on the Ombudsman's recommendation. The visitors independently monitor residential services provided to people with a disability and children and young people in out-of-home care — to ensure the quality of these services is high.

They do this by:

- making regular visits to eligible services
- enquiring into the adequacy of the care provided
- acting on issues raised by residents, staff or others having a genuine concern for the welfare and conditions of residents
- resolving or progressing complaints with service management where possible

- reporting on problems that may be broadly based or systemic as well as promoting 'good practice' examples
- providing residents with information about advocacy services to further promote and protect their legal and human rights.

We administer the official community visitor scheme and are responsible for recruiting and supporting visitors in their work. This year we have also introduced new support systems to help visitors manage their caseloads and report progress on their visiting schedules. A separate annual report on the activities and results of the scheme will be available later in 2006.

The recurrent budget for the scheme in 2005-06 was \$752,000, up from just over \$724,000 in 2004-05. Fourteen new visitors have been appointed, taking the total to 33.

Visitors generally work alone or in small teams, but we bring them together regularly to discuss their work. For example, we provide forums for sector briefings, training, conferences, information exchange, and regular meetings with representatives from DoCS and DADHC and the relevant Ministers.

We consult with visitor representatives four times a year to discuss systemic and service issues and the relationship between visitors and our office. We also prepare monthly bulletins to keep visitors up to date with changes and issues in the sectors and promote good practice ideas.

During the past few months we have been developing and implementing an enhanced induction and training program for new visitors. We have also increased support and training for the visitor mentoring program. This aims to provide new visitors with up to 30 hours mentoring with an experienced visitor over their first 6 months to ensure adequate orientation and transfer of expertise and knowledge. There will also be increased team visiting and handover strategies to ensure smooth and effective transition for both residents and service management and staff. If necessary, we attend meetings with services and visitors to help resolve particularly serious or systemic concerns.

This year there were 1,210 services, with more than 6,500 residents, eligible for visiting under the *Community Services (Complaints, Reviews and Monitoring) Act* — down slightly from 1,218 in 2004-05. Visitors made 2,569 visits in 2005-06 and spent 7,581 hours talking with residents, families and staff, report writing, raising issues of concern with service providers and monitoring outcomes. See figure 37.

Issues raised with visitors

Some of the most common issues raised with visitors include concerns about:

- behaviour management
- entry to and exit from services
- individual service plans
- the provision of medication
- nutrition, hygiene and health care
- the service environment and facilities
- management responsibilities.

During 2005-06, visitors identified 2,528 issues and 1,238 (49%) of these were finalised. The rest are still ongoing. Of the issues finalised, 89% were resolved. See figure 38.

Case studies 25 and 26 are examples of issues that have been raised with visitors.

CaseStudy25

On a visit to a residential unit that houses 21 men with intellectual and developmental disabilities, visitors learned that over the past year some 900 pairs of underpants and 800 pairs of socks had gone missing en route to the laundry, never to be retrieved. The residents were all on disability support pensions and had to keep paying for new clothing. When visitors asked unit staff about the issue, they said they did not think much could be done about it, as they suspected two of the residents were flushing the clothing down the toilet.

The visitors wrote to the unit's CEO asking for immediate action to ensure the financial security and dignity of the residents. Soon after this, the organisation indicated that they would investigate the losses and supply all 21 men with new underpants and socks.

Number of visits made by official community visitors in 2005-06

fig 37

Target group of services	No. of services	No. of residents	No. of activity hours	No. of visits	
				04/05	05/06
Children and young people	96	246	1,293	363	414
Children and young people with a disability	42	144	422	162	134
Children, young people and adults with a disability	22	125	316	76	109
Adults with a disability in residential care, including boarding houses	1,050	6,046	5,550	2,175	1,912
Total	1,210	6,561	7,581	2,776	2,569

Outcome of issues identified by OCVs finalised in 2005-06

fig 38

Target group of services	No. of visitable services	No. of issues identified	No. of issues finalised (% of issues identified)	No. of issues resolved* (% of issues finalised)	No. of issues unresolved** (% of issues finalised)	No. of issues closed*** (% of issues finalised)
Children and young people	96	412	138 (33%)	72 (52%)	26 (19%)	40 (29%)
Children and young people with a disability	42	157	90 (57%)	41 (45.5%)	8 (9%)	41 (45.5%)
Children, young people and adults with a disability	22	160	101 (63%)	60 (59.5%)	24 (23.5%)	17 (17%)
Adults with a disability including residents of boarding houses	1,050	1,799	909 (51%)	682 (75%)	61 (7%)	166 (18%)
Total	1,210	2,528	1,238 (49%)	855 (69%)	119 (10%)	264 (21%)

* 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 our office with a view to complaint or other action.

*** Where issues are no longer relevant. For example, because a service closes.

CaseStudy26

In early 2006, we were advised that in a regional four-bed respite unit for children with disabilities, all the beds were 'blocked' — meaning people were living there permanently, instead of short-term, to offer their families respite from caring for them. A visitor learnt that two of the beds had been blocked for more than two years and another for more than a year. Every week a respite bed is blocked two families miss out on an opportunity for a much needed break. The unit's managers initially did not acknowledge that the four children were permanent residents — meaning they did not have individual plans and related supports. In addition, unit staff had been trained to work with temporary residents but not with those who were permanent.

The visitor met with management on several occasions to monitor progress towards ensuring that the children's needs were being met. This has now been achieved. The unit is also working towards finding another property that will offer respite accommodation for four more children with disabilities. We also intend to follow up on the broader issue of blocked respite places.

Reviewing deaths

Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA), we review the deaths of:

- children, and the siblings of children, who were reported to DoCS as being at risk of harm at any time in the three years before they died
- children whose deaths were a result of abuse or neglect, or occurred in suspicious circumstances
- children in care
- children in detention
- people with disabilities living in care
- people living in licensed boarding houses.

We seek information and assistance from government and non-government agencies and have the power to inspect all agency records in relation to these deaths. We examine systemic issues concerning the circumstances leading to a person's death, identify any emerging trends, and make recommendations about policies and practices that may prevent or reduce deaths of people in similar circumstances in the future.

Our focus

During 2005-06 we reviewed the deaths of 184 people who died in 2005. This included 54 people in DADHC operated or funded services, 13 who were living in licensed boarding houses and 117 children. 109 of the child deaths we reviewed were of children about whom a risk-of-harm report was made to DoCS in the three years before the child's death, or who were a sibling of a child so reported.

This year we took action under the Ombudsman Act in relation to concerns we identified in our reviews of 22 deaths. In ten cases, this involved making preliminary inquiries of agencies. Seven of these matters have now been resolved without progressing to investigation, and three are not yet finalised. We started 23 investigations arising from our reviews of 14 deaths.

Under section 43(3) of CS-CRAMA, we can also report to service providers or other appropriate people on matters related to a reviewable death or arising from a review. This year we issued such reports in relation to the deaths of 33 people. Figures 39 and 40 provide a summary of the deaths we reviewed in 2005, compared with those in 2004 and 2003.

Deaths of children

fig 39

	2003*	2004	2005**
Registered child deaths	605	540	598
Deaths in jurisdiction	161	104	117
Jurisdiction not yet determined due to insufficient information	20	28	68
Child known to DoCS – reports made about the child and / or their sibling	121 of 161 (78%)	96 of 104 (99%)	108 of 117 (93%)

Deaths of people with a disability

fig 40

	2003*	2004	2005**
Deaths notified to our office	114	98	70
Deaths in jurisdiction	110	93	67
Deaths in residential care (<i>Disability Services Act 1993</i>)	89 (81%)	69 (74%)	54 (81%)
Deaths in licensed boarding houses	21 (19%)	24 (26%)	13 (19%)

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

** These figures are correct as at the time of writing but may not be identical to the figures reported in our reviewable deaths annual report for 2004-05, which will incorporate information that becomes available later in 2006.

Annual report

CS-CRAMA requires us to table an annual report to Parliament on our work and activities in reviewable deaths during the previous calendar year. This report will be tabled later in 2006, and will examine the deaths of 116 children and 68 people with a disability that occurred in the 2005 calendar year.

In December 2005, we tabled our second reviewable deaths annual report in NSW Parliament. The report, titled *Report of Reviewable Deaths in 2004*, covered the 12-month period between 1 January and 31 December 2004, and reviewed the deaths of 104 children and 93 people with a disability.

We made 55 recommendations in the report directed to DADHC, DoCS, NSW Health, NSW Police, the NSW Child Protection Senior Officers Group and the NSW Government.

We have received responses from agencies to our recommendations and will continue to monitor their ongoing implementation.

This year we have decided to table the report in two volumes — one focusing on the deaths of people with a disability and the other on child deaths. This will allow for more focused consideration of the unique issues raised in the child protection and disability sectors.

Expert advisory committees

Two expert advisory committees assist us to perform our reviewable deaths functions. In 2005–06, both the reviewable child death advisory committee and the reviewable disability death advisory committee met on three occasions. These committees provide us with valuable advice on complex child and disability death matters, policy issues and health practice issues.

Reviewable disability death advisory committee

Mr Bruce Barbour	Ombudsman (Chair)
Mr Steve Kinmond	Deputy Ombudsman (Community Services Division)
Ms Margaret Bail	Human services consultant
Dr Helen Beange	Clinical Lecturer, Faculty of Medicine, University of Sydney
Mr Michael Bleasdale	Director, NSW Council on Intellectual Disability; Senior Researcher, Disability Studies and Research Institute
Ms Linda Goddard	Course Coordinator, Bachelor of Nursing, Charles Sturt University
Associate Professor Alvin Ing	Senior Staff Specialist, Respiratory Medicine, Bankstown-Lidcombe Hospital and Senior Visiting Respiratory Physician, Concord Hospital
Dr Cheryl McIntyre	General practitioner
Dr Ted O'Loughlin	Paediatric Gastroenterologist, The Children's Hospital, Westmead (appointed January 2006)
Associate Professor Ernest Somerville	Prince of Wales Clinical School, Neurology (appointed April 2006)
Ms Anne Slater	Physiotherapist, Allowah Children's Hospital
Dr David Williams	Acting Director, Department of Neurology and Clinical Senior Lecturer in Medicine, University of Newcastle (resigned from the committee in December 2005)
Dr Rosemary Sheehy	Geriatrician / Endocrinologist, Central Sydney Area Health Service

Reviewable child death advisory committee

Mr Bruce Barbour	Ombudsman (Chair)
Mr Steve Kinmond	Deputy Ombudsman (Community Services Division)
Dr Ian Cameron	CEO, NSW Rural Doctors Network
Dr Judy Cashmore	Associate Professor, Faculty of Law, University of Sydney and Honorary Research Associate, Social Policy Research Centre, University of New South Wales
Dr Michael Fairley	Consultant Psychiatrist, Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital.
Dr Jonathan Gillis	Senior Staff Specialist in intensive care, The Children's Hospital at Westmead
Dr Bronwyn Gould	Child protection consultant and medical practitioner
Ms Pam Greer	Community worker, trainer and consultant
Dr Ferry Grunseit	Consultant paediatrician, former Chair of the NSW Child Protection Council and NSW Child Advocate
Assoc Prof Jude Irwin	Associate Professor, School of Social Work and Policy Studies, Faculty of Education and Social Work, University of Sydney
Ms Toni Single	Clinical psychologist, private practice
Ms Tracy Sheedy	Children's Registrar, Children's Court of NSW

Complaining to the Ombudsman

Anyone can make a complaint to the Ombudsman. If you do not want to complain yourself, you can ask anyone — a relative, friend, advocate, lawyer, your local member of parliament — to complain for you.

How do I make a complaint?

Start by complaining to the agency involved. Contact us if you need advice about this. If you are unhappy with the way an agency has handled your complaint, you can complain to us, preferably in writing. Your complaint can be in any language. If you have difficulty writing a letter, we can help. We can also arrange for translations, interpreters and other services.

What should I include with my complaint?

Briefly explain your concerns in your own words. Include enough information for us to assess your complaint to determine the most appropriate response. For example, describe what happened, who was involved, when and where the events took place. Remember to tell us what action you have already taken and what outcome you would be satisfied with. Include copies of all relevant correspondence between you and the agency concerned.

What happens to my complaint?

A senior investigator will assess your complaint. We may phone the agency concerned to make inquiries. Many complaints are resolved at this stage. If we are not satisfied with the agency's response, we may investigate.

We do not have the resources to investigate every complaint, so priority is given to serious matters, especially if it is an issue that is likely to affect other people. If we cannot take up your complaint we will tell you why.

If your complaint is about a police officer, we will refer your complaint to NSW Police for resolution or investigation. They will contact you about any action that they have taken as a result of your complaint. We will oversee how they deal with your complaint.

What happens in an investigation?

The first step is to require the agency to comment on your complaint and explain their actions. Generally, we will tell you what the agency has said and what we think. Some matters are resolved at this stage and the investigation is discontinued.

If the investigation continues, it can take several months until a formal report is issued. We will tell you what is likely to happen.

If we find your complaint is justified, the findings are reported to the agency concerned and the relevant minister. You will be told by us or the agency of the findings. In a report, the Ombudsman may make recommendations. We cannot force an agency to comply with our recommendations, however, most usually do. If they do not comply, the Ombudsman can make a special report to Parliament.

What if I am unhappy with the Ombudsman's actions?

If you are unhappy with our decision you can ask for it to be reviewed. However, a decision will only be reviewed once. A senior staff member who did not originally work on your complaint will conduct the review. To request a review, telephone or write to us.

If you are unhappy with any of our *procedures* write to:

Clerk to the Committee, Committee on the Office of the Ombudsman and the Police Integrity Commission, Parliament House, Macquarie Street, Sydney NSW 2000.

The committee monitors and reviews our functions. It cannot review our decisions about individual complaints.



Emily Minter, Project Officer, Executive
Lisa Formby, Desktop Publishing Officer

Acknowledgements

Our annual report is a public record of our work and through it we are accountable to the people of NSW.

Our report is prepared against criteria set out by NSW Treasury and the Annual Report Awards. It is available from our office or our website at www.ombo.nsw.gov.au.

Many thanks to everyone who contributed to this year's annual report, including Selena Choo (Project Manager, Executive) for helping us coordinate the project.

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