17th General Meeting with the NSW Ombudsman
Response to questions on notice

Annual Report 2010 – 2011

1. **You have now completed your first year operating under your new structure. Have you noticed any issues that have arisen during this time, either anticipated or not? Are there any further issues that have been identified through the new structure as needing attention?**

There have been many benefits to the restructure, including but not limited to:

- Better co-ordination of external training including the development of new fee for service training courses which has substantially increased our revenue
- Improved work practices and a more co-ordinated approach to dealing with agencies and issues, particularly in our human service branch
- Better internal co-ordination and a greater focus on internal consistency of work processes and benchmarks
- Expanded delegations and responsibilities to cost centre managers (level below statutory officers) resulting in better ownership of issues and improved decision making.

There have been some unexpected issues following the restructure.

Our decision to move complaints about Juvenile Justice, Housing NSW and NSW Health from our Public Administration Division to the Human Services Branch was reviewed and changed. Although there were some benefits of having all human service matters in the one branch, it was more practical and efficient for the work to be done by our Public Administration Division.

The better co-ordination of our training and the development of new training courses identified the need to have experienced trainers available rather than use existing staff to deliver courses. Over time we have built up a pool of trainers, available on a fee for service basis, to meet the increasing demand for our courses.

Continual changes to the public sector structure has also been an issue for us, however this would have been an issue whether or not we restructured. Our case management system is based on the public sector structure and any changes have an impact on our data collection and reporting.

The reduction of senior staff positions, although necessary for budgetary reasons, has also had an impact on not only staff but on the remaining senior officers who took on greater responsibility. It has taken time for these changes to be embedded, but higher levels of delegation and responsibility to cost centre managers have minimised the risks associated with deleting senior officer positions.

2. **You note in the earlier Annual Report that two senior positions were lost as part of the restructure. In this Annual Report you mention that two new senior positions have been created - do these effectively replace the ones lost last year?**

Ongoing financial pressures was one reason we undertook a major restructure of the office in 2009-2010. With the planned departure of a number of statutory officers we took the opportunity to streamline our structure, better aligning our work and processes to the public sector 'super agency' structure.

We deleted two statutory officer positions – the Assistant Ombudsman (General) and the Assistant Ombudsman (Children and Young People). As the roles and responsibilities of these two deleted positions were allocated to two existing Deputy Ombudsman positions, the Ombudsman sought an external evaluation of these Deputy Ombudsman positions. This external evaluation determined that both positions should be SES Level 5, rather than the then grading of SES Level 4. The third Deputy Ombudsman position remained at SES level 4.

In answer to the question, the Ombudsman has not replaced the two deleted statutory (or senior) positions. Two existing positions underwent re-evaluation, due to the increase in work and responsibilities assigned to those positions following the restructure of the office in 2009-2010

3. **In the Sixteenth General Meeting with the Committee you anticipated that there would be reductions in staff which would impact greatly on the amount of work the office was able to complete. Has this been your experience?**

New roles and responsibilities that we are given by Parliament and the subsequent funding for staff to undertake these roles can mask the reduction of staff numbers in our complaint handling and in the other established areas of the office.

In figure 11 of our 2010-2011 Annual Report we advised that as at 30 June 2011 we had an effective full-time staff number of 185.19. This figure includes staff employed to undertake our public interest disclosures role as well as additional staff employed following the transfer of the child death review team to the office. In addition, we have a number of staff employed specifically to undertake legislative reviews in our police area or to work on our audit of the interagency agreement to tackle Aboriginal child sexual assault (ACSA). Funding for the legislative reviews and ACSA audit is temporary as are the staff employed to undertake these roles.

The average monthly staff number for this financial year is 183.88, a slight reduction from June 2010. However, this figure includes additional staff we have employed following Parliament's recent decision to have the Ombudsman review new police powers.

4. **You mention that you have developed a new set of cross office KPIs and this project is currently in stage two of its implementation. How many stages are there and when do you expect the process to be complete and when will you commence reporting against these KPIs?**

Our Key Performance Indicator (KPI) project has two stages.

In stage 1 we examined how we collect, record and report complaint information from our case management system (RESOLVE). A significant amount of work was done on aligning, where possible, the like work processes of all our divisions so that we could compare performance statistics and set consistent internal benchmarks. In undertaking this review/alignment, we needed to ensure that all legislative requirements were considered.

We monitor and report our performance against these KPIs, with senior staff receiving reports monthly. We will also be reporting some of the measures in our annual report.

Stage 2 involves the non-complaints area of our work. This is more challenging as we have a number of different data capturing systems that will need to be reviewed and if possible integrated. Our small Business Improvement team is managing this project, working with the division managers and reporting to the senior officer group. A project plan, including a timeframe, will be developed following the initial scoping stage which is expected to be completed in June 2012.

5. The 2010-2011 Annual Report indicates that there has been a significant decrease in some complaint statistics compared with 2009-2010 (notably Departments and Authorities, Freedom of Information and employment related child protection). Do you have an explanation for this?

Following the restructure in 2009-2010, some of the work previously undertaken by the now Public Administration Division was transferred to the Human Services Division. These matters, which related to complaints about Housing NSW and NSW Health, were reported separately in 2010-2011 but were included in the Department and authorities subject area in previous annual reports.

As can be seen from figure 2 in the 2010-2011 Annual Report, there were 386 human services agencies matters finalised in 2010-2011. If this figure was included with Department and Authorities, as it was in previous years, the total finalised figure for Departments and authorities would be 1,768 an increase of 354 matters or 25% over the previous year.

Freedom of Information (FOI) complaints reduced in 2010-2011 as a consequence of changes to the access to information regime in NSW. Following the commencement of the *Government Information (Public Access) Act 2009*, the Information Commissioner is responsible for dealing with these types of complaints.

The reduction in the number of matters finalised in our employment related child protection division (figure 2 in the 2010-2011 report) is directly related to the reduction in the number of matters received. This reduction was expected and resulted from the office entering into agreements (known as class and kind agreements) with certain agencies who have demonstrated that their investigative practices have reached an acceptable standard and we are confident that these practices will continue. There are legislative provisions that allow us to do this. We are able to focus our resources on the more critical matters, giving greater priority to serious allegations. Our direct investigations in the employment related child protection division increased from four in 2009-2010 to ten the following year.

6. How has the establishment of the Public Interest Disclosures Unit affected your operations, in terms of both staff and financial resourcing as well as overall business outcomes?

The NSW Ombudsman has been an investigating authority under the former *Protected Disclosures Act 1994*, now the *Public Interest Disclosures Act 1994* (PID Act) since it came into force in 1995.

Amendments to the PID Act in 2011 saw the statutory role of the Ombudsman expand to include the following functions:

- promoting public awareness and understanding of this Act and promoting the object of this Act,
- providing information, advice, assistance and training to public authorities, investigating authorities and public officials on any matters relevant to this Act,
- issuing guidelines and other publications for the assistance of public authorities and investigating authorities in connection with their functions under this Act,
- issuing guidelines and other publications for the assistance of public officials in connection with the protections afforded to them under this Act,
- monitoring and providing reports (monitoring reports) to Parliament on the exercise of functions under this Act and compliance with this Act by public authorities,
- auditing and providing reports (audit reports) to Parliament on the exercise of functions under this Act and compliance with this Act by public authorities,
- providing reports and recommendations to the Minister about proposals for legislative and administrative changes to further the object of this Act
- acting as Chair of, providing secretariat support to and reporting on the work of the Public Interest Disclosures Steering Committee.

The Ombudsman has established the Public Interest Disclosures Unit (PID Unit) within the Public Administration Division of the Office of the Ombudsman to perform these functions.

To date, the PID Unit has:

- acted as secretariat to the Public Interest Disclosures Steering Committee, which recently met for the third time.
- developed and published over 40 hard copy and on-line publications;
- delivered specialist training, including targeted e-Learning, to thousands of public sector employees;
- delivered promotional material, addresses at forums and workshops;
- developed programs for monitoring and auditing compliance with the Act;

- established a global research program to deliver best practice in legislation, policy, publications, investigation methodology, evaluation, promotions and training and
- developed an on-line reporting tool for agencies.

Post the initial implementation; we are now moving into the auditing, monitoring and reporting phase, as well as providing the on-going advice, training and guidance to agencies and staff and providing support to the PID Steering Committee.

In 2010-11 funding was provided for the establishment of the Unit. In our initial funding application the Ombudsman flagged that he was submitting a conservative estimate and he was likely to seek additional resources for this important role. Due to the demands of agencies for greater support and the increasing number of complex and serious disclosures being made to this office, additional funding was sought as an enhancement in our 2012– 2013 budget allocation. However, our supplementation request was denied.

It is now this office's view that the original budget estimates were significantly underestimated when considering the scope of the new role and the resources required to effectively perform the new functions and the extra work arising out of these functions. Some of the change drivers and hidden costs that have impacted on the office's original Public Interest Disclosures function budget estimate are:

- As a result of the greater awareness of the objects of the Public Interest Disclosures Act 1994, there appears to be more confidence in the system of reporting wrongdoings in public authorities. Early trends indicate a significant increase in the seriousness and complexity of disclosures made to this office. Many of these disclosures have been made by more senior staff of agencies. This was our previous experience
- The increase in disclosures to the office has meant that additional resources are required for dealing with these disclosures, including conducting investigations. This has impacted on our complaint handling staff in all divisions and branches. The office is also proposing to provide conciliation services, as envisaged by recent legislative amendments. To be able to establishing this service will require an initial investment of funds to recruit appropriately skilled conciliators.
- The changes to the legislation have increased obligations imposed on heads of agencies and their staff. This has been further complicated by the former Super Agency now Principal Agency bureaucratic structure. The PID Unit has supported public authorities by establishing a framework including model policies, guidelines, fact sheets, etc. However, it is evident that authorities require significant support in embedding the framework into their organisations. Without this support, agencies will suffer significant costs including industrial/staffing dislocation, particularly if disclosures are not managed effectively.
- There is an increasing call for the provision of e-learning modules as an alternative and cost effective method of reaching broader audiences unable to attend facilitated sessions in the short term. This type of learning will enable public servants to view

material at convenient times and reduces lost time due to having to attend structured training, etc. We are currently in the process of releasing our second and third e-learning modules but had planned to enhance these modules with video clips.

- Training feedback and enquiries to date have highlighted a significant deficit in terms of agency investigative capacity and capability. Research has shown a correlation between an agency's investigative capability and higher rates of serious and repeat reporting, reinforcing the crucial importance of good investigation practice and capacity. There is an existing need for the development of an accredited administrative investigations course in collaboration with an external learning facility.

This office is in a unique position to assist agencies to improve NSW public administration by dealing effectively with public interest disclosures. However, we do not have the resources to do so.

7. You note that one of the goals you did not meet over the 2009-10 year was the review of internal procedures manuals. Can you provide a progress update of when you expect this review to be completed?

Procedure manuals have been developed over the years for each area of the office and are used by staff to guide them in their work.

Following the restructure and other reviews of work processes and practices (for example the review undertaken for the key performance indicator project) it was decided that a comprehensive review of our procedure manuals was required.

Each division is tasked with keeping its manuals up to date, with most conducting reviews on a set basis eg each year. Some however undertake progressive reviews eg a section at a time or ad hoc reviews when a policy or procedure changes.

8. Can you explain your understanding as to why complaints from public housing tenants have substantially increased this year (up 39% on the previous year)?

Complaints to this office about Housing NSW have steadily increased over the last 5 years. The proportionality of the issues, however, remains generally stable. The top 5 issues are:

- contractual issues, such as maintenance
- customer service
- complaint handling
- approvals (applications)
- charges and fees (rent and utility calculations)

Changes over the last 5 years that likely contribute to the increase in contact with us are:

- Changes in tenancy contracts from lifelong to defined terms. This was in recognition that circumstances change and a tenant may not always require housing assistance.
- Introduction of tenant water charges for public housing tenants.

- National Building Economic Stimulus Program including forced relocation of longstanding tenants to allow redevelopment of outdated properties.

Housing NSW has undergone significant change in recent times:

- Moving into the Department of Human Services.
- Introducing Housing Pathways, including the reallocation of assets under management (tenancies) from Housing NSW to community housing providers
- Upgrades in technology, e.g. new database HOMES.
- Outsourcing of property maintenance.

The identified complaint increase from 2009/10 to 2010/11 is approximately 3 times the overall rate of increase in contact with the Ombudsman's office during this period. Including informal complaints, Housing NSW tenants contacted us 1167 times in 2009/10 and 1324 times in 2010/11, an increase of just over 13%. The increase from 2008/09 to 2009/10 was just over 14% and current year to date we are looking at an increase of around 5%.

We have seen an increase around application approvals and customer service, with the former seemingly a 2010/11 spike as it has returned to more normal levels to date this year. We are aware that the introduction of the HOMES database caused some teething problems in processing applications. Another factor in complaints about applications is refusal for the type of assistance applicants want because Housing believes the applicant can satisfy their own housing needs. In short, Housing believes they can obtain private rentals.

There does not appear any one single identifiable cause for an increase in customer service complaints, however, anecdotally our complaints and inquiries indicate a level of dissatisfaction with the Housing Contact Centre (HCC) and clarity between the reporting of problems, communication and the resolution of the reported problem. We are currently unclear who takes responsibility for the 'management' of an issue when reported to the HCC and have contacted Housing NSW to arrange a visit to the HCC and a branch office to understand practically how this process works.

One of the internal factors impacting on the number of complaints we record is the 2005 amendment to our legislation enabling us to accept complaints orally. We exercise this power regularly in relation to Housing matters where we assess that an imminent impact on a complainant may be unreasonable, such as an alleged failure by Housing to complete urgent maintenance to a property, like securing a property or repair plumbing etc.

We also exercise this power where we believe the person is vulnerable and/or unable to pursue the matter sufficiently themselves, such as youth complainants or those with mental illness, cognitive disabilities or personality disorders.

In 2006/07 we accepted about 50 complaints this way, last year that number was over 70 and this year's forecast is over 90. Our Annual Reports often include case studies of complaints taken this way.

We are committed to maintaining regular direct liaison with senior Housing NSW staff to resolve informal complaints and to exchange information that assists both us and them in our work, including discussion around systemic change that enables our complaint handling staff to respond to public housing tenants' complaints.

We have commented in our last two annual reports about the transfer of public housing assets, and their respective tenants, to community housing providers and our lack of jurisdiction. Housing NSW published in its last year's annual report (to 30 June 2011) that community housing organisations manage 48,680 social housing tenants, which is just under 15% of all social housing tenants in NSW. This is an increase of over 25% in the last 4 reporting years alone.

These tenants cannot complain to this office under the Ombudsman Act 1974 about the community housing provider, like a public housing tenant can about Housing NSW, because such providers do not meet the definition of a public authority. While certain aspects of community housing providers work falls under Community Services (Complaints, Review and Monitoring) Act, it is a very small group and for very specific functions. The issues we handle about Housing NSW, including the top 5 listed above, are not matters that we can independently review and informally resolve in relation to community housing providers.

This is an ongoing concern. In 2006/07 we recorded 8 contacts about community housing organisations. This has increased over time to 72 in 2010/11 and 59 so far this reporting period.

Section 67B(c) of the Housing Act 2001 sets out that the Registrar of Community Housing is to '…investigate complaints and other matters in respect of registered community housing providers'. The registrar to date appears to exercise this function through its regulatory role of ensuring compliance with the Housing Act, and specifically the regulatory code set out in Schedule 1 of the Housing Regulation 2009.

It is reasonable to expect that the sorts of issues Housing NSW's tenants currently contact us about exist with community housing providers. Considering the increases we have experienced, we believe it would be unlikely that the registrar's existing resources could manage the related complaint load from community housing tenants, let alone an expected increase. However, many of the matters are suitable for informal resolution, like the matters we current resolve with Housing NSW.

We will continue to refer such complaints to the registrar and monitor their handling, however we hope this issue can be resolved so that all social housing tenants in NSW have direct access to the complaint and resolution processes of this office.

The tables on the following page show the breakdown of issues over the last 5 years, the number of contacts (both Complaints and Enquiries) and the growing contact form social housing tenants about Community Housing providers:

Issue/year	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12*	total
APPROVALS	20	31	25	21	70	34	201
CHARGES/FEES	19	28	23	29	32	17	148
COMPLAINT HANDLING	44	44	41	42	41	59	271
CONTRACTUAL ISSUES	52	81	85	95	95	94	502
CUSTOMER SERVICE	50	86	86	67	101	108	498
ENFORCEMENT	6	4	7	6	11	11	45
INFORMATION	13	17	9	10	16	14	79
MANAGEMENT	1	2	8	13	9	11	44
MISCONDUCT	8	4	2	4	5	0	23
NATURAL JUSTICE	0	3	1	1	4	1	10
NJ->CONDUCT NJ	3	2	6	2	0	0	13
OBJECT TO DECISION	12	23	20	17	33	20	125
OTHER	0	0	1	9	11	0	21
POLICY/LAW	6	2	7	3	4	7	29
	234	327	321	319	432	376	

5 year contacts about Housing NSW comparison

Year	E	C	Oral^	Total	% ch yr/yr
2006/07	699	155	52	**854**	3.02%
2007/08	877	224	60	**1101**	28.92%
2008/09	829	187	51	**1016**	-7.72%
2009/10	930	237	46	**1167**	14.86%
2010/11	1015	309	72	**1324**	13.45%
2011/12*	1084	300	97	**1384**	4.53%

5 yr contact about Community Housing

2006/07	8	
2007/08	20	
2008/09	52	
2009/10	42	
2010/11	72	
2011/12*	59	yr to date

*forecasted on complaints rec'd year to date

^oral complaint numbers are included in the Complaint and Total numbers

9. You conducted an investigation into the management of a contract by the Department of Services, Technology and Administration for asbestos surveys in schools. Have you completed this investigation and what were the outcomes?

Our final report is due to be released to the Minister for Finance and Services by the end of April 2012. We found that a large number of asbestos surveys of schools in 2007/2008 were conducted by unqualified and inexperienced persons and that this did not comply with the contract conditions for the project. We will be recommending:

- An independent review be conducted of the adequacy of the Department of Finance and Services procedures for monitoring and ensuring compliance with contract conditions.
- An independent review be conducted to ascertain if information from the school asbestos surveys and in asbestos registers enables the Department of Education and Communities to be satisfied it is meeting its OH&S and common law duty of care obligations to students, staff, people who conduct work on school premises and other users of schools.
- School sites assessed by unqualified/inexperienced persons be re-audited.

10. You mention the difficulties involved in correctly assessing complaints made through phone calls by inmates in the correctional system. Do you have any data that would help assess the value and outcomes of these calls? Are you able to identify any improvements or changes that could be made to the way the system operates?

Assessing an inquiry or complaint within a 10 minute phone call can sometimes be difficult. The most important strategy we have in place to address this is having expert staff available to take the calls, make the assessment and provide relevant advice/information. We discussed this issue in the annual report to inform the Parliament, the Committee and the community generally about how we do our work, and to highlight the importance of having specialist staff working in this area. As would be expected many of our contacts in the custodial services area can be adequately dealt with in the 10 minutes and so our real challenge is devising strategies to deal with those which cannot. To this end we also discussed a little further into this part of the report some of the other challenges of working with those in a closed environment and noted that each of these challenges contribute to the ongoing need for - and relevance of - our regular visits to correctional centres. This part of the annual report chapter was designed to demonstrate the need for a 'whole' approach to oversight of the custodial environment – experienced staff, knowledge of the custodial system, visible presence in the custodial environment.

The value of the contacts we receive over the phone, and the outcomes we achieve, is easily reviewed using information extracted from our complaints database. Before that, however, a brief explanation is needed - we classify our contacts (whether they are received by phone, on a visit or in writing) as either formal or informal. Formal contacts are those on which we take

some action, informal contacts are those where we provide advice or referral to another agency or some more appropriate way of dealing with the issue.

During the 2010/2011 reporting year we received 865 formal contacts, 440 by phone (50%) and a total of 3352 informal contacts, 2830 by phone (84%). Apart from speaking to our staff on visits, the phone is the preferred method of contact for those in custody. This is unsurprising given the generally acknowledged low literacy levels of the inmate population and that complaints about custodial matters often require an immediate intervention as the consequences are not always easily mitigated at some later time.

In terms of the formal phone contacts on which we took direct action there was a positive outcome in 74% of the issues. Details are as follows:

193	Resolved outright
1	Suggestion made to agency to resolve issue
184	Inquires made and substantial advice given but no evidence of wrong conduct
15	Inquiries made and advice to complainant, no formal finding of wrong conduct
4	Inquiries made and no further action was required

It would of course be simple to suggest that the time limit on calls to our office from correctional centres be lifted but we do recognise that for all the challenges it presents us, the 10 minute limit is a practical response to managing access to phones, as well as the cost of calls. We also need to consider that we are one of several 'freecall' agencies inmates need to contact. An ability to easily make arrangements for specific inmates to have access to an untimed phone location to receive a call from our staff would improve the situation on some occasions.

Overall, however, experience has shown our best strategies for managing these challenges is to maintain a group of specialist staff to respond to the calls we receive, and to continue to regularly visit correctional centres where we can talk to inmates about their issues, identify further systemic issues and generally observe the operations within the custodial environments.

11. You express serious concern about the beds in Grafton Correctional Institution and the fact that they provide hanging points for inmates. You note that the Commissioner has implemented some harm minimisation procedures but you wish to see more. Can you update us on what progress has been made on this issue?

We are not aware of any further progress on this issue – we are visiting Grafton Correctional Centre on 2 May 2012 and will once again review the accommodation areas. As the Committee would have noted from the discussion in the 2010-2011 Annual Report, this is not the first time we have raised concerns with the Commissioner of Corrective Services about accommodation at Grafton. While on this occasion (ie following our visit of February 2011) it was a concern about the 'hang points' some beds presented, in a previous report (2006-2007

p108) we wrote about the privacy and dignity issues when adult men must live in dormitory style accommodation in the minimum security units at Grafton.

Each time we have raised these issues with Corrective Services NSW we have been told the accommodation is 'fit for purpose'. In response to our concerns about hanging points, we were referred to the overall policies and procedures they have in place for managing offenders at risk of self harm. We acknowledge these policies and procedures are generally comprehensive but maintain the view that no measurement of risk can totally remove the potential for self harm, including spur of the moment decisions made by inmates who are not generally considered to be at risk, in the way that removing the opportunity to hang themselves can.

Grafton Correctional Centre was built in 1893 and much of the current accommodation was gradually constructed over the ensuing century. None of it is recently built. The changes required at Grafton are wholesale. Several years ago the government of the day identified Grafton as a centre which would be replaced by a new regional centre. We understand a feasibility study and business case was submitted to the then Cabinet but no approval or funding was given for the proposal to proceed. It is important to the overall effective operation of the correctional system for a correctional centre to be maintained in the Grafton area and unfortunately the current centre continues to struggle with existing facilities.

12. You refer to a report you previously conducted into Manly Council's poor administrative practices and indicate that the Council only partially acted on your recommendations. In your continued monitoring of their actions have you been satisfied that there is a significant improvement?

24 recommendations were made to Manly Council in relation to the investigation we reported in our Annual Report. Some related to redress to the complainants both in the form of apologies and compensation. Many of the recommendations related to improving administrative policies and practices. Council declined to comply with two of our recommendations that related to apologising to one of the complainants, and to providing them with compensation.

Throughout the reporting process, the Council has provided this office with substantial detail relating to a number of new and amended policies to improve the consistency and quality of their decision making. In conjunction with these new and amended policies, Council provided evidence of the rolling out of these policies with Council-wide staff and councillor training.

We conducted an audit in September 2011 to determine how the roll out of these policies and training programs has affected the Council's administrative practices. This involved attending Council's office, viewing Council's complaint handling files and talking about these processes with the on-ground staff involved with these issues. It became clear to us that the staff were quite positive about the new policies and the training they received, and consistently agreed that they felt their decisions were more reliable and they were confident in the way they made decisions with clearer processes in place.

Concurrently with our own monitoring, and in accordance with another recommendation made by us, the DLG conducted a promoting better practice audit at the Council, and their report about Council's governance, policies and procedures further provided reassurance of the improvements at the Council.

We continue to monitor the Council's performance through the complaints we receive. Each complaint is assessed on its merits and the evidence available. To date, there has been no further evidence that would warrant our further investigation of the Council's performance.

13. You describe the Professional Standards Command as often investigating police misconduct complaints in an informal manner, an approach you do not agree with. Do you have data supporting the use of one type of investigative method over the other, or that indicates higher rates of satisfactory resolution?

Since last year's annual report we have had further consultation with the Professional Standards Command (the PSC) about this issue. In December 2011 the PSC published a revised edition of the *Complaint Handling Guidelines* which made it clear that commanders have discretion to determine an appropriate level of investigation for complaints. This is a positive change that may address some of our concerns.

In our annual report 2011- 2012 we reported the number of complaints investigated formally and informally by the NSWPF. This table indicates the increased use of informal resolution over the last three reporting years.

Figure 41: Action taken in response to formal complaints about police that have been finalised

Action taken	**08/09**	**09/10**	**10/11**
Investigated by police and oversighted by us	1,395	1,145	1002
Resolved by police through informal resolution and oversighted by us	443	751	979
Assessed by us as local management issues and referred to local commands for direct action	468	340	398
Assessed by us as requiring no action (eg alternate redress available or too remote in time)	788	857	899
Total complaints finalised	**3,094**	**3,093**	**3,278**

In our annual report 2011- 2012 we also reported the overall number of complaints that were not investigated or resolved in a satisfactory manner:

We closely reviewed the quality of the way police investigated or resolved complaints, and found that 1,645 (83%) had been handled satisfactorily. However in 333 matters (17%) we considered the handling of the complaint to be deficient. Of these, 157 matters were deficient only because there were unreasonable delays in investigating or resolving them.

We are aiming to enhance our data collection about unsatisfactory informal resolutions so that we can analyse this issue in more detail.

14. You mention 100 matters that you discovered through audits of police records which the Ombudsman was not notified about and should have been. Have you been able to follow up on the outcomes of these issues? Is this number of complaints being improperly registered acceptable?

Every year the Ombudsman undertakes audits of police complaint records to inspect and check for compliance with the complaints legislation, policy and our class or kind agreement.

Section 160 of the Police Act continues to be an effective tool for the purpose of scrutinizing the complaint handling system to identify complaints about serious police misconduct which have not been accurately assessed and registered onto C@tsi, the police complaint database by NSWPF (for whatever reason).

The 100 complaint matters referenced in our 2010/2011 annual report includes the results from internal audits of the police and Ombudsman complaint databases and our visits to identified commands where Ombudsman officers are able to physically interrogate and inspect the command's complaint management recording systems. The audit process also gives us opportunity to share good practice examples, identify poor practices and emerging patterns and concerning trends.

In our view the 100 complaint matters identified during our audits over the financial year is proportionately insignificant when measured against the 5,000 odd complaints received (at over 100 commands) about the alleged misconduct of police officers during a year. At this time we have no concerns and consider the number (and percentage) acceptable, particularly when allowing for human/administrative error at the local level. Overall there is very good compliance by NSWPF however the findings do highlight the importance of having a continuing audit program.

We provide formal written advice to NSWPF of our assessment decisions (that a complaint appears to be of a type which requires the oversight of this office) and the reasons why we consider the police complaints database needs to be amended and further inquiries to be conducted. We follow up with each of the commands and provide a final report on the agreed outcomes.

The auditing process allows for NSWPF to disagree with our assessment decision however in the vast majority of matters are reclassified and notified to this office without further negotiation or disagreement.

15. You provided your audit report to NSW Police on the PoliceLink Command in June 2011. Have you received a response to this report yet?

We have received a response from NSW Police. We have met with Police recently regarding their response and will finalise this audit report in the near future. We have experienced two delays in finalising this report due to unexpected staffing absences.

16. The use of tasers by the Police Force has been an issue you have been monitoring over the past few years. In this Annual Report you provide detail of a substantial review into the use of tasers, drawing on both the international experience and domestic records. Can you provide an update to the Committee on the status of this research?

Our investigation into the use of tasers by general duties police is ongoing. In October 2011, after considering 1668 taser incidents (which occurred between 1 October 2008 and 20 November 2010) and conducting a detailed review of 632 incidents, we wrote to NSW Police regarding some issues and queries, and the application of the Standard Operating Procedures. We have received a response from NSW Police and are currently finalising our investigation report.

17. You have reporting responsibilities in relation to the Terrorism (Police Powers) Act 2002 the law Enforcement (Powers & Responsibilities) Act 2002 and the Crimes (Criminal Organisations Control) Act 2009. Could you provide the Committee with an overview of your activities in relation to this, any conclusions you have reached and any recommendations you have made.

The Ombudsman reported to the Minister for Police and the Attorney General about the operation of Parts 2A (Preventative Detention Orders) and Part 3 (Covert Search Warrants) of the *Terrorism (Police Powers) Act 2002* in August 2011. The recommendations made by the Ombudsman are set out in the report which is available on the Ombudsman's website. Our next report is due in December 2013. We will continue to monitor the implementation of recommendations from the August 2011 report and keep under scrutiny any use of the powers by police under Part 2A and Part 3. The Commissioner must notify the Ombudsman of any preventative detention orders made under Part 2A.

The Ombudsman is to keep under scrutiny the exercise of powers conferred on police officers under Part 6A of the *Law Enforcement (Powers and Responsibilities) Act 2002* which relates to Emergency Powers- Public Disorder. The Ombudsman includes a report about these activities in the annual report.

Section 39 of the *Crimes (Criminal Organisations Control) Act 2012* requires the Ombudsman to review and report on the operation of the powers conferred on police under this Act. The Ombudsman is to report to the Minister as soon as practicable following 4 years of the operation of Act which commenced 21 March 2012. We have not made any recommendations as the review has only recently commenced. We have started consultation with the NSWPF about an information agreement for the review and are recruiting project review staff.

18. You mention a draft policy released by Community Services for unaccompanied children in homeless services and several concerns you have in relation to this policy. Have you had any feedback on the development of the policy or your concerns?

In September 2010, Community Services provided us with a copy of its draft policy, '*Assisting unaccompanied children under 16 years who are in SAAP youth accommodation services*'. We reviewed the draft policy and provided feedback to Community Services, noting that overall, the policy was largely equivocal about when the agency will offer support and the nature of financial and casework support that will be provided.

We also raised specific concerns about whether the draft policy provided adequate guidance to staff in assessing the individual needs and circumstances of children presenting to homelessness services and whether it adequately promoted the sharing of information to promote the safety, welfare and wellbeing of young people.

Following receipt of our feedback, Community Services committed to revise the draft to take account of the concerns we had raised.

In April 2011, Community Services provided us with a copy of its revised draft policy, however, we remained concerned that it too narrowly defined the circumstances in which homelessness services could contact Community Services for support, that is, only to children under the parental responsibility of the Minister, or with an open case plan at Community Services. In the context of an increased emphasis on shared responsibility, we argued that specialist homelessness services should be encouraged to contact Community Services where contact is appropriate, including, but not limited to the following circumstances:

- when risks are apparent and the service requires information and/or advice from Community Services to inform their risk assessment and related decisions about how best to provide support;
- when the presenting risks are so high that the service is unable to meet the child's needs and the service determines, on reasonable grounds, that Community Services may be best placed to meet all (or some) of these needs; and
- when children are residing at the service without parental knowledge or consent, and consistent with s.122 of the *Children and Young Persons (Care and Protection) Act 1998,* the service need advice and/or assistance form Community Services in determining the nature of the contact which should be made with the parent.

In addition, we were also concerned that the draft policy required children to have been residing in a specialist homelessness service for three months before they were deemed abandoned and at risk of significant harm. We said any assessment of risk should be based on a child's individual circumstances.

In August 2011 and in response to the issues we identified, Community Services undertook to make further revisions.

In addition, our August 2011special report to Parliament, *Keep Them Safe?* stressed the critical importance of developing a policy and practice framework for supporting vulnerable older children and adolescents– particularly where there is evidence of serious physical or sexual abuse; significant risk of death from abuse, neglect or suicide; or a lack of the basic necessities of life.

Following the tabling of *Keep Them Safe?* a Ministerial Adolescent Working Group has been formed to look at how service systems and supports for "at risk" adolescents and their families can be strengthened and improved.

We will continue to monitor the actions taken by relevant agencies to address the issues we identified in our *Keep Them Safe?* report, including actions to improve responses to vulnerable young people such as those residing in homelessness services. In this regard, we are currently reviewing a number of matters that are illustrative of our concerns and will refer our findings to Community Services and Minister's Adolescent Working Group to inform their work.

19. In the Sixteenth General Meeting with the Committee you stated that you would actively monitor issues arising from a review of large Department of Ageing, Disability and Home Care residential centres. What outcomes have you seen as a result of this?

Since 2009, we have been monitoring ADHC's actions to address the issues raised in our review of 60 individuals living in the agency's large residential centres. In August 2010, we tabled a report in Parliament, *People with disabilities and the closure of residential centres*, which highlighted evidence from our work that showed that the existing residential centre model restricts the rights and opportunities of the people with disabilities who live there. We emphasised the critical need to progress the devolution of large residential centres, and made recommendations aimed at achieving this outcome.

Subsequent to our report, the second phase of *Stronger Together* included the commitment to close all ADHC operated and funded residential centres by 2017/18. We are monitoring ADHC's actions to progress the closure of the remaining centres, and will continue to do so until the work is completed.

A key element we are monitoring is ADHC's actions to ensure that people with disabilities living in the residential centres, their families, and other representatives, have meaningful and direct involvement in the planning for the closure of those centres. As part of this work, we have had involvement with the Metro Residences Family and Friends Group, and have provided independent scrutiny and analysis of consultation surveys undertaken by ADHC and the Family and Friends Group.

We are currently reviewing ADHC's most recent report to us on its actions to progress devolution and to ensure that residents and families are partners in this work. Our assessment will include consideration of the extent to which ADHC and funded services have:

- advanced the planning for closure and transition to community-based accommodation options;
- developed clear strategies for working in partnership with residents, families and other stakeholders in this process;

- identified the need for, and facilitated access to, independent advocates to support residents to have meaningful involvement as early as possible; and
- ensured that person-centred and flexible approaches to support are reflected in the planning process.

20. Regarding the shift in responsibilities that has seen you take over as the Convenor of the Child Death Review Team, are you confident that you are able to perform the associated functions effectively?

Yes. We have fully established the function within the Ombudsman's office, properly constituted the Team, produced a statutory annual report and have commenced work on a number of projects to further the capacity of the team to undertake relevant research.

21. Is the funding you have received for the Child Death Review Team component of your work sufficient?

In September 2009, we provided an estimate of what we believed would be the minimum level of funding to perform the CDRT functions. We estimated this to be $539,000 per annum. As we have progressed the work however, it has become apparent that this level of funding is not sufficient to meet necessary staffing and infrastructure costs.

Staffing

Our initial view was that the work could be undertaken with the addition to the existing reviewable death staff team of:

- One grade 9/10 position to supervise review staff and manage the research / reporting process
- Two grade 7/8 review officers, to undertake reviews
- One grade 3/4 position to manage correspondence, records and resource CDRT members

In addition, we estimated a cost of approximately $150,000 for expert coding of cause of death and collation and analysis of data for reporting.

We have now had the CDRT function for over a year.

Since the transfer, we identified a need to upgrade positions, particularly in relation to research needs. We have created two senior positions of Principal Review Officer and Principal Research Officer, and increased the number of substantive review officer positions to five, with an additional temporary position.

Our establishment staff costs for CDRT related work are approximately $800 000. Not all positions are filled.

Team members have proposed a range of valid research priorities that, to properly undertake and promote resulting prevention initiatives, will require strong staff support in addition to the buy-in of relevant high level expertise.

Infrastructure

In addition, we have identified significant infrastructure needs.

Of critical importance is the need to review and likely rebuild the Child Death Register.

The register has outgrown its original platform and does not provide a system that has the maturity to meet the longer-term needs of the CDRT. The database became unwieldy due to size, and to address this in the interim, it has been separated into two parts. The system has limited reporting and analytic capability, and no workload management function. Aside from technical issues, the data capture is also inconsistent and new well constructed specifications are required.

We have recently completed stage one of a proposed three-stage process to determine business requirements and implement an electronic solution that supports the current and future needs of the CDRT and reviewable deaths. Stage one has produced a requirements specification. Stage two and three are at present, unfunded. The costs of building a new and effective technology solution are likely to be substantial.

Forward plans

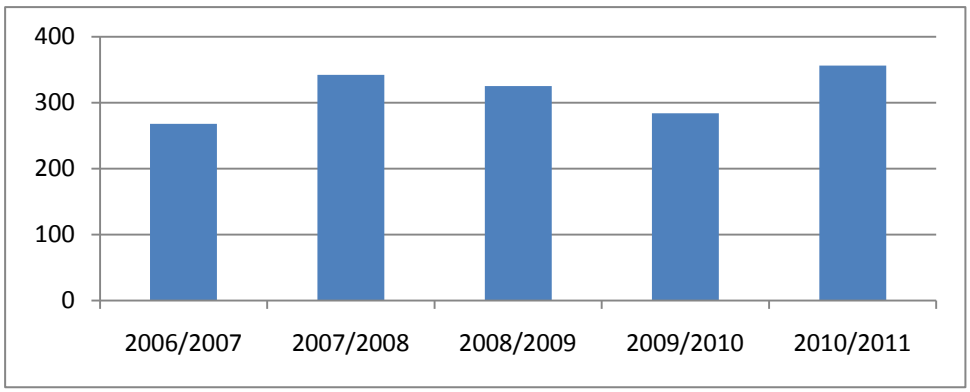
We have been able to meet additional staff costs, and costs associated with using external experts to undertake required developmental work through enhancement funding provided by the government. This funding is a temporary allocation to 2014/15 of $500,000 per annum to support our work relating to children at risk and child deaths. Part of this funding has been allocated to CDRT work.

Given the resourcing needs described above, particularly related to technology solutions, we will be seeking additional funding as part of the 2013-2014 budget cycle.

22. You note a 25% increase in complaints on behalf of young people in juvenile justice centres for this year compared to the previous. Do you have any explanations for this?

It is often difficult to speculate on why complaints increase – or decrease – over any given reporting period. In custodial environments there are occasionally significant systemic issues, such as overcrowding, reduced access to amenities and the like, which can account for an upward trend. In areas where the overall numbers are comparatively small – such as Juvenile Justice - one significant decision in one centre could potentially lead to many young people contacting us about the one problem causing an apparent spike.

A review of complaint/contacts from young people in Juvenile Justice Centres over a range of recent years provides some evidence of variable complaint trends.



While the increase between 2009/2010 and 2010/2011 was 25%, the actual difference was only 72 contacts. It is our view the increase was not a result of any specific problems within the juvenile justice system and conversely seems to have been a return to similar levels for previous years, with the low level in 2009/2010 being the anomaly. For the four years up until 2009 we had consistently held concerns, and reported on, the serious levels of overcrowding in the juvenile justice system. By 2009/2010 this had been addressed by the opening of the Emu Plains Juvenile Justice Centre which had given the system a small amount of additional space and reduced the pressure on bed availability.

Of course it is also important to note that contacts received from and on behalf of young people in the juvenile justice system is only one way in which we keep the system under scrutiny. Our visits to the centres also play an important part in keeping abreast of issues, as does our legislated role of reviewing notifications of all young people segregated over 24 hours to ensure these young people are appropriately managed.

23. The Young People in Custody Health Survey 2009 highlights many social and environmental risk factors for young people. You state that you are keen to monitor the actions and strategies that relevant agencies are implementing to support these young people. Have you been able to actively monitor or assess any such strategies? How do you plan to do so?

We are always keen to monitor the impact of significant reports about how government could best provide comprehensive and complementary services to vulnerable members of our community. In regard to the Young People in Custody Health Survey 2009 we reviewed our ability to formally monitor the way in which the various agencies involved would take account of the key findings outlined in the survey report. Our priorities must of course match our resources and with the office already heavily involved in other significant wide ranging reviews, such as our work on Aboriginal child sexual assault, and other specific investigations in the custodial services area, we have not been in a position to undertake a formal review. During our visits to juvenile justice centres we routinely discuss ways Juvenile Justice links young people into services they require, including those undertaken in conjunction with other agencies.

24. You anticipated a considerable impact on your office from the changes to children's care services regulations (particularly those relating to day care) at the beginning of 2012. Can you elaborate on the impact this is having and how you are coping with it?

On 1 January 2012 the new national regulatory framework for education and care services (formerly known as children's services) came into operation.

One of the key changes arising from the introduction of this framework is the inclusion of out-of-school hours services (OOSH) within national regulation. This means that the 1,400 services providing out-of-school hours care now fall within our employment-related child protection jurisdiction.

We anticipated that the knowledge base for OOSH services coming into our jurisdiction for the first time would be minimal. Since the national regulations commenced in January 2012, we have received only two notifications of reportable conduct from OOSH services, reinforcing our view that there is a real need for targeted education and training for this large and disparate group of services.

Unfortunately, this office has not been resourced to manage the potentially significant demand that is likely to arise as child protection awareness within the sector increases.

Under the *Education and Care Services National Regulations,* approved providers are required to ensure that staff are informed about current child protection law. We are keen to see the development of strategies to promote enhanced awareness amongst the education and care services sector in relation to their child protection responsibilities. We have liaised with the Department of Education and Communities about potential opportunities for us to work with them to promote this awareness and to raise the knowledge and skills of approved providers so that they are equipped to respond appropriately to reportable allegations and other child protection concerns. We will continue to promote the need for initiatives in this area.

25. The 2010-2011 Annual Report makes particular mention of reports into 'Restoration of Children on short term care orders' and 'Deaths of people with disabilities in care' Could you provide the Committee with an update on the implementation of your recommendations and any strategies that may have been adopted to address the issues highlighted in the reports.

Restoration of children on Short Term Care Orders

We provided our final report of the group review of children on short term care orders with a view to restoration to the Minister and agencies in April 2011. We made the following recommendations:

1. Community Services' review of its restoration practice should ensure the advice/guidelines and training available to caseworkers ensures that relevant staff have key competencies to:

a. Prepare care plans where the goal is restoration that:

   i. include minimum outcomes that are appropriate to the child's circumstances and needs and address the issues that led to the child entering care;

   ii. detail the services and supports required to support restoration;

   iii. specify how the changes required of parents will be assessed.

b. Adequately present to the Children's Court the rationale for the permanency plan.

c. Know when it is appropriate to seek supervision orders following care orders.

d. Know when it is appropriate to include what supports are required, not just to facilitate the child going home but also after the child has gone home.

2. By 30 June 2012, Community Services should:

a. Provide this office with a progress report on its Restoration/Preservation and Family Supervision project.

b. Advise this office of the agency's progress to review the restoration advice/guidelines and training available to caseworkers and other relevant staff.

3. By 30 July 2011, Community Services should advise this office of the outcome of the agency's Legislative Review Unit's consideration of whether an amendment to section 76 of the *Children and Young Persons (Care and Protection) Act 1998* is warranted.

In July 2011, Community Services provided the first of two required progress reports. Community Services agreed that a review of policy, procedure and guidance is needed to support sound restoration practice and advised that this is being addressed in ongoing projects. The agency intends to update its out-of-home care policies and procedures in line with the outcomes of the pilot 'Short Term Court Order, Restoration/Preservation and Family Supervision project'[1] and its out-of-home care accreditation project.

The agency advised that as at July 2011, progress on the out-of home care accreditation project included:

- implementation of a revised case planning framework and template commenced in May 2011
- revised casework practice procedures had been drafted for further consultation within the agency

[1] A pilot project in five Community Service Centres that is subject to external evaluation over two years. The aim of the project is to enhance the agency's focus *'on more timely work with families, including collaboration with relevant non government and community partners to keep children, where it is safe and appropriate, with their families or restore them to their immediate or extended families after a period of intensive intervention'* through the use of dedicated and trained family preservation and restoration teams.

- feedback on a draft record keeping framework had been received and would be considered prior to implementation/publication
- practitioner teams were to commence in four networks to support practice and cultural change.

In relation to recommendation 3, Community Services advised that it was considering seeking amendment to section 76 of the *Children and Young Persons (Care and Protection) Act 1998*, with a view to extending the period supervision orders may be made for. The agency advised it was consulting with the President of the Children's Court and with other key stakeholders, including the NSW Law Society and the Legal Aid Commission on this issue, and will advise this office of the outcome as soon as it is available.

The second progress report from Community Services is due by 30 June 2012. Community Services is expected to report on the progress of the 'Short Term Court Order, Restoration/Preservation and Family Supervision project' and on the agency's progress to review the restoration advice/guidelines and training available to caseworkers and other relevant staff.

Deaths of people with disabilities in care

We tabled our last biennial report on the deaths of people with disabilities in care in Parliament in September 2011. The report included 15 recommendations targeted at ADHC and/or NSW Health, aimed at improving the health outcomes of people with disabilities in care and reducing preventable deaths. These included the need to:

- Improve the work of disability and health services to identify and minimise the risks faced by individuals, including nutrition, swallowing and respiratory risks.
- Enable equitable access to community-based health programs, including chronic disease management and other out-of-hospital programs.
- Review the use of antipsychotic medications for people with disabilities in care.
- Improve the support for people with disabilities in hospital.
- Improve the assessment and provision of health care to residents of licensed boarding houses.

ADHC and NSW Health were required to provide us with a response to the recommendations by 30 December 2011, and a progress report on implementation of the recommendations by 27 July 2012. The progress reports in July will provide a useful indication as to the adequacy of the agencies' actions to implement our recommendations. However, we are already aware of progress that has been made in key areas.

<u>Access to out-of-hospital programs</u>

Chronic disease management and other out-of-hospital programs enable the early detection and treatment of conditions to avoid emergency hospitalisation; management of long-term

health rather than just fixing immediate symptoms; and effective partnerships between health providers.

One of the important points in our report was that none of the people with disabilities in care with chronic illnesses whose deaths we reviewed had access to Health's chronic disease management program or other out-of-hospital programs. This included at least 49 people who died in 2008-09, many of whom had multiple hospital presentations in relation to their chronic illnesses.

NSW Health has provided advice to us on the actions it will take to identify people with disabilities in care who need this support, facilitate their access to these programs, and meet their needs. This includes consultation with ADHC, GP peak organisations, and the Agency for Clinical Innovation, and the development of a proactive engagement and enrolment strategy.

Health service framework for people with intellectual disability

NSW Health has advised that two additional specialised clinical service pilots would commence in January 2012: one at Sydney Children's Hospital Network and Sydney South West Local Health District; and one at Northern Sydney Local Health District and the Developmental Disability Health Unit.

Access to health services for people with dual diagnosis

NSW Health and ADHC have developed an implementation plan for the *Memorandum of Understanding and Guidelines for the provision of services to people with an intellectual disability and mental illness*, and have established clear reporting structures to enable monitoring and oversight of local implementation.

We are also examining implementation of the MOU across Local Health Districts/ ADHC regions as part of our current inquiry into the access of mental health inpatients to services and support under the *Disability Services Act 1993*.

Other relevant work

We are in the process of developing accessible and targeted factsheets for disability services, licensed boarding houses, and medical practitioners, on the key messages from our work in reviewing the deaths of people with disabilities in care. The factsheets will be aimed at direct care staff and their managers, Boarding House Reform Program staff, and GPs, as the practice of these individuals can directly assist in reducing preventable deaths.

We are currently consulting with key staff and other stakeholders to identify the best ways to communicate this information, engage the intended audience, and facilitate their adoption of the critical messages and required actions.

26. A key outcome of the 2011 Annual Meeting of the Pacific Ombudsman Alliance was to develop five year action plans. Can you update on the progress of this and your office's obligations under it?

Development of the five year action plans was driven by the resolution of Pacific Ombudsman Alliance (POA) members to coordinate regionally on strategically important goals. The plans would support or draw upon pre-existing corporate plans, indicating the office's objectives over the next three to five years, and the areas where the POA can provide support to assist members to achieve these objectives.

In light of the resource constraints that restrict our colleagues from conducting in-depth, strategic analyses of their existing levels of capacity, the POA Secretariat[2] proposed developing the action plans in stages. The first stage was to develop a diagnostic tool that could be applied to elicit information to guide strategic planning decisions and develop assessments of existing capacity. Stage two will then utilise these assessments to create strategic action plans for POA members.

The first iteration of the diagnostic tool was presented to the POA Board at the September 2011 meeting. This first iteration set out a series of questions that support analysis of each office's strengths and challenges, structure and enabling legislation and management in operational and corporate areas.

The POA Board suggested further refinement and simplification of the tool before approving trials with two POA members. The Secretariat trialled the diagnostic tool with the Vanuatu Ombudsman's Office in March 2012 and has prepared a full report which will be submitted to the POA Board for consideration at the May 2012 Board meeting. A second trial is scheduled for late April 2012 with the Samoan Ombudsman's Office.

When the assessment tool is finalised, each member office will use it to assess its own capacity and form a country action plan. It is proposed to discuss or finalise these plans at the members' meeting in November 2012.

Although the application of the diagnostic tool and strategic planning process is facilitated by the POA Secretariat, the responsibility for creating action plans rests with each member. As such, the New South Wales (NSW) Ombudsman's Office does not have any obligations in relation to the development of these plans.

27. You identify a deficiency in cross-agency reporting of adults working with children checks, in that there is no national system of reporting or register which increases the chance that high risk cases will not be managed appropriately. Have you given any consideration to how this issue might be addressed?

Following on from the 2010 statutory review of the *Commission for Children and Young People Act 1998,* the Commission for Children and Young People (CCYP) is proposing to introduce an accreditation system for working with children checks that will provide five year accreditation to people working with children in NSW. Legislation to effect this change is anticipated to be introduced this year.

[2] The POA Secretariat is hosted by the Commonwealth Ombudsman's Office and also includes an officer from the NSW Ombudsman's Office.

In our submission to the statutory review and subsequent correspondence to the Minister for Citizenship and Communities following the release of the review report in June 2011, we supported the objective of moving towards a nationally consistent approach to working with children checks. However, we urged that any such move should not simply consider employment screening in isolation, but have a broad ambit that includes detailed consideration of the need to ensure that high risk allegations are consistently identified, competently investigated, and where relevant, the outcomes are factored into employment screening systems.

In addition, we argued that adopting a nationally consistent approach to working with children checks must be conditional on demonstrating that it strengthens the ability of employers to identify and manage risks to children. In is therefore critical that a national approach does not weaken aspects of the NSW system that are superior to other jurisdictions.

We also expressed our view, based on 12 years of experience in oversighting child employment-related investigations, that it is essential for a national approach to guarantee that findings from significant relevant employment proceedings are taken into account as part of the screening process. This currently occurs in NSW and is critical as it allows employers to give due consideration to the actions or behaviours of prospective employees that do not meet the threshold for police investigation or criminal charges, but nevertheless provide critical information relating to potential risks to children.

28. You mention discussions you have held with Police about the release of relevant information to prospective employers when conducting working with children checks, and instances where this has not occurred. Have you made any progress on this issue?

In our 2010-11 Annual Report we indicated that we had facilitated discussions with police early in 2011 about the use of police intelligence holdings to help protect children.

Our discussions focussed on when it might be appropriate for police to release information arising from credible and relevant intelligence holdings to prospective employers in certain circumstances – particularly where the potential risk to children is very high. We indicated at that stage, we were keen to further explore with police how a fair and rigorous system could be established to ensure critical police intelligence of this type is identified, and only used in circumstances that are justified.

We undertook to record additional case examples identified through our child-related employment oversight which provide evidence that provision of available police intelligence would have been useful, or in some cases pivotal, to the process that responsible agencies undertake when conducting risk assessments and making informed decisions as to whether certain people should be employed in a child-related position. A number of cases were subsequently identified and provided to the NSW Police Force.

In March this year, we facilitated a meeting with the Acting Deputy Commissioner (Field Operations) and senior police personnel from the child protection and sex crimes area, to

discuss the best way to progress this important issue in the context of changes taking place in relation to the working with children check process.

Under the new system, approval will be given to suitable people accredited to work with children for up to five years, and relevant details will also be recorded on the NSWPF COPS system. The COPS system will send up an 'identification flag' if people approved to work with children come to the attention of police in relation to certain offences when their details are entered into the system. This will trigger a notification by police to the relevant body. However, these systems improvements will not deal with risks posed to children identified by police through credible intelligence, as this type of information is currently not required to be shared with potential employers.

Police highlighted in their discussions with us that there will be a substantial resource impost on their organisation to enter the details of relevant people who are entering the system for the first time, as well as the details of those people changing positions –which also triggers a new check. The NSW Police Force has not been provided with extra resourcing to carry out this critical work despite the fact that it is likely to involve entering the details for a very significant number of people.

Against this background, we acknowledged that in order for police to be in a position to conduct the necessary checking of credible intelligence holdings, additional resourcing would be required together with appropriate information technology solutions to create an efficient system for flagging 'potential' child sex offenders. We also emphasised that an identification system of this type would need to be supported by a process where relevant intelligence is put through a quality assurance process.

The Acting Deputy Commissioner indicated he would discuss the issue further with senior police personnel to gain a better understanding of the potential impacts of such a checking process on police resourcing and the organisational implications of sharing sensitive information of this type with external bodies. We will make contact with the A/Deputy Commissioner shortly to ascertain the NSW Police Force's views in this regard.

29. You state that there are significant differences in the way that Aboriginal and non-Aboriginal inmates are treated at Goulburn and you are waiting on a decision by the Administrative Decisions Tribunal in relation to this. Have you heard this outcome or made any further inquiries into this situation?

The Committee may be aware that inmates in the maximum security sector at Goulburn Correctional Centre are segregated in their accommodation units and their 'yards' by cultural background/race. The groups generally are: Aboriginal; Anglo-Australian; Asian; Islamic/Middle Eastern; Polynesian. Aboriginal inmates are generally accommodated on the bottom landing of 4 or "D" wing (remandees of various cultural backgrounds are accommodated on the upper landing), though some Aboriginal inmates with specific needs may also be accommodated in other areas of the centre, primarily those areas where inmate association is limited for various reasons.

Racial segregation within Goulburn has been in place since the mid 1990s when the centre experienced unprecedented inmate violence including several murders. Several other practices for managing Aboriginal inmates at Goulburn were also adopted by Corrective Services NSW in response to a serious incident which occurred in April 2002 when Aboriginal inmates rioted and several officers were very seriously injured, and a large amount of damage was caused to the buildings.

A decade later many of these practices are either still in place, or are only slowly being revised. Since late 2003 we have consistently raised with various Governors/General Managers at Goulburn the importance of reducing these restrictive practices.

When an inmate complained to us about these practices, we became aware that he and several others had already complained to the Anti-Discrimination Board (ADB), and their matter had been referred to the Administrative Decisions Tribunal (ADT). The complaints made to the ADT/ADB were similar to the issues we had been raising and included:

- limiting the number of Aboriginal inmates who can be accommodated in the wing to 25;
- removing access to work opportunities including not allowing Aboriginal inmates to take up "sweeper" (domestic worker) roles within their own wing which is the norm;
- providing limited (if any) access to education and program areas within the centre;
- requiring Aboriginal inmates to be placed in two out cells despite vacant one out cells being available;
- having security mesh welded to the doors and grills of the cells in the wing, which is not the case in other wings;
- Aboriginal inmates are mustered four at a time and other inmates are not
- Receiving their clinic service in their cells instead of being able to approach the "clinic window" in the main part of the centre as other inmates do.

As the ADT had scheduled the matter for a case conference we agreed to monitor the progress and outcome before deciding if any further action should be taken. During 2010 and 2011 several case conferences were scheduled but on a number of occasions were either missed because of administrative failures by CSNSW in not bringing the complainant/ inmate to an appropriate phone location to participate or stood over by either the Tribunal or the inmate's legal representative. In late November 2011 – and before the case conference could be held – the inmate was released to parole. As a result his case no longer had standing at the ADT as he was no longer subjected to the allegedly discriminatory treatment/management. On a side note this matter identified a lack of policy and procedure for inmates attending ADT case conferences. As a result of our intervention CSNSW have since introduced such policies and procedures.

There has been some minor progress at Goulburn in recent times – for approximately four years there had been plans to open a specific work area for Aboriginal inmates where they could work with Aboriginal overseers and mentors on culturally based work programs. When we visited Goulburn on 8 December 2011 we met with an Aboriginal delegate who told us

that approximately 10 inmates were now working in the program. He also advised, however, there had been no changes to anything else in the wing, including not having an Aboriginal sweeper. We have constantly spoken with the various General Managers at Goulburn about the significance this would have with the Aboriginal inmates if this were to be allowed to happen. The consistent response has been that "union would never allow it".

Unfortunately a decade later Aboriginal inmates continue to pay for the actions of those who were in Goulburn Correctional Centre and participated in the incident in 2002. We acknowledge that many staff who work at the Centre were there on the day, had family and friends who were involved and who were seriously injured. However, we do not see this as a reason to continue to discriminate against a group of people on the basis of their race. With the matter now not proceeding before the ADT we are reviewing what action we can take.

30. You state that you "aim to be more responsive" when dealing with stakeholders who raise issues that are in the public interest. Can you give some detail about how you plan to implement this?

Engaging stakeholders regularly is critical to successfully undertaking our oversight and review responsibilities. As outlined in our answer to question 8 above, we have identified the need to continually review our internal business practices to ensure that across our organisation we are systematically identifying which stakeholders we should be proactively engaging, which staff are best placed to provide advice about, or take part in, particular consultations, and ensuring that information obtained from our consultations is used to inform our current and future investigative and review work, and our community education and training programme.

Any significant outcomes from consultations are promptly brought to the attention of the Ombudsman and/or relevant statutory/senior officers and are also discussed at weekly executive team meetings. In addition, we have established a monthly meeting between senior officers engaged in systemic project and review work, and a quarterly projects and auditing steering committee meeting to share information and ideas between project managers from each division. The overall aim is to encourage greater collaboration and strategic thinking at all levels of the organisation to ensure a greater level of responsiveness to significant public interest issues identified through stakeholder engagement.

We have also allocated portfolio responsibility to particular divisions and/or individuals for leading our work with specific agencies or target groups (for example, Aboriginal communities and people with disabilities) and in relation to particular issues (for example, the implementation of *Keep Them Safe* and the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*). Although our jurisdiction is broad, it is also necessary for us to examine discrete issues often raised by individual complaints, therefore we must be careful to approach agencies and other stakeholders as 'one organisation' rather than as separate divisions to prevent duplicated effort (on both sides) and efficiently share information obtained from our stakeholders across our organisation – in other words avoiding the 'silo' approach.

Part of this responsibility involves regular and targeted engagement with agencies and stakeholders operating across various sectors to supplement long-standing processes such as convening child and disability death advisory committee meetings, regular agency liaison meetings, and hosting roundtable forums on specific practice issues. Our extensive regional visit programme brings us into contact with frontline agency managers and their staff, non-government organisations and community members who provide us with valuable insights into the particular service delivery challenges being faced by rural and remote communities. We regularly meet with senior agency personnel to provide feedback about our consultations.

This approach allows a group of senior personnel to build up a body of knowledge about issues of significant public interest and to keep pace with changes to the operating environment of government agencies, the non-government sector and peak interest groups. The relationships we build with key stakeholders allow us to better identify systemic problems and where appropriate, provide prompt and constructive advice to agencies to assist them to develop solutions.

Our consultations with stakeholders have also allowed us to identify critical areas where staff from government agencies and the non-government sector would benefit from Ombudsman training. Over the last 18 months, we have responded to identified gaps in knowledge by developing courses in relation to handling serious child-related employment allegations, disability awareness and Aboriginal cultural appreciation, and we will shortly be rolling out a training course on implementing a quality complaints system for the disability sector. Our training courses bring us into regular contact with a broad range of practitioners – at both a senior management and frontline level – providing us with additional opportunities to hear about issues facing organisations we oversight and how these issues impact on service delivery and customer service generally.

31. Could you explain the drop in the number of community education activities in 2010-2011 compared with 2009-2010?

There has in fact been an increase in both the number of community education activities and training workshops conducted by our office during the 2010-2011 period. The perceived ‘decrease’ would appear to stem from the different way these activities were reported in our previous Annual Report.

In our 2009-2010 Annual Report we reported on the total amount of community education and training activities conducted for that year (see p.41). However, in the 2010-2011 Annual Report, we reported on our training and community education activities separately (see p.101 and p.103).

Year	# training workshops	# of community education activities	Total # of training and community education activities
2009-2010	144	127	271
2010-2011	156	140	296

Since forming our office-wide Community Education and Training (CET) Unit in late 2009, we have focussed on developing a number of new workshops and reviewing and updating existing training programs and related materials.

2011-2012 will again see a significant jump in the overall number of training workshops conducted due to our new public interest disclosures training function and the successful promotion of some of our new workshops.

NSW Child Death Review Team Annual Report 2010

1. **At the time of writing the Annual Report you stated that there were outstanding issues around the legislative amendments necessary to transfer the function of the CDRT to the Ombudsman. Have these issues been satisfactorily resolved?**

Almost all legislative issues have since been resolved.

The legislative provisions for the transfer generated a range of issues. Some administrative complexities were addressed in part through 'machinery' changes in November 2010. However, at the time of writing the CDRT Annual Report in mid to late 2011, significant problems with the legislation were still apparent.

Most problematic was that the legislation governing the Team had been retained in the *Commission for Children and Young People Act*. This effectively tied certain CDRT functions to Commission functions, and incorporated provisions relevant to the work of that agency that were unsuitable for the Office of the Ombudsman. For example, the Ombudsman, as Convenor of the CDRT, was required to provide a draft report to a Minister prior to tabling the report in Parliament. Retention of the legislation in that Act also required the Ombudsman to report to two different Joint Parliamentary Committees on overlapping work.

In April 2011, we wrote to the Premier seeking further legislative change, with a specific request for the legislation to be moved to the *Community Services (Complaints, Reviews and Monitoring) Act* (CS CRAMA).

In November 2011, Parliament passed the *Children Legislative Amendment (Child Death Review Team) Act 2011*, which provided for the majority of changes we sought.

In particular, the legislation governing the Team now sits as Part 5A within CS CRAMA; the Team is required to provide a *final* report to the Minister, with no requirement to provide a draft report. The oversighting parliamentary committee is the Joint Parliamentary Committee on the Police Integrity Commission and the Ombudsman.

There is only one provision that we sought that has not been implemented. Section 34P (1) provides that the Minister has responsibility for review of the validity of the policy objectives of Part 5A CS CRAMA. We had proposed that responsibility for such review would most appropriately sit with the Joint Parliamentary Committee.

2. **You state that it is priority to determine a valid and reliable measure of socioeconomic status as the current instrument is not satisfactory. What is the progress on developing this?**

We have engaged Professor Peter Saunders from the Social Policy Research Centre at the University of NSW to undertake a review of appropriate options for measuring and reporting socioeconomic status in relation to children who die. In addition and related to this, Professor Saunders will also advise on appropriate options for analysing and reporting child deaths in NSW on a geographic basis.

The advice will consist of a review and commentary about previous methods used by the Team; strengths and weaknesses of various methods used in social research; and in the context of the Team's purpose and access to data, methods the Team could adopt to effectively measure and report – including reporting on trends over time – socioeconomic status and child deaths by geographic location.

We anticipate the work will be completed by late June 2012.

3. You acknowledge the difficulties that may occur in making a correct determination of a person's indigenous status, particularly if one relies solely on birth and death records. Has the Team developed any internal policies or guidelines for staff in making such assessments, or is this still carried out in a relatively ad hoc manner?

We have developed internal policies and guidelines for staff in order to make assessments of Aboriginal or Torres Strait Islander status as accurately as possible.

Aboriginal or Torres Strait Islander status of children is determined following assessment of individual and family records accessed through:

- Registry of Births, Deaths and Marriages, related to the child's death
- Registry of Births, Deaths and Marriages, related to the child's birth
- NSW Perinatal Data Collection
- A range of government and non-government and private provider agencies, including police records, coronial records, health records, education records, community services records, non-government support service records, or private health provider records.

Staff record a child as Aboriginal or Torres Strait Islander if BDM data records a child as such, and/or where other information reviewed provides reasonable evidence that a child is of Aboriginal or Torres Strait Islander background. This process does require judgement on the part of a review officer, however where there is uncertainty, the decision is referred to senior and/or principal review staff.

In the 2010 report, the Team provided information about Aboriginal and Torres Strait islander status according to BDM data only, and in comparison, BDM and other sources. The comparative information will also be included in the report on deaths in 2011.

4. You note that Aboriginal children have a much higher rate of injury related death than non-Aboriginal children. Has the Team considered what type of response or research might be best in addressing this issue?

The Team has consistently identified an overall higher mortality rate for Aboriginal children, including among injury related deaths. To date, the Team has not identified any particular response that could address this issue, nor has the Team proposed specific research about injury related rates of death of Aboriginal children.

5. Seventeen of the fifty (34%) infants who died from Sudden Unexpected Death in infancy had previously been the subject of a report of risk of harm and a further six

also had siblings who were reported as being at risk. Has the Team considered what type of response or research might best address this issue?

The Team has not considered any particular specific response to SUDI in the context of child protection history. SUDI is a complex area that continues to be a significant focus for the Team (refer question 8). We will continue to examine SUDI cases with a view to identifying any feasible preventive strategies, including specific child protection interventions.

This issue was however considered in some detail in the Ombudsman's *Report of reviewable deaths in 2008 – 2009* (August 2011). Of 90 SUDI in NSW in this period, 10 were reviewable. Eight of the ten families had a child protection history. The report notes some concerns identified about the response to child protection concerns by Community Services in five of these cases. These concerns mirror broader systemic issues about cases being closed while risks were still apparent, lack of timely and/or comprehensive risk assessment, and inadequate support to young parents. The five deaths were also subject to review by the Community Services Child Death and Critical Reports Unit, which identified similar concerns. The Unit's reviews resulted in practice and case reviews to incorporate lessons into current policy and practice.

The *Report of reviewable deaths* also describes relevant child protection initiatives, including:

- Community Services' *Safer Sleep* resource pack to assist caseworkers to highlight the risks of co-sleeping with parents and carers, and to promote safe sleeping options. The agency has also developed similar resources targeted specifically to Aboriginal families;
- Certain initiatives under Keep Them Safe, including the expansion of home health visiting services to work intensively with vulnerable families in pregnancy and in the first two years of life; and
- NSW Health drugs in pregnancy services, which have subject to review and development following a previous recommendation of the Ombudsman.

These issues, and the progress of various initiatives, will inform both the work of the Ombudsman and the CDRT in consideration of any recommended responses to prevent or minimise SUDI in families with a child protection history.

6. In June 2011 the Dept of Premier and Cabinet advised the Team that the Department was reviewing recommendations made around the inspection of swimming pools by local authorities. Are you aware of any updates of this review and if the recommendations have been accepted?

In January 2012, the Division of Local Government advised us that the Government was seeking views about proposed amendments to the *Swimming Pools Act 1992* to increase the safety of very young children. We were invited to make a submission to the Division on the review discussion paper.

The main amendments to the Act proposed in the discussion paper are new requirements for private swimming pool owners to register their pool with their local council and to self-certify

the pool barrier's compliance with the *Swimming Pools Act*; and new requirements for councils to undertake private swimming pool inspections within their local government areas.

We provided a submission to the review in February 2012. The submission included an analysis of CDRT and reviewable death information relating to 40 children who drowned in private swimming pools over a five year period (2007 – 2011). The findings from this work provide support for the proposed changes to the Act.

The CDRT has prepared a public issues paper on the drowning deaths of children in swimming pools (see Attachment A).

Submissions are now closed and we are awaiting the outcomes of the review.

7. Can you provide an overview of how you are monitoring the implementation of the Keep Them Safe program?

Through our complaints, reviews, investigations and consultation work, we have been closely monitoring the implementation of Keep Them Safe since it commenced in January 2010. In the early phases of implementation, we consulted widely with key stakeholders including government agencies, non-government peak organisations, service providers and frontline human service, health and education staff to identify emerging issues relating to the capacity of the new system to meet the needs of vulnerable children and families.

After the new system had been operating for just over 12 months, we initiated an Inquiry in March 2011 to examine whether the post-reform capacity of the child protection system to respond to children at risk of significant harm had improved as a result of Keep Them Safe.

In August 2011, we tabled in Parliament our report, *Keep Them Safe?* which, amongst other things, found that despite a significant drop in demand as a result of changes to the threshold for making a child protection report to Community Services, fewer children were recorded as receiving a face-to-face- assessment under the new system.

Data we sought from Community Services showed that compared to the period before the Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry), there was a 55% drop in the number of responses to reports recorded as resulting in a comprehensive face-to-face assessment – 19,826 compared to 46,757. In addition, during the first 12 months of Keep Them Safe, one quarter of reports assessed by Community Services as requiring some form of intervention received no response at all. Given that child protection reports to local Community Service Centres have reduced under the new system by over 100,000 – or more than 50% - we were concerned by the evidence which suggests there had been a substantial decrease in face-to-face work with families.

In responding to our draft report, Community Services acknowledged that the capacity of the statutory child protection system to respond to children at risk of significant harm is inadequate. Our report stressed that in order to address capacity shortcomings, there is a need for Community Services to enhance productivity and to more effectively target existing resources.

Our report also identified a range of major system challenges that need to be addressed before the Wood Inquiry's vision for an improved child protection system can be realised. We targeted recommendations to the Departments of Family and Community Services and Premier and Cabinet aimed at achieving this outcome.

Since we released our report, we have met with senior representatives from both agencies on several occasions to discuss the actions they are taking to address the issues identified in our report. Both agencies have committed to providing us with regular progress reports.

In February 2012, we received the Department of Premier and Cabinet's formal response to our recommendations. Noting that many of the initiatives referred to are in the early stages of development, we provided detailed feedback to the department indicating the areas in which we intend to seek further advice in due course. One of the key areas we will be monitoring closely is the Department of Premier and Cabinet's interim review of Keep Them Safe, which is due to be finalised in December 2012. We have had input into the department's plan for the interim review and the development of related performance indicators.

The Department of Family and Community Services is due to provide us with their response to our recommendations by the end of April 2012.

We will continue to actively monitor the action taken by relevant agencies to deliver on the Wood Inquiry's vision and to address the specific concerns we have raised in our *Keep Them Safe?* report. In particular, we will be keen to see progress in relation to:

- the development and implementation of an 'intelligence-driven' approach to child protection work that would, among other things, enable Community Services and partner agencies to systematically identify children at most risk of experiencing significant harm;
- the implementation by Community Services' of their *Action Plan to Improve Capacity in Child Protection* and related measures to improve productivity and substantially lift responses to risk of significant harm reports*;*
- filling staff vacancies - particularly in the chronically under-resourced Western region of NSW - and employing strategies to retain experienced staff;
- the upgrade of Community Services database to provide frontline staff with the necessary tools to quickly obtain comprehensive child protection history information; and
- the work of the newly formed Keep Them Safe Senior Officer's sub-groups to improve responses to older children and adolescents with complex needs (including those who are habitually absent from school) and to consider how various agencies could potentially play a greater role in providing practical support to families in circumstances where Community Services are unable to lead a child protection response.

8. A Preliminary Investigation of Neonatal SUDI in NSW 1996-2008 made recommendations that were supported by NSW Health. NSW Health advised they

would review the relevant policy and reissue it in late 2011 or early 2012. Are you able to provide a progress update on this?

The CDRT has actively pursued the progress of NSW Health in relation to reviews of two significant policy directives.

In December 2011, in response to our request, the Director General of the Ministry of Health provided copies of the audits of the policy directives *Death – Management of Sudden Unexpected Death in Infancy* and *Babies Safe Sleeping in NSW Maternity Facilities*.

The Director-General advised us that a full review of the *Babies Safe Sleeping in NSW Maternity Facilities* policy directive was underway, and that the '*having a baby book'*, which is distributed to all women birthing in NSW public health facilities, was also being revised in relation to the safe sleeping section. We were advised that the revised publication would be released in 2012.

In relation to the management of Sudden Unexpected Death in Infancy, an audit of compliance with the Forensic Protocol (which is an appendix to the *Death – management of Sudden Unexpected Death in Infancy*) has led to an early review of this policy directive. The Director-General advised that officers are auditing the compliance of Local Health Districts with the policy directive, with findings of this process expected to be available in mid 2012.

We have reviewed the compliance audit reports with CDRT experts in paediatrics and SUDI (Professor Les White, Professor Heather Jeffery and Dr Bronwyn Gould). In April 2012, we wrote again to the Director-General providing comments on some aspects of the audits. We also sought further advice on the outcome of audit recommendations, and about specific proposals to support the release of revised directives, such as educational resources.

We have requested a meeting with the Deputy Director-General to discuss the protocols in place and how these might be improved, staff education and training strategies, and the potential for a centralised approach to SUDI investigation.

9. You mention that the formal exchange of information about child deaths between jurisdictions is currently an issue under discussion by the Australian and New Zealand Child Death Prevention Group. Are you able to elaborate on this process?

The Australian and New Zealand Child Death Review and Prevention Group brings together agencies that are responsible for review of child deaths in each state and territory, and New Zealand. The group is not a funded entity, and at present, is chaired by the Queensland Commission for Children and Young People.

At present, child death review functions across Australia and New Zealand are at varying stages of implementation and have individual legislative frameworks, jurisdiction, functions and reporting requirements.

The aim of the group is to identify and share information about trends and issues in infant, child and youth mortality, and to work collaboratively towards national and international reporting. Although capacity to exchange information varies, the group is committed to

working to achieving national consistency in reporting, particularly in relation to the risk factors associated with child deaths and injuries. This commitment led to the inclusion of the work of the group in developing more consistent data as a strategy under the *National Framework for Protecting Australia's Children 2009–2020*.

Queensland, as the chair of the group, has published a basic national data set in its Child Deaths annual report, which includes data provided by NSW, Queensland, South Australia, Victoria and Tasmania. In addition, most states now formally exchange information (generally on a de-identified basis) about the deaths of children who die in a different state to the child's home state.

In June 2011, the group submitted a funding proposal to the Families, Housing, Community Services and Indigenous Affairs (FaCHSIA) for a project on preventable infant mortality utilising mortality data available from child death review mechanisms in each jurisdiction. The aim of this research was to assist the Commonwealth to establish an evidence-based national agenda for the further prevention of infant deaths by addressing modifiable risk factors. In addition, it was seen as a first major step to a national data collaboration by members.

In September 2011, the Group was advised by FaCHSIA that this proposal was not supported. The group has expressed concern about some assumptions underpinning this decision, including that the project would duplicate existing data collections in each state and territory, which is not the case.

The group has decided to continue to prioritise preventable infant mortality, and is considering how it can progress with a national data collection and analysis.

NSW Ombudsman Annual Report 2009 – 2010

1. **Have you finalised the review of your sick leave policy?**

In our 2009-2010 Annual Report we outlined the significant changes to the public sector award conditions and workforce reforms in a number of areas – including sick leave. These changes required a significant amount of work including making changes to our electronic leave management system and reconciling the sick leave and other entitlements of all staff.

It was our intent to develop a sick leave policy to outline the Ombudsman's views on a range of matters. In this regard however, it should be noted that the award provisions do not provide a lot of flexibility to the Ombudsman as the department head. With the release of the public sector managing sick leave policy in mid 2009, we felt that there was no longer a need for the office to develop its own policy immediately. We directed our resources to implementing the award changes.

The sick leave policy is again on the agenda and our internal joint consultative committee is currently negotiating its terms.

2. **The number of people with a disability who are employed by the Ombudsman has remained unchanged, but significantly below the new target you set after the 2009-10 annual report. How did you decide on your target and do you have any plans to assist in meeting this figure?**

Targets for the representation of different EEO groups in our staffing profile are set by the Government, through EEO and Anti-Discrimination policies. Up to and including the 2009-2010 reporting year the following two targets for employing people with disabilities had been set:

- 12% of staff have a disability
- 7% of staff with disabilities require work-related adjustments.

Changes to Government policy have removed the benchmark/target for employing people with disabilities. However, there is still a benchmark/target for people with disabilities requiring work-related adjustments. This revised benchmark is 1.5% of staff. From the 2010-2011 reporting year, we are reporting against the changed benchmarks/targets.

Our 2009-2010 Annual Report indicates that we had an increase in the number of staff with disabilities – up from 7% of staff to 12% (see performance indicator on page 19). Twenty three of our staff identified as having a disability (see figure 15 page 20), an increase of 10 from the previous reporting year. The number of staff requiring work-related adjustments increased from 2.6% of all staff to 3.7%.

3. **In the 2009-10 Annual Report you mention that there were 42 Official Community Visitors working that year, although ten needed to be replaced as their terms had expired. In the 2010-11 Annual Report you state that there were 31 Official Community Visitors working. Can you explain why the numbers have not been replenished?**

At the commencement of 2009-2010 there were 42 Official Community Visitors (OCVs). That year, 15 OCVs left the scheme because their term of appointment ended or because they resigned for personal reasons.

In June 2010, the Ombudsman undertook a targeted recruitment for OCVs in the mid and far north coast of NSW. An OCV was recruited and appointed in the mid north coast area in August 2010. The Ombudsman was not able to recruit an OCV in the far north coast area but made arrangements for a Sydney-based OCV to visit key services pending recruitment of a suitable OCV.

The Ombudsman initiated a general recruitment for new OCVs in August 2010, and in November, recommended the appointment of 12 new OCVs to the Ministers for Disability Services and Community Services. The OCVs were appointed on 6 February 2011, inducted in March 2011 and began visiting in April 2011.

In 2010-2011 there were 27 OCVs at the beginning of the year. During the year 10 OCVs left because their term of appointment ended or because they resigned for personal reasons. As a result of the recruitment referred to above, 13 OCVs were appointed during the year.

We are currently recruiting for up to seven new OCVs, targeted to areas in NSW where OCV numbers are low, including the Far North Coast, the Hunter/Central Coast, the Central West and the western and northern areas of metropolitan Sydney.

OCVs have reported that a number of issues impact on their decisions to resign or not seek re-appointment, including the unique nature and conditions of the appointment, the level of remuneration, and changes in personal circumstances. The unpredictability of OCV retention affects the Ombudsman's ability to maintain a consistent number of OCVs.

When OCV numbers decrease, the Ombudsman negotiates with relevant OCVs a temporary increase in their visiting allocation pending recruitment and appointment of new OCVs. This enables a continuation of visits to as many services as possible, within budget.

4. The Official Community Visitors in 2009-10 report averaged an allocation of .95 of an hour per resident they visited. In the 2010-11 report this has decreased to an average of .79 of an hour spent with each client. Can you provide some more detail on this? (check these figures)

The number of visitable services and residents of visitable services has increased throughout the life of the OCV scheme. In recent years there has been significant growth in the disability services sector under *Stronger Together 1 and* 2 and a parallel growth in the number of residents in visitable services.

The decrease in the average number of hours per resident in visitable services relates to the increase in the number of residents within services without a concomitant increase in the budget allocated to the OCV scheme.

The Ombudsman allocates funds for the OCV scheme from within the overall Ombudsman budget and allocates visits to services within the OCV scheme budget allocation.

Between 2000 and 2011 there has been an overall increase of 43% in the number of visitable services, (from 1,014 in 2000-2001 to 1,452 at 1 July 2011). During this period, there was a one-off funding increase of $100,000 in 2010-2011 to cover a 14% increase in OCV remuneration. The funding did not increase the capacity of the scheme.

In November 2011 the Ombudsman submitted a budget maintenance proposal to Treasury to address both the past increase, and the additional projected 20% increase in the number of visitable services by 2015-2016. This proposal was not successful.

5. You noted that you intended to review the independent education sector over the next year. Did you conduct this review and what were the findings?

Following the publication of our 2009 – 2010 annual report, we conducted extensive work with the Association of Independent Schools NSW (AISNSW) in relation to their child protection responsibilities.

In early 2011 the Association of Independent Schools NSW (AISNSW) informed us that they wished to limit the application of their class or kind determination to member schools of AIS, which meant that Christian Schools Australia (CSA) and Christian Education National (CEN) member schools no longer had access to the employment-related child protection training and advice provided by the AIS, or to exemptions provided by the Ombudsman under the class or kind determination.

In response, we entered into extensive negotiations with AISNSW, CSA and CEN in relation to strengthening child protection knowledge and practice amongst their respective member schools, supported by class or kind determinations. CSA and CEN subsequently developed proposals to provide comprehensive systems for outsourced child protection advice, training and support to their members. As a result, we finalised class or kind determinations with CSA and CEN in late 2011.

We proposed to review child protection practice in AISNSW member schools once the new class or kind determination with AISNSW was implemented. Following extensive negotiations, the revised class or kind determination with AISNSW was finalised in March 2012.

6. The Department of Aging, Disability and Homecare received a report into an assault that occurred in respite care. The report made over 180 recommendations which you resolved to monitor. Can you provide an update on this?

We have continued to monitor ADHC's actions to implement the recommendations from the independent review that was conducted following the assault of a 15-year-old girl in an ADHC respite service. The recommendations were extensive, and related to practice in the ADHC Region in which the service was located, and more broadly across the organisation.

ADHC developed detailed action plans to implement the recommendations, and provided progress reports to us in May and October 2011 that included detailed reporting against those plans. The progress reports indicated that considerable work had been undertaken by ADHC staff to implement its Safety and Quality Improvement Plan, including actions to facilitate

necessary cultural change in the Region, and to ensure staff compliance with ADHC policy and practice requirements.

ADHC has appointed an independent consultant to undertake another external review, to review progress and the delivery of real change for clients and families in the Region. We will continue to monitor ADHC's actions in relation to this matter, and will obtain a briefing from ADHC on the external review in the near future.

More broadly, this case reinforces the need for more rigorous systems for reporting serious matters across the disability sector. We consider that there would be considerable benefit in establishing systems for reporting serious complaints and incidents in disability services and licensed boarding houses; including allegations of serious abuse, assaults and neglect, and other critical incidents.

In relation to serious incidents, we note that there are robust systems in place for reporting and oversighting the handling of serious incidents in the employment-related child protection area, as outlined in Part 3A of the *Ombudsman Act 1974*. However, no comparable system currently exists in relation to particularly vulnerable individuals with disabilities who receive disability support. We have written to the Chief Executive of ADHC in this regard, and have attached a copy of our correspondence for your information (see Attachment B).

7. Have you observed any improvements in the way young people with disabilities are being placed in nursing homes?

Our 2011 report on the deaths of people with disabilities in care includes recommendations aimed at improving the policy guidance for disability services on supporting people with disabilities as they age. In particular, our work indicates a strong need for clarity regarding ADHC's position on 'ageing in place', as we have found that the lack of clear guidance tends to result in inconsistent practice across disability services.

Through our reviewable deaths work, we continue to identify individuals under the age of 65 years who are referred by staff of disability services and/or hospitals for aged care assessments and placement in residential aged care. Typically, this is linked to an increase in the person's support needs due to ageing or other decline in their health, and has been noted with both ADHC and funded services. The practice continues to be inconsistent – some services go to considerable lengths to enable people with disabilities in care to 'age in place'; while others tend to seek aged care placement at an early point, and before they have adequately explored options for continuing to support the person at home.

We will continue to monitor ADHC's work in this area, and will be keen to see significant progress against this recommendation when the agency reports to us in July.

8. You mention that you established an internal working party to develop a stakeholder engagement strategy. Can you advise on the progress of this?

As part of implementing a new organisational structure in the 2009-2010 year we established a number of internal committees including a working party to examine how we could improve our engagement of our stakeholders. The stakeholder engagement working party's initial

focus was to reach a common understanding about who our key stakeholders are and how best to engage with them across the organisation. Feedback from our consultations informs our strategic planning and ongoing decision-making about those issues most worthy of examination given our finite resources.

As a first step in developing a comprehensive engagement strategy the working party surveyed each division of the office to identify current engagement activities and document good practice in this area for broader promotion across the organisation. Internal consultations were held with project managers from across the organisation to gain a better understanding of successful engagement methods employed principally through our systemic review work, to ensure project managers are considering a broad suite of engagement 'tools' when planning their investigations/reviews.

A literature review was also conducted to identify successful techniques used by other similar organisations, and consultations were held with stakeholders who had recently been engaged by our office via formal investigations/reviews, to hear from them about how our interactions with them throughout the process either added value to their work, and where we could improve our engagement.

An implementation plan was developed as a result of the working group's findings.

Implementation included the stakeholder engagement strategy being reflected in our office wide strategic plan 2010-2012. The strategic plan includes a number of 'critical success factors' and one of these is 'engaging effectively with partners and stakeholders'. These critical success factors inform our business planning and are built into each branch/division's annual business plan as well as organisational policies and plans which outline our commitment to improving access to our services by key groups including young people, Aboriginal communities and people with a disability. Project plans for major systemic and investigation work must also outline how affected stakeholders will be engaged throughout the process. Finally, staff performance agreements articulate individual responsibilities in relation to effectively engaging stakeholders.

In the past year we have focussed on streamlining the way we capture information about our stakeholder engagement through the development and implementation of an office-wide register for recording stakeholder engagement activities. Our new processes are designed to:

- Improve information sharing and consistency of recording about our engagement activities across our organisation.
- More readily identify opportunities for joint work with other agencies and oversight bodies
- Record the feedback from our stakeholders about how our work adds value.

The register includes guidance on the types of groups/entities that should regularly be engaged and provides a variety of methods for doing so. The fields are designed to capture information relating to the objective of the engagement activity, key outcomes and geographic and demographic data. Divisions record their activities throughout the year and report on

them through their business plans and our annual report. Periodic review of the register is useful for creating future benchmarks, identifying gaps in our engagement and looking for ways to improve our practices in this area.

This enhanced stakeholder focus has improved our professional and cooperative relationships with a diverse group of stakeholders which is reflected in the number and variety of stakeholder engagement activities carried out across our organisation since the strategy was developed (for further details see the stakeholder engagement chapters contained in our 2009-2010, 2010-2011 Annual Reports).

Additionally, a number of the objectives of the working group were addressed through the establishment of a centralised Community Education and Training Unit (CET) located within our Strategic Projects Division – also a key outcome of our organisational restructure in late 2009.

The CET Unit plays a key role in promoting who we are and what we do through its broad training and education program. Through the CET Unit we have established improved systems for coordinating the various training, education and outreach activities carried out by each division leading to a more consistent and wider message being delivered about our various functions and how we can assist members of the public and peak interest groups.

The CET Unit has worked with various divisions to review and update existing training materials and develop new products. A project officer position was created to coordinate training and education activities across the office, and identify new ways to promote the Ombudsman's role to a wider range of stakeholders.

Other key activities undertaken to implement the stakeholder engagement strategy include the following:

- Broadening the focus of *Ombo Info*, our e-newsletter, previously targeted to the community services sector –as a result, *Ombo Info* now has a wider audience and circulation.
- Consolidating and expanding our contacts database.
- Developing a communications plan for marketing our training activities.
- Extending our Ombudsman outreach forums, Right Stuff workshops for consumers of disability services and our training programme.
- Ensuring that our Youth Liaison Officer and Aboriginal Unit regularly consult with key interest groups across the state.
- Dedicating a chapter in our Annual Report (since 2009-2010) to significant outcomes from our stakeholder engagement.
- Rebuilding our office website.

For further information about our stakeholder engagement see answer to question 30.

9. You planned a review of police processes on complaint resolution and complainant satisfaction. What is the progress with this? (note: this was mentioned in the 2009

AR and again in the 2010 report as not having been done, but on the agenda for 2011-12)

In our annual report 2009/2010 under the heading of 'Future Directions' we expressed our commitment to working with police to develop an effective and good complaints systems. We believed the current system is able to achieve this goal.

At the moment, the system achieves two important complaint handling functions. It provides a mechanism for the public to complain about the alleged wrong or unreasonable conduct of a police officer. The system also has adequate internal mechanisms to check that the conduct of its officers is proper, fair and lawful.

Our work in the coming years will be to focus on improving how the police respond to the less serious matters and developing a mechanism for redress and remedial action when it has been agreed that things have gone wrong (or could have been done better). An important part of improving the responsiveness of the complaints system also includes being able to collect data that can highlight the effectiveness of certain policies and potentially lead to systems and organisational improvement.

As it stands, police continue to spend time and resources on investigating the more serious matters with inadequate attention given to providing feedback or apologies to complainants (where it is legitimately warranted). There is also systemic failure to look for possible underlying causes of misconduct, or to patterns and trends which may lead to service and process improvements. Instead, the focus is to find fault or blame with the individual officers or complainants.

Since 2010 we have commenced work towards developing methodology and planning for a comprehensive review of how police survey and measure complainant satisfaction for both the less serious informal resolutions and the evidence based investigations. The responsibility for this task currently sits with the grade 9/10 investigation officer (audit) position. This position is also responsible for conducting all our internal and external audits. As such the progress of this work is affected by existing resource limitations. The task of conducting such a review remains a priority.

The work we have undertaken so far includes closely monitoring an alternative dispute resolution pilot program (as an alternative to any form of investigation) being rolled out by police after a review of the complaints handling guidelines.

We also require police to comply with Condition 4 of the class and kind agreement and conduct a survey to measure the satisfaction of complainants in the handling of less serious resolution matters. The survey is conducted annually and (at a minimum) needs to include a random sample of contactable external complainants selected from the pool of complaints finalised in the preceding 6 month period. Survey results are reported to this office and we will be consulted on the survey instrument and methodology.

We have requested NSWPF provide a report for 2011 (as required under condition 4) with the relevant methodology details. It is timely to review this process now since police have piloted two surveys in 2009 and 2010.

10. You note that you have no general statutory power to require information about action taken by agencies in response to legislative review reports. Is this still the case?

Yes.

11. Can you provide an update on the Department of Education and Training's response to the issue of nitrogen dioxide and heating in schools?

Following the Woolcock Institute's study of unflued gas heaters in schools conducted in 2010, the Department of Education and Communities arranged for an Environmental Health Risk Assessment to be conducted of school heating options. The Assessment reviewed the research, recommended a replacement program and conducted a health cost analysis. It was completed in October 2011 and made public on the department's website in November 2011.

Unflued gas heaters have already been replaced in around 100 schools in the coldest areas of the state in response to the Woolcock report. In addition, based on the advice in the ERM assessment, the government announced in February 2012 that unflued gas heaters would be replaced with flued gas heaters when the majority of unflued gas heaters in a school reached the end of their serviceable life. Flued gas heaters will be installed in new school buildings. During one off maintenance, unflued gas heaters will continue to be replaced with unflued gas heaters.

Attachment 'A'

nsw cdrt child death review team

Child deaths: drowning deaths in private swimming pools in NSW

An occasional series to highlight issues and prevention strategies arising from reviews of the deaths of children in NSW

The NSW Child Death Review Team

The purpose of the NSW Child Death Review Team is to prevent and reduce the deaths of children in NSW. The work of the Team includes identifying trends and undertaking research in relation to child deaths, and making recommendations to prevent or reduce the likelihood of child deaths. The NSW Ombudsman is the Team's Convenor.

Drowning deaths of children in private swimming pools - NSW

On average, six children drown in private swimming pools in NSW each year. This figure has remained constant over the 15 years the Team has collected this information.

In 2012, the NSW government announced a review of the *Swimming Pools Act*. The Act, among other things, deals with requirements for child resistant safety barriers around private swimming pools.

This paper describes the findings of our review of the drowning deaths of children in private pools in NSW for the five years between 2007 and 2011. Over this five year period, the Team registered the deaths of 40 children.

The children

Most of the 40 children who drowned (24) were male; 16 were female.

The majority of the children (34 of 40) were under five years of age: Most of the under-fives (30) were aged three years or less, and more than half of the under-fives (18) were aged two years or less.

Six children were aged between five and nine years. Three of the six older children had a disability, injury or impediment that was a contributing factor in their drowning.

Where the children drowned

Most of the children (27) drowned in a swimming pool at their own home. At least four other children drowned in pools at properties where small children lived. In addition, a number of other children drowned at the homes of relatives, where they were regular visitors.

For the 38 pools where the information was known, most (28) were in-ground or semi-in-ground, and 11 were above ground portable or large inflatable pools.

In most cases, the properties were owned by the child's family. Six properties were rented; four from social housing providers and two from private rental agencies. The pools at four of the rented properties were above ground, portable pools.

The swimming pools: child safety barriers

Information about the standard of pool fences or safety barriers was available for 37 of the pools, and almost all of these (33) did not have a functioning safety barrier.

Unfenced pools

Nine pools were unfenced. Eight of these were above ground pools, all of which were required to have a barrier fence under the *Swimming Pools Act*. One in-ground pool met the criteria for exemption from fencing that the Act provides.

Seven of the nine children who drowned in unfenced pools accessed the pool from the house without the knowledge of supervising adults. Six of these children were under three years of age.

Defective child safety barriers

Twenty eight of the pools were fenced. The safety barriers for 24 of these pools had one or more defects that potentially enabled a child to gain access to the pool area.

- All 24 had reported issues with the gate or latch mechanism. In most cases, this meant that the pool gate did not self-close because it either had no latch mechanism, or the mechanism was damaged, or problems with the gate or fence resulted in the gate jamming open.
- In addition, 15 of the 24 barriers had additional defect(s), mostly related to the fencing. Fourteen fences were defective either due to broken palings or damage, or the fences did not meet the minimum height requirements under the Act. Another five had permanent structures built close to the pool that provided children with a potential climbing frame into the pool area.

For 20 of the children who drowned, investigations following the incident found that the defect was the most likely point at which the child entered the pool area.

Four pools had compliant child safety barriers. The children were either let into the pool area by an adult, or accessed the pool through gates that had been propped open.

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Adult supervision

All children who drowned did so in the absence of adult supervision.

Royal Life Saving Australia promotes 'active supervision' of children around water. Active supervision means *'focusing all of your attention on your children all of the time, when they are in, on, or around the water. You must be within arms reach of your child and be ready to enter the water in case of emergency.'*[1]

While the level of supervision for some of the children who drowned was significantly inadequate, many of the children were unsupervised for relatively short periods of time, often as a result of a momentary lapse in direct supervision by parent(s) or carers.

For 26 children under five years of age who drowned, details were available about the length of time they were reportedly left unsupervised:

- The majority (15) were reportedly unsupervised for 10 minutes or less, with some children reportedly being out of sight for five minutes or less. Scenarios included parents changing another child's nappy, going to the toilet, cleaning or cooking. Where the child was in or around the pool area, the issue was lack of active arms-length supervision, with the child entering the water unseen.
- Eleven children had been unsupervised for longer than 15 minutes. This included children who had been placed for sleep, but awoke earlier than expected and left the house unseen. Other circumstances including the responsible carer attending to other children, or the child leaving the house at a time when families were involved in a number of activities. Unclear responsibility for supervision was also an issue. This was particularly at gatherings of family or friends, and resulted in a situation where the child was assumed to be with another, but was in fact unsupervised.

Preventing drowning deaths in private swimming pools

For parents and carers

Our review of 40 drowning deaths of children in NSW confirms there are two critical factors to keeping children safe around swimming pools:

- Supervise: Adults must actively supervise young children in or around water; and
- Restrict Access: Pool fences must be regularly inspected and maintained to ensure they are - and remain - child resistant. Where a pool is not fenced, it is essential that doors and windows are secured and locks are child resistant.

Pool fences can never take the place of active supervision of children around pools, but where there is a lapse in supervision, a child resistant safety barrier will save lives.

Supervise and *restrict* access are major component of Royal Lifesaving Australia's Keep Watch program, which also promotes *water aware* and *resuscitate*.

See Royal Lifesaving http://www.royallifesaving.com.au/www/html/156-fact-sheets.asp

For government and policy makers

Relevant government and non-government agencies with a role in regulation of private swimming pools and drowning prevention initiatives should give careful consideration to the findings of our review. In particular:

- Most children drowned in pools at their own home, and in some other cases, in pools at homes where children resided.
- Almost a quarter of the pools in which children drowned were above ground portable pools.
- In all cases where the pool safety barrier was defective, the defects included issues with a gate and/or latch mechanism.
- In many cases, children were unsupervised for a relatively short period of time, during busy or distracting periods for parents or carers.

Six children, on average, die each year in NSW swimming pools. It is difficult to determine the number of near-drowning incidents as there is no centralised data collection that records this information in NSW. Such information is critical to understanding the impact of injury and death, and developing effective prevention strategies.

1 Royal Life Saving Fact Sheet 1 Supervise, accessed http://www.royallifesaving.com.au//resources/documents/Fact_Sheet_No._1_Supervise.pdf

For more detailed information, see the Ombudsman/Child Death Review Team submission to the Swimming Pools Act review, at http://www.ombo.nsw.gov.au/publication/PDF/other reports/Submission to the Swimming Pools Act Review 2012.pdf.

Attachment 'B'

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Mr Jim Moore
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Attention: Coordinator, Client Relations
Public Accountability Branch
Office of the Chief Executive

Dear Mr Moore

Development of systems for reporting complaints and serious incidents in disability services

In response to my previous correspondence in relation to this matter, on 23 February I met with Samantha Taylor, Helene Orr, and Robert Wright to discuss options for strengthening the management and oversight of complaints and serious incidents. I appreciate the advice that they provided.

As discussed at the meeting, we consider that one of the goals in the current disability sector reforms should be to establish a complaints reporting system for ADHC provided and funded services that is compliant with Australian complaint handling standards and NSW disability services standards. In this regard, we expect that the work we are undertaking to develop a disability complaints training package for the sector will provide a useful framework for the development of a core industry complaints model.

As indicated in our previous correspondence, the Victorian complaints reporting system for disability services provides a useful starting point for consideration of a potential framework for NSW. As agreed at the meeting, we will liaise with the Victorian Disability Services Commissioner to facilitate a meeting with your staff to examine the scope and operation of the reporting system established by his office.

On a related note, there would also be considerable benefit in establishing a system for reporting serious incidents in disability services – this system would need to be integrated with any broader complaints system. Such incidents would need to include allegations of serious abuse, assaults and neglect, and other critical incidents.

We are of the view that, in developing systems for reporting complaints and serious incidents, there will also be a corresponding need to ensure that, at least, the handling of serious incidents is actively oversighted. In this regard, we believe that consideration needs to be given to the oversight arrangements in place under Part 3A of the *Ombudsman Act 1974*.

Related to the need to look at systems that could drive service improvement insofar as complaints and serious incidents are concerned, the meeting was also productive in enabling us to discuss the work we are currently undertaking to produce a number of factsheets on basic requirements relating to the management of, and effective response to, critical health and safety risks. This is an area that we have consistently raised in our reviewable disability deaths reports; particularly in relation to swallowing, falls, medication, and respiratory risks.

At this stage, it is our intention that the factsheets will be targeted to residential support staff in ADHC-operated and funded disability accommodation services; staff working with residents in licensed boarding houses; and health professionals.

After development of the factsheets, two further steps will need to be taken: development of a strategy for ensuring sector-wide education in relation to this material; and assessment of the level of 'coal-face' take-up of the key messages.

I am keen to get your views on the specific issues and proposals discussed in this letter. Given the significance of these issues, I believe that it is absolutely essential that there be a strong partnership between ADHC, the sector and this office around ensuring that we achieve significant improvements in these areas, consistent with person-centred support.

I would appreciate your early advice on these issues, either via a further meeting or through correspondence.

Please contact Kathryn McKenzie, Principal Project Officer, Disability, on 9286 0984 or email kmckenzie@ombo.nsw.gov.au if you have any queries or concerns.

Yours sincerely

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner
5 April 2012

cc: Minister for Disability Services