S42

Community Services (Complaints, Reviews and Monitoring) Act 1993 – review of the Act.

Submission to the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission

February 2008

Contents

1. Introduction 2

2. Background 4

3. Issues identified by the Committee for consideration in the review **7**

3.1. The extent of implementation and impact of Ombudsman recommendations made in reports to Parliament and arising from investigations 7

3.2 The percentage of complaints which are resolved 14

3.3 Complainant satisfaction with our handling of complaints 15

3.4 Public recognition of our role in relation to community services 18

3.5 Audit initiatives concerning Indigenous issues 24

3.6 Promoting access to advocacy support 28

3.7 Facilitating immediate responses to emergency situations 29

4. Issues arising from submissions to the Committee **32**

4.1 Summary of issues raised in the submissions 32

4.2 Ombudsman comments 38

5. The terms of the legislation **44**

5.1 Part 2: Official Community Visitors 44

5.2 Our reporting powers 49

5.3 Part 6: Reviews of Deaths 50

5.4 Issues raised in the submission of the Children's Guardian 53

1. Introduction

The *Community Services (Complaints, Reviews and Monitoring) Act* (the Act) 1993 provides for the Committee on the Office of the Ombudsman and the Police Integrity Commission (the Committee) to undertake a review of the Act. Section 53 (1) of the Act states that the purpose of the Committee's review is to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

The review is to be undertaken as soon as possible after the period of five years from the date of assent to the *Community Services Legislation Amendment Act* 2002 (Section 52 (2)), on 3 July 2002.

In July 2007, the Committee wrote to all funded services inviting them to make submissions to the review, and also advertised for submissions. The Committee advised this office that 40 submissions were received and copies of each of these submissions - with the exception of two confidential submissions - were provided to us in October 2007.

We received copies of the submissions made by the following organisations:

1. Inner West Neighbour Aid Inc
2. New Haven Farm Home Ltd
3. Coalition of Appropriate Supported Accommodation
4. Carers NSW
5. Dubbo Neighbourhood Centre Inc
6. Bellingen Shire Meals on Wheels
7. Nardy House Inc
8. Gosford City Council
9. Central West Community Care Forum Inc
10. Jobsupport
11. Care Connect Ltd
12. NSW Commission for Children and Young People
13. Jennings Lodge
14. New Era Independent Living Centre Inc
15. Confidential
16. Parkes Aged and Disabled Support Scheme
17. Sydney South West Area Health Service
18. Multicultural Disability Advocacy Association of NSW
19. Aunties and Uncles Co-operative Family Project Ltd
20. ACWA
21. Richmond Community Services Inc
22. Narrabri Home and Community Care Inc
23. Ability Incorporated Advocacy Service
24. People with Disability Australia Incorporated
25. COTA (NSW)
26. Confidential
27. NSW Women's Refuge Movement Resource Centre
28. Goulburn Family Support Service Inc

29. NSW Office for Children
30. Bathurst Emergency Accommodation Place Inc
31. Intellectual Disability Rights Service
32. Council of Social Service of New South Wales
33. Department of Ageing, Disability and Home Care
34. Hunter New England Area Health Service
35. Greater Southern Area Health Service
36. Maari Ma Health Aboriginal Corporation
37. Woolgoolga Neighbourhood Centre Inc
38. Aboriginal Child, Family and Community Care State Secretariat
39. Goori Home Modifications
40. Disability Council of New South Wales

On 30 November 2007, we received a letter from the Committee, requesting that we provide a response to those submissions, as well as any other matters we wished to raise in relation to the review.

2. Background

The *Community Services Legislation Amendment Act* 2002 abolished the Community Services Commission (CSC) and conferred its functions on the NSW Ombudsman. In July 2005, the Committee decided to conduct a stakeholder review of the merger of the CSC into the Office of the Ombudsman. Report No. 14/53 - October 2006, reports on the stakeholder review.

With regard to the stakeholder review of the merger, Mr Paul Lynch MP, Committee Chairman, said:

> ... [the stakeholder review] *is a precursor to the Committee's review of the Community Services (Complaints, Reviews and Monitoring) Act to be undertaken in 2007. The Committee considered that it would be informative to get a sense of how major interest groups in the community services sector deemed the Community Services Division of the Ombudsman's office was working for them.*
>
> *It is apparent from the responses received by the Committee that initially some stakeholders had reservations about the merger of the Commission into a large organisation. These misgivings appear to have been assuaged in part by the strength of the legislative powers available to the Ombudsman.*
>
> *However some concerns remain. It is hoped that the issues which have emerged from this review will be examined in greater detail and form part of the deliberations of the Committee of the 54th Parliament when it conducts the statutory review in 2007.* [1]

The Committee identified the following matters for greater consideration in the current statutory review:

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

> *In relation to access, the Committee is also of the view that, if the Deputy Ombudsman's audit initiative in relation to indigenous issues is extended across the Ombudsman's jurisdiction, any results relevant to the community services area should be considered in the statutory review or, if the auditing has not commenced, that the feasibility of extending the reach of this initiative be considered.*

---

[1] Chairman's Foreword, Committee on the Ombudsman and the Police Integrity Commission 'Stakeholder review of the merger of the Community Services Commission into the Office of the Ombudsman', page vii.

> *Of particular concern to the Committee is the extent to which, under the new legislative scheme, the Ombudsman is able to:*
>
> - *promote access to advocacy support for people receiving, or eligible to receive, community services to ensure adequate participation in decision making about services they receive; and*
> - *facilitate immediate responses to emergency situations not adequately dealt with by DoCS or other service providers.* [2]

We have addressed each of these matters in detail below, provided a response to certain issues arising from submissions to the Committee, and provided comments about the terms of the legislation.

[2] pp 21 – 22.

3. Issues identified by the Committee for consideration in the statutory review

3.1 The extent of implementation and impact of Ombudsman recommendations made in reports to Parliament and arising from investigations

Much of our work results in us making recommendations about systemic improvements. As we emphasised in our submission to the Committee for the stakeholder review, we do not have determinative power to enforce the recommendations that we make, and therefore a very important part of our work is to convince agencies of the benefits of, and need for, change.

In the vast majority of cases, agencies accept the findings of our reviews, inquiries and investigations and our subsequent recommendations. We closely monitor agency progress in implementing the recommendations, until we are satisfied that the issue that we identified has been resolved or there is a clear commitment by the agency to do so.

We regularly report on the progress made by agencies in implementing our recommendations - in our annual report, in our reviewable deaths annual reports and in special reports to Parliament.

The following examples provide some illustration of how our work and recommendations have led to positive change within agencies:

Reviewable deaths

Reviewable disability deaths

In preparing our *Report of Reviewable Deaths in 2006*, tabled in Parliament in December 2007, we sought the views of DADHC and NSW Health about our work in reviewing the deaths of people with disabilities. In particular, we sought their views about how our recommendations have contributed to improvements in the agencies' capacity to respond effectively to the needs of people with disabilities living in care. As noted in the report:

> *NSW Health told us that our work has had a positive impact on the provision of quality care and support to people with disabilities, and pointed to three key initiatives that had indirectly or directly resulted from our recommendations:*
>
> - *An independent evaluation on the implementation of the 'People with Disabilities: Responding to their needs during hospitalisation' policy directive across Area Health Services.*
> - *The development of the NSW Health and DADHC discussion paper on the development of a service framework to improve health care for people with intellectual disabilities, including a strong focus on developing training of health care workers on the health care of people with disabilities.*
> - *Progress in relation to the Interagency Standing Committee on Disability's work on access to health services for people with disabilities. This includes*

> *the development of the whole-of-government strategy 'Better Together' – involving improved coordination, planning and delivery of services for people with disabilities and their families, and improvements to the whole service system.*

DADHC indicated that it had implemented a range of initiatives in response to our recommendations, including first aid training and a standardised record keeping system for client information in DADHC services, and noted that the reviewable disability death function has provided a useful function in its oversight of licensed boarding houses.

DADHC also highlighted examples of where our reviewable disability death function has had a positive impact on its practice and policy, including:

- *reviews of the 'Epilepsy', 'Health Care', 'Abuse and Neglect', 'Client Risks', 'Medication', and 'Decision Making and Consent' policies,*
- *external evaluation of the 'Ensuring Good Nutrition' and 'Palliative Care' policies, and*
- *implementation of the Inclusive Communication and Behaviour Support (ICABS) project.* [3]

Reviewable child deaths

In preparing our *Report of Reviewable Deaths in 2006*, we also sought the views of DoCS, NSW Health and the NSW Police Force about our work since 2002. In particular, we asked whether our work had contributed to improvements in the agencies' capacity to respond effectively to children at risk of harm. As the report states:

> *"DoCS considered the recommendations arising from our work, and noted that the department had accepted the vast majority of provisional recommendations made through investigations of individual deaths. DoCS said that these recommendations can serve to reinforce the need for improved performance by individual CSCs in particular areas of work, and can be a useful management resource.*
>
> *In regard to recommendations contained in the reviewable deaths annual reports, DoCS considered that many of the recommendations made related to action already contemplated, or underway, by the department, indicating that our work at times serves to confirm what DoCS already knows. DoCS however acknowledged that this outcome is inevitable in the context of a $1.2 billion reform program.*
>
> *The NSWPF said they had responded to our findings by issuing guidance to police regarding identifying and reporting risk of harm, including risk associated with parental substance abuse. They said their reviews of standard*

---

[3] NSW Ombudsman, *Report of Reviewable Deaths in 2006: Volume 1: Deaths of people with disabilities in care*, November 2007, pp 6 – 7.

> *operating procedures relating to domestic violence and child protection would take account of our recommendations.*
>
> *NSW Health told us that it strongly endorsed the work of this office, and noted the 'improvement in both internal collaboration within NSW Health and interagency collaboration in child protection responses'. NSW Health noted our work had been effective as a catalyst, in areas such as examining the intersection between child protection and other areas, such as drug and alcohol abuse. It had also contributed to initiating reviews into important issues, such as methadone-related child deaths. NSW Health also noted policy change to help ensure child safety when working with victims of domestic violence, and legislative change, particularly relating to pre-natal reports.*[4]

A table on pages 11 and 12 of our child deaths report summarises the main recommendations we have made in the five years of reviewing child deaths in NSW, and relevant agency developments and achievements to progress our recommendations. This table is also contained in this submission at Attachment 1.

Complaints and Investigations relating to individuals

Since amalgamation, the Division has initiated 90 investigations into 59 matters. The majority have concerned child protection issues. In 2006 – 2007, we finalised 22 investigations and commenced a number of new investigations. Investigations arising from our complaints and review work predominantly focus on individual cases, but often have a much broader impact on agency operations.

We monitor completed investigations to ensure agency compliance with our recommendations and we have internal benchmarks to measure our performance.[5] Section 3.2 below details our achievements in complaint resolution.

The following examples are provided to give some illustration of the impact of our work and recommendations. We have only provided a couple of examples. Should the Committee require more detailed evidence of the many outcomes from our large number of investigations we will be happy to provide further examples.

Child protection

- In 2007 we issued a final report into an investigation into matters arising from our review of the death of a child as a consequence of non accidental injuries. Our investigation considered the conduct of DoCS and two Area Health Services. We made adverse findings in relation to all three agencies. As a consequence of the investigation:
- One of the Area Health Services reviewed and amended its procedures in relation to discharge follow-up in cases where child protection concerns have been raised. The service has also reviewed and amended its procedures

[4] NSW Ombudsman, *Report of Reviewable Deaths in 2006 – Volume 2: Child Deaths*, December 2007, pp 10 – 11.

[5] 20 completed investigation each year resulting in recommendations for service improvements, with a benchmark of 80% agency compliance with our recommendations.

concerning follow-up of children referred by other agencies with medical and or surgical problems and with child protection concerns.
- The second Area Health Service put in place procedures to ensure that when a child presents to the Emergency department. the hospital's medical records for the child, including any previous reports to DoCS, can be accessed from the Clinical Department for review.
- DoCS established an intake team at the Community Service Centre (CSC) in question to allow for improved intake procedures, and agreed to facilitate a meeting at a senior level between the three agencies to discuss how interagency child protection responses can be improved.

Disability Services

- In 2007 we finalised our investigation into DADHC's assessment and approval of a non-government service as an 'approved provider' of disability services. We found that DADHC's assessment was inadequate. As a result of the investigation, DADHC reviewed its pre-qualification process, and commenced monitoring action against services identified as approved providers.

In care reviews

Since amalgamation, the Division has conducted four group reviews of individuals in care:

- Children under five years of age (two reviews)
- Young people with disabilities leaving care
- Children under the parental responsibility of the Minister placed in Supported Accommodation Assistance Program services.

In addition, we have undertaken seven in-care reviews focused on particular services.

In total, the circumstances of over 150 individuals have been reviewed. Reviews have resulted in recommendations directed to improving the circumstances of individuals; addressing service-wide issues impacting on the safety or wellbeing of service consumers, and systems improvement in cases where identified issues had implications for the wider service system.

As a result of our review of children with disabilities leaving care, for example:
- Individual outcomes included care plans being finalised for a number of the young people subject to review, and young people being provided with services they were eligible for but had not been receiving prior to the review.
- On a systems level, we recommended that DoCS formalise a leaving care policy. To date this has not been finalised and we are continuing to monitor progress. However, in the context of our report's observation that eligibility for DADHC services was no guarantee of a seamless transfer from statutory care to supported disability accommodation, we were pleased to see DADHC's budget for the following year provided funding enhancements for young people with a disability leaving DoCS' care and requiring ongoing supported accommodation.

Inquiries and systemic investigations

Police reporting: Child protection

In 2007, and in relation to our reviewable child death work, we conducted a targeted review of NSW Police Force (NSWPF) and DoCS records for a sample of children who died and their families. The review identified 29 events involving 18 families where police reporting of risk of harm to DoCS did not appear to meet mandatory reporting requirements, and / or internal police procedure.

Our findings raised concerns about:

- The reasons why police officers may not be consistently meeting their reporting obligations for children at risk of harm.
- Whether police are adequately recording verifying information about reports to DoCS, and how supervisors are monitoring reporting.
- Why, in some cases, reports are recorded as being made, but there is no record of this on the DoCS' computer system.

We reported our concerns to the NSWPF, who advised us that they had established a working party to consider the issues we raised. Tthe working party would be discussing strategies to:

- Improve compliance with risk of harm reporting requirements
- Improve the quality of the police response to children at risk of harm
- Provide police with better information and support in relation to managing children and young people at risk of harm and working with other agencies
- Implement a more systematic, focused approach in Local Area Commands relating to children at risk of harm.

We are continuing to monitor outcomes in this area.

Inquiry into monitoring of licensed boarding houses

In June 2006, following an Inquiry, we tabled a special report to Parliament: *DADHC: Monitoring standards in boarding houses*. Our work identified serious problems with the way boarding houses in NSW were licensed and monitored by DADHC. In summary, we found that regional compliance with the department's policy had been variable, with implications for resident health, safety, and welfare. We also found that uncertainty over the enforceability of certain licensing conditions was adversely affecting DADHC's capacity to effectively monitor and enforce licence conditions.

Since the tabling of our report, a number of steps have been taken to address many of the issues identified, including a review of record-keeping in licensed boarding houses, revision of a policy manual and establishment of regional workplans for monitoring licensed boarding houses, and recruitment and training of additional DADHC monitoring and casework staff.

Concerns relating to practice in licensed boarding houses, and monitoring of these facilities by DADHC have also been raised in our reports on reviewable deaths from 2005 to 2007). Through monitoring our recommendations, we have noted key developments such as the reauspice of primary and secondary health services, clinical review of the health needs of licensed boarding house residents in Sydney's inner-

west, and planning for a review of the screening tool for entry to licensed boarding houses.

Aids and appliances for people with disabilities

In 2005 we investigated DADHC's arrangements for the provision of, and payment for, aids and appliances to residents of DADHC group homes and residential centres. We found that DADHC had failed to take adequate steps to resolve problems and inconsistencies with its aids and appliances program. As a result of the investigation and recommendations, DADHC revised the program, issued clear policies and procedures to guide staff practice, and reviewed its protocol with the Office of the Protective Commissioner.

Access to SAAP services

In 2004, we issued a special report to Parliament *'Assisting homeless people – the need to improve their access to accommodation and support services'*. In our report, we highlighted that certain groups of homeless people faced a high possibility of being excluded from services funded under the Supported Accommodation Assistance Program, and in some cases, exclusions appeared to be unreasonable and possibly unlawful, as well as possibly being in contravention of SAAP standards.

Our special report to Parliament made a number of recommendations to DoCS and SAAP service providers, that were aimed at ensuring that the program maintained non-discriminatory and fair approaches to client eligibility, access and exiting.

Over time, we have monitored the implementation of our recommendations and we have noted significant change within the SAAP system. In April 2007 we appointed an independent consultant – RPR Consulting - to assess SAAP agency responses to our 6 recommendations for service providers.
The consultant used surveys and interviews to assess the impact of our work. The consultant reported to us as follows:

> *Taken as a whole, the findings of this project indicate that there has been substantial progress in implementing the recommendations of the Ombudsman's 2004 report that were directed at the SAAP sector. Further, the findings indicate that, overall, there has been a significant shift in awareness and practice of SAAP services in relation to access and exiting issues.* [6]

One of the main strategies arising from recommendations made in our report included the development and roll-out of a risk assessment tool for SAAP service providers. The assessment tool aims to provide a fair and consistent basis upon which agencies can make objective decisions about whether a client poses a risk, and if and how any risks can be managed by the service. RPR consulting found that by mid 2006, the tool was being used by the majority of agencies.

---

[6] RPR Consulting, *Assessing SAAP agency responses to the NSW Ombudsman's 2004 Inquiry into access and exiting issues – final report*, June 2007, p 9.

People with an intellectual disability and the criminal justice system

In 2004 we investigated DADHC's role as lead agency for a cross-government Senior Officer's Group (SOG) responsible for improving the interagency coordination of support for people with an intellectual disability who are in contact with the criminal justice system.

Our investigation found that DADHC had failed in its leadership role and that the SOG had failed to implement its terms of reference.

In our 2005 – 2006 annual report we followed up on the issue. We reported our concerns about the development of a new strategic plan, which focused on implementing specific projects, rather than a whole of government approach to the government's commitments in this area.

In response to our concerns, DADHC has now drafted a set of overarching cross agency principles – *People with an Intellectual Disability and Criminal Justice Service Principles and Protocols* - to guide the individual and collaborative work of the nine participating government agencies. There are also a number of initiatives linked to *Stronger Together* directed to improving services for people with a disability in the criminal justice system.

However, in relation to the SOG, we have received several progress reports indicating that progress has been slow. We are currently analysing the information received during the three years since the report, and deciding how we will report on our concerns.

Services for children with a disability and their families

In April 2004 we issued a special report to Parliament concerning DADHC's implementation of its policy for children and young people with a disability – *Living in the Community – Putting Children First.* This policy accepts that the best outcomes for children and young people with a disability are achieved when they are able to live in the community, and that the focus of services should therefore be on support and early intervention.

The focus of our investigation was on the support that the department was providing to families at risk of giving up the care of their child. We also looked at the arrangements to support children and young people voluntarily placed into care.

In 2006 we issued a follow-up report to Parliament. That report documents the measures that the department is implementing through its action plan for improving services in order to address the problems identified by our investigation. The report highlights the need for further close monitoring of this area. Some significant outcomes include:

- Following the release of our report (and as part of the 2004/05 budget), DADHC was allocated $30.6M over four years to expand the number of services it provides or funds that support families at risk of giving up the care of their child (included intensive family support services and the family support program).

- Employment of 20 further caseworker consultants to work with children and young people, and 20 new local support coordinators.
- Additional funding for flexible respite packages.

3.2 The percentage of complaints which are resolved

As was outlined to the Committee in our submission on the stakeholder review, it is important to appreciate that not all complaints to the Ombudsman are able to be resolved. This may be because:

- they are outside of our jurisdiction
- we may assess that the agency the subject of the complaint has acted reasonably
- action may be inappropriate due to current legal proceedings
- a complainant might be pursuing – or should pursue – other appropriate avenues to resolve their complaint
- the matter complained about may have happened a long time ago and there is no utility in us pursuing the matter.

Number of complaints

Each year in our annual report, we report on the number of complaints received by us. At page 80 of our 2006 – 2007 annual report, we reported the following complaint numbers:

Year	Formal	Informal	Total complaints
2003 – 04	531	1209	1740
2004 – 05	667	1184	1851
2005 – 06	595	1088	1683
2006 – 07	560	1200	1760

To update the Committee on our complaint numbers since 30 June 2007, we have recorded the following complaint numbers over the period 1 July 2007 – 31 December 2007:

- 353 formal
- 725 informal
- 6 month total complaints = 1078

Outcomes of formal complaints finalised

We also report on the outcomes of formal complaints finalised about agencies providing community services. This information was contained in our annual report at figure 39, page 81.

To update the Committee on the outcomes of complaints finalised since 30 June 2007, between 1 July 2007 and 31 December 2007 the CSD finalised 308 formal

complaints. We resolved and/or made recommendations for service improvement in 151 of these finalised formal complaints

At figure 39 of our annual report at page 81, we reported that in 2006 – 2007 we resolved 43% of formal complaints after inquiries. Our data for 1 July 2007 – 31 December 2007 indicates that this rate of resolution has increased to 47%.

In our annual report, we also report on another performance indicator – the number and proportion of finalised complaints resolved and/or where services are improved. We currently aim to resolve and/or suggest and recommend improvements to services in 50% of finalised formal complaints.

The following sets out the proportion of finalised complaints that are resolved and/or where services are improved, as taken from previous annual reports:

- 2003 – 2004: 38% of formal complaints
- 2004 – 2005: 45% of formal complaints
- 2005 – 2006: 55% of formal complaints
- 2006 – 2007: 54% of formal complaints

This performance indicator is comprised of the number and proportion of total complaints resolved (47% year to date as noted above) and the number of suggestions and recommendations for service improvement in relation to our complaints and direct investigations. We are still developing reports in our new data base about the latter. However, we will be able to report about both complaint resolutions and service improvement suggestions and recommendations in our forthcoming annual report.

When finalising complaints, we also provide complainants with an opportunity to request a review of our decision, where they are dissatisfied with the outcome of their complaint to us.

As we reported in our annual report, in 2006 – 2007, there were 8 requests for a review of our decision making in the community services division – this represents a percentage of approximately 1.4% of formal complaints finalised.

We also encourage feedback about our complaint handling practices and take steps to improve our practices, where appropriate.

3.3 Complainant satisfaction with our handling of complaints

In May 2007, we engaged independent consultants, ARTD, to develop a client satisfaction framework for the CSD and to conduct a pilot implementation of the framework and report on the findings of the pilot. The project involved surveying CSD stakeholder groups (in June 2007) in order to ascertain their level of satisfaction with their involvement with us.

It is important to note that the client or stakeholder groups identified were broader than just complainants - and included formal and informal complainants, child and family and disability peak agencies, and official community visitors.

The sample group involved 46 formal complainants, 23 informal complainants[7], 22 peak agencies, 3 community service providers and 9 community visitors.[8]

The areas in which the views of stakeholder groups were sought were:

- accessibility (contacting our office) and helpfulness
- timeliness - whether we consider matters brought to our attention promptly
- referral to appropriate organisations - where we are unable to handle a matter ourselves, explain why and identify any other appropriate organisation that may be able to provide assistance
- fairness and impartiality
- transparent actions, and
- service system solutions and improvements – whether we seek solutions and improvements that will benefit the broader community.

Set out below is more detailed information about the findings of the client satisfaction survey, with particular emphasis on the findings with regard to complainants.[9]

Overall, a high proportion of complainants were positive about all aspects of interaction with us, indicating that generally complainants appear to be satisfied with how we handle their complaints.

However, while positive about how we handled their complaints in a broad sense, only 40% of complainants ultimately reported that they were satisfied with the outcome of their complaint. In this sense, complainant satisfaction directly relates to the percentage of complaints that are resolved - see above for further information. It is important to note however, that complainants may report not being satisfied with the outcome of their complaint for a range of reasons and despite experiencing positive interactions with us.

79% of complainants reported that they agreed or tended to agree that it was easy to find out how to contact us and 71% said it was straightforward to reach the right person within our office. The consultants reported that the level of satisfaction was similar between informal and formal complainants, but was lower among those complainants who were generally not happy with the outcome of their complaint.

With regard to helpfulness, 98% of complainants said that the person that they mainly dealt with within our office was courteous, 75% said the person understood their

---

[7] Formal complaints are usually in the form of a written complaint or notification and generally lead to follow up or intervention with a service provider. Informal matters generally do not lead to such follow up and in some cases the issues are not within our jurisdiction.

[8] With regard to the sample, the consultants noted: "In our view, the collected data provides a reliable snapshot of satisfaction among clients of the Community Services Division. However, due to the relatively small sample sizes the complainant responses should be treated cautiously." This was explained to be due to the following: "Assuming 600 formal complaints per year, the confidence intervals are about ± 13%. Also because not all complainants could be contacted or agreed to participate, there may be some selection bias."

[9] This is due to the Committee's expressed interest in complainants' satisfaction with the outcome of their complaints.

concerns, 78% said the person was competent to deal with their concerns and 87% said they listened to their concerns.

74% of complainants said that we dealt with their complaint in a reasonable timeframe. With regard to the timeframes in which we deal with complaints, at page 81 of our annual report, we reported that we assessed and determined 63% of complaints within 10 weeks during the 2006 – 2007 year. Since then, we have taken steps to improve our case management practices to increase the percentage of complaints assessed and determined within 10 weeks. Our current report for the period 1 July 2007 – 31 December 2007 indicates that approximately 88 % of complaints are now being assessed and determined within 10 weeks. We are somewhat cautious about relying too heavily on this figure at this stage, as the CSD has only recently moved to commence using the Resolve database. As a result of this move, we are still settling our business rules and reporting, and our use of Resolve will formally be reviewed in May 2008. However, we are confident that we can report an overall improvement in turnaround times for complaints and we will provide detailed figures outlining turnaround times for complaints in our next annual report.

74% of complainants reported that we were able to deal with their complaint and of those who did not have their matter dealt with by us, 72% said we explained why we could not deal with their complaint and 65% said that another appropriate organisation was identified.

78% of complainants indicated their belief that we were fair and impartial in dealing with their complaint.[10]

70% of complainants agreed that actions and decisions about their complaint were adequately explained to them and 65% felt they were kept informed about the progress of their complaint. (In section 4.2 below, '*Feedback to complainants and monitoring the outcome of complaints*' we provide detailed information about some of the measures that we have introduced in response to this feedback).

The consultants noted with regard to service system solutions and improvements, that our work in this area mainly concerns broader investigations and projects and therefore largely concerns peak agencies and service providers. However 21% of complainants reported that our work as a result of their complaint had led to system-wide improvements for service receivers.

The client satisfaction survey also reported very positive views of peak agency stakeholders, community visitors and community service agencies.

Peak agency stakeholders in particular, were reported as having an improved perception of the CSD's engagement with the sector in recent years. The consultants noted that among peak agency stakeholders, ongoing professional relationships with

[10] The consultants indicated that this figure was strongly associated with complainants' satisfaction with the outcome of their complaint - with all those satisfied with the outcome of their complaint expressing the view that we had been fair and impartial but just over half of those who were dissatisfied with the outcome of their complaint.

the CSD senior staff have led to "*better communication, collaborative practices and has fostered a view of the Ombudsman's Office as a partner agency.*"[11]

In particular:

- 90% of peak agencies found the Ombudsman's Office very accessible (74%) or somewhat accessible (16%).
- 100% of the peak agencies believed the Ombudsman's Office was accessible to complainants.
- All peak agencies (100%) believed the Ombudsman's Office is impartial in dealings with complainants, and almost all (94%) believed the office's dealings with complainants was consistent.
- Peak agencies were very positive about the CSD's engagement with the sector and contributing to solutions (to issues and problems in the sector). In particular, peak agencies commented positively about their access to, and the responsiveness of, senior CSD staff, and the awareness of CSD staff about key issues affecting the sector.

Community Visitors also reported being very positive about the role of the Ombudsman's Office in supporting them, and in achieving broader results in the sector. All but one of the interviewed OCVs agreed or tended to agree that the CSD contributes to systemic service delivery improvements for service users, and all but two OCVS agreed or tended to agree that we are effective in promoting the Community Visitor's Scheme as a mechanism for protecting the rights of people in care.

3.4 Public recognition of our role in relation to community services

As outlined above, the complainant satisfaction survey suggests that a high proportion of people who need our help, found it easy to find out how to contact us and also found it was straightforward to make such contact. 19 of the 22 peak agencies that were interviewed had contacted our office and almost all (89%) found us accessible. 100% of peaks interviewed believed that we are accessible to complainants who need to contact us.

The complainant satisfaction survey also found that peak agencies were very positive about the role taken by the CSD in engaging with the sector and contributing to solutions.

> *All but one peak agency stakeholder agreed or tended to agree that Community Services Division staff adequately engage with the sector, and all agreed that staff are flexible in the way they engage with the sector. They commented both on their access to, and the responsiveness of, senior Community Services Division staff.*
>
> *An equally high proportion of peak agency stakeholders agreed or tended to agree that Community Service Division staff are aware of what is going on in*

[11] ARTD Consultant's Report, NSW Ombudman's Office Community Service Division, Client satisfaction findings, p3.

> *the sector (all but one agreed or tended to agree), and that they act on key issues (all but two agreed or tended to agree).*
>
> *All but one peak agency stakeholder agreed or tended to agree that Community Service Division staff contribute to service delivery improvements across the sector through recommendations, suggestions and other work. Many stakeholders pointed to specific examples of DADHC and DoCS acting on recommendations. ..*
>
> *Some stakeholders commented on recent changes and developments in the role of the Community Services Division, commenting that since merging with the Ombudsman's Office, a more practical and flexible approach by the Division was evident. They also commented that since the merger, there has been more systematic engagement with the sector, and better engagement with Indigenous matters.*[12]

These findings would seem to suggest a high level of public recognition of the role of our office in relation to community services.

The trend in our total complaint numbers over the last five years, which compares favourably with complaint numbers received by the Community Services Commission, also suggests that there is strong public recognition of the role of the Ombudsman in relation to community services.

Due to different counting rules, it is not possible to directly compare the total number of complaints received by the former Commission to those received by the Ombudsman. For example, the Commission's intake team handled all routine telephone inquiries about matters within their jurisdiction. By contrast, routine telephone inquiries made to our office that might only involve giving basic advice to the caller about how they can pursue their matter will not always be referred to the CSD. This difference impacts on the recording of the CSD's total complaint numbers. Nevertheless, despite this difference, the CSD's complaint numbers compare favourably with the Commission's figures.

A reasonable basis for comparison is the number of formal complaints received by the former Commission and those received by the Ombudsman.

[12] As above, p 13.

Comparison - formal complaints received by the Commission and NSW Ombudsman

No. formal complaints received	Community Services Commission	NSW Ombudsman	Average formal complaints per month
1998-1999	365		30
1999-2000	411		34
2000-2001	299		25
2001-2002[13]	149		12
2002-2003[14]		599	50
2003-2004		531	44
2004-2005		667	56
2005-2006		595	50
2006-2007		560	47
2007-08 (to 31/12/07)		353	59

After an initial increase in formal complaints following the December 2002 amalgamation of the Community Services Commission with the NSW Ombudsman, complaint activity remained somewhat static between 2004-05 and 2006-07 (average of 51 formal complaints per month for these three financial years).

Since the end of last financial year, we have experienced an increase in formal complaints (an average of 59 formal complaints per month, between 1 July 2007 – 31 December 2007).

Our preliminary analysis indicates that the majority of this recent increase is likely to be attributable to an increase in complaints about DoCS' child protection activities, following intense media coverage of child deaths in late 2007. However, there have also been increases in complaints about out-of-home care, disability accommodation, supported accommodation and other services.

In the second half of the 2007 calendar year, we also experienced an increase in informal complaints, up from an average of 98 informal complaints per month in the overall period since the amalgamation 2003 - 2007, to 121 informal complaints per month in the period 1 July 2007 – 31 December 2007.

The vast majority of informal complaints about community services – more than 90% - are complaints within jurisdiction. We handle these by providing information, advice and referral so that complainants can resolve their complaints quickly and directly

[13] The reduced numbers of complaints to the Commission in 2001-2002 was the result of the successful challenge to the Commission's jurisdiction, preventing it from handling complaints about DoCS child protection services. These complaints were referred to the Ombudsman from 2001 until the merger.
[14] In the year of the merger (2002-2003), the Ombudsman and former Commission jointly received 2,158 informal and formal complaints. However, because of confusion within the sector about the jurisdiction of both agencies, particularly in relation to child protection, this figure involved multiple contacts about the same matters and, therefore, cannot be validly compared to the former Commission's complaint activity before 2002-03 and the Ombudsman's complaint activity since.

with service providers. This is consistent with the intention of the Act to enable resolution of complaints at the local level.

Informal complaints received by the NSW Ombudsman

2003-2004	1209	101
2004-2005	1184	99
2005-2006	1088	91
2006-2007	1200	100
2007-08 (to 31/12/07)	725	121

Community education, information and awareness

We have continued to invest significant resources in community education, information and awareness activities, to further promote our role in relation to community services. This work not only increases the public recognition of our role, but it is also important in influencing change in the culture and quality of community services in NSW, promoting the rights of consumers of community services and informing the sector of the findings of our work.

We have a number of important statutory functions under the Act that directly impact the level of public recognition of our role in relation to community services. These include:

- providing information, education and training in relation to the making, handling and resolution of complaints s.11(1)(i),
- assisting service providers to improve their complaints procedures s.11(1)(g),
- to promote and assist the development of standards for the delivery of community services s.11(1)(a),
- to educate service providers, clients, carers and the community generally about standards [for the delivery of community services] s.11(1)(b); and
- to promote access to advocacy support for person receiving, or eligible to receive, community services to ensure adequate participation in decision-making about the services they receive s.11(1)(j).

In our 2006 - 2007 annual report, we provided a summary of our community information, education, training and information and awareness activities[15]. To update the Committee on our work in this area, set out below is further detailed information about our work for the 2007 calendar year (to 31 December 2007) and proposed work for 2008.

Our work in 2007

In 2007, we developed and implemented a significant communication and education strategy, and we increased our reach to diverse audiences throughout NSW. We undertook approximately 60 information and education activities. These included 18 rural or regional activities and 43 workshops and training sessions run by our community education team. In addition to our education activities, the Deputy

[15] see pages 94 – 95.

Ombudsman attended more than 170 meetings with agencies throughout the year and staff of the CSD also attended many more meetings with agencies. The Ombudsman will also meet with key agencies on a regular basis in order to deal with critical issues. We submitted a number of articles and stories for inclusion in sector publications and gained rural radio and media coverage.

Some of our other activities included:

- Producing new resources - including posters - in community languages and 'easy English' resources.
- Updating Ombudsman information on many external agency websites.
- Distributing information to over 1,000 sector workers and managers through conference satchel inserts and post-conference mail outs.
- Reviewing and further developing our training courses, including a new investigations training module.
- Running sector forums, including:
    - The Regional Outreach program facilitated by the Deputy Ombudsman (three forums). These forums have the dual purpose of providing information about the role and work of our Division as well as consulting with regional communities about issues in their area.
    - Partnership forums with the Energy and Water Ombudsman of NSW for disability service providers across the metropolitan area (four forums).
    - Boarding House forums.
- Developing an across-office communications and accessibility proposal for the upgrade of the Ombudsman website and publications, to meet internationally recognized standards of accessibility. This comprehensive review will take place in 2008,
- Distributing information packs to key access points for potential complaints such as community centres - including over 300 Neighborhood Centres in NSW, local councils, community legal centres and libraries.
- Producing sector specific overviews of our annual report for all peak bodies to use in member newsletters,
- Commencing the development of new fact sheets for service providers on complaints management and handling; and
- Participating in a range of events such as conferences, community expos and cultural events.

Our plans for 2008 and beyond

In the coming year, the key focus of our activities will be to maximize opportunities to increase access and awareness through a program of regional visits, to hold forums to discuss our role and work, and to hear issues from the community and the sector. The Deputy Ombudsman will be visiting regional areas and, within a three-year period, plans to ensure that coverage of the state is achieved.

Following careful analysis of information gathered through our complaints, project and reviewable death work, we plan to target the health sector as a priority for our

education, information and awareness activities, particularly areas where the child protection system interacts with health services and staff.

We also have several joint outreach forums planned for the year, through our Joint Outreach Initiatives Network[16] and with western Sydney communities and disability services providers.

We are working to develop innovative approaches to educate consumers of community services about their rights, including possible partnership projects and train-the trainer strategies.

We are also developing strategies over the next three years to:

- Provide specific information forums/activities for advocacy groups in both the disability and child and family sector.
- Provide training to senior staff in the Community Services Grants program area in DoCS following on from our complaint handling review work.[17]
- Develop strategies to increase our contact with ethnic and regional media and CALD and ATSI communities and increase our presence in regional areas,
- Continue our Boarding House Education project *Solving Problems – Right at Home*, which is run in partnership with official community visitors.[18]
- Continue to produce articles and stories for sector and peak agency newsletters/publications from our work including summaries of the annual report, articles arising from public reports and significant projects.
- Commence planning around the production of an electronic newsletter to further promote and enhance information delivery across the sector about the CSD and Ombudsman.

Our work with young people

In our submission to the Committee for the stakeholder review, we responded to observations that children and young people rarely make complaints, and discussed strategies that we were employing to improve children and young people's access to this office[19].

Our 2006 - 2007 annual report provides detailed information about our work with young people.[20] We have now developed internal guidelines for dealing with youth complaints and a training package for all staff to improve our service delivery to children and young people. Given the positive feedback we have received about this work, our guidelines are now in the process of being published and placed on our website for external use by other agencies.

We have also given many presentations to youth workers, teachers and young people across NSW and worked with the agencies that provide services to children and

---

[16] members include other complaint handling bodies such as the Commonwealth Ombudsman, Energy and Water Ombudsman of NSW, Department of Fair Trading, Office of the Privacy Commissioner.
[17] Refer to page 83 of our 2006 – 2007 annual report for background information.
[18] Refer to page 95 of our 2006 – 2007 annual report for background information.
[19] See page 7 of our submission, which addressed in part concerns raised by ACWA.
[20] See pages 45 – 46 of our 2006 – 2007 annual report.

young people to increase the public recognition of our role.

Similarly, we have undertaken work to strategically promote public recognition of our role to other vulnerable groups within the community. This work has included visits to regional and remote communities in NSW,[21] our work to promote our role to culturally and linguistically diverse communities,[22] through our work with people in residential care,[23] and our work with residents of boarding houses and older people.[24]

3.5 Audit initiatives concerning Indigenous issues

Aboriginal Strategic Direction

In its report on the stakeholder review, the Committee expressed an interest in our audit initiatives concerning Indigenous issues and noted that this review might further consider this issue.

Our 2006 - 2007 annual report provided detailed information about our audits of the NSW Police Force's implementation of its Aboriginal Strategic Direction (ASD) and the effectiveness of the ASD in individual commands.[25] We started our audit program 4 years ago, and completed it in June 2007, having conducted 36 audits (which included 14 repeat audits).

Our consultations involved more than 3,500 Aboriginal people from more than 90 communities across the state, representatives from more than 400 agencies and services, as well as police such as Local Area Commanders and specialist liaison officers.

Our 2005 report to Parliament[26] outlined the findings of the first phase of our audit program. Since that time, we have completed a second phase of the program - which was to return to areas previously visited, to talk with police, service providers and the community about any changes that police had made since our earlier review. As was reported in our 2006 - 2007 annual report:

> *We found marked improvements in almost all of the areas we returned to and a significant change in attitude by many police - they now see this work as core business rather than just an 'add-on' to other policing work. This change is reflected in the diversity of programs and strategies they are providing to support victims of domestic violence and divert young people from crime. Police also now integrate relationship-building into their policing strategies.* [27]

---

[21] See page 47 of our 2006 – 2007 annual report.
[22] See page 48 of our 2006 – 2007 annual report.
[23] See page 48 of our 2006 – 2007 annual report in which we note that "the work of official community visitors (OCVs) and community education officers is critical to improving access to our services for this group of people. This year our OCVs made more than 3,164 visits to 1,230 residential services and had contact with 6,582 residents. they resolved 1,643 service provision issues in consultation with people living in care, their families, advocates and other representatives."
[24] See page 49 of our 2006 – 2007 annual report.
[25] pp 12, 42 – 44, 2006 – 2007 annual report.
[26] NSW Ombudsman , *Working with local Aboriginal communities: Audit of the implementation of the NSW Police Aboriginal Strategic Direction (2003 – 2006),* ,April 2005.
[27] p 42.

In August 2007, the NSW Police Force released its *Aboriginal Strategic Direction (2007 to 2011)*. The revised ASD includes important new objectives focusing on Aboriginal substance abuse and a stronger response to policing sexual assaults in Aboriginal communities, including the investigation of child sexual assaults.

This office's cross-agency team (CAT) is currently planning the future direction of our ASD audits.[28] Clearly the issues of Aboriginal substance abuse and sexual assault – and in particular child sexual assault – have direct relevance to the community services area. For example, our recent annual report on child deaths highlighted the fact that Aboriginal children were again over-represented in reviewable child deaths and as in previous years, many children whose deaths we reviewed were from families with a history of parental substance abuse.

With this in mind, we are currently devising an appropriate audit methodology and determining targeted audit locations throughout the state. In light of the need for a more interagency approach – rather than a solely policing response – to the issues of Aboriginal substance abuse and child sexual assault, we decided to meet with senior representatives from a range of lead agencies, prior to commencing our audit program.

To date, we have attended a range of meetings with senior representatives from lead agencies including DoCS, the Department of Aboriginal Affairs (DAA), and representatives from NSW Police Force including Assistant Commissioner Peter Parsons (Corporate Sponsor for Aboriginal Issues), Peter Lalor (Manager - Aboriginal Coordination Team), Superintendent Helen Begg (Commander - Child Sex Crimes Squad) and Superintendent Dave Cushway (Corporate responsibility for responding to the NSW Interagency Plan). We have also met with Brewarrina Shire Council and members of the Murdi Paaki Regional Assembly. In addition, we have sought formal advice from DoCS about its plans to enhance its services in the Western Region, and from NSW Police Force about their plans to address the issue of child sexual assault.

On 29 January 2008 the Ombudsman, Deputy Ombudsman and other senior staff met with the DAA, to gain a better understanding of the DAA's coordinating role in relation to the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities, given its relevance to our planned audit strategy.

Through this meeting we were able to gain a better understanding of the reporting and monitoring structures that the DAA has put in place to track whether agencies have implemented the actions listed in the interagency plan. We also received advice that the DAA is in the process of developing performance indicators to measure the success of these strategies, as well as the locations of the intensive sites that they plan to establish.

At the meeting, it was agreed that we would develop an audit framework and provide it to the DAA for their feedback. Our aim is to develop a localised audit strategy that compliments the DAA's coordinating role. We also agreed that we should regularly share information and coordinate any community/agency consultations. We are

[28] Our cross agency team came into operation in March 2007 and is staffed by members of the Aboriginal Unit, our youth liaison officer and project officers and has expertise in relation to whole of government initiatives and aspects of our work across the various teams of this office.

currently in the process of requesting information from the Minister for Aboriginal Affairs about the responses provided to the DAA by agencies, as well as a copy of the performance indicators. These documents will help inform our audit strategy.

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

This office also commenced a project in March 2007 to better understand the needs of foster carers of Aboriginal children, and to examine the support systems for carers that are currently in place. We have completed the first stage of the project which involved interviews with over 100 carers from around the state and analysis of our survey data.

The project has examined issues relating to case management such as:

- information provided to foster carers before a placement is made
- financial entitlements
- case planning and conferencing
- health and development issues
- education
- carer training, and
- carer support groups and other support systems.

The project also has a major focus on the cultural needs of Aboriginal children in care and the support given to carers to meet these needs through:

- cultural support planning
- the Aboriginal Placement Principle, and
- consultation processes as defined by the Principle.

The second stage of the project involved consultations with senior DoCS staff, to discuss our survey findings, and seek their views on areas that they would like us to further explore. The Department indicated a strong interest in better understanding the nature of carers' concerns about case management support and possible suggestions for improvement, complaint handling practices, and good practice relating to carer support groups, cultural planning and consultation around placing children in accordance with the Aboriginal Placement Principle.

The response to our project from carers has been very positive and their contribution has given us valuable insights into the particular issues faced by carers of Aboriginal children. Our direct contact with carers has also raised awareness about the role of the Ombudsman and our Aboriginal Unit. This in turn appears to have led to a significant increase in the number of concerns raised by carers directly with our Aboriginal Unit staff. Many of these concerns have been raised by carers that were not interviewed as part of our project but who learned about our research from other carers. So far, we have received 41 matters. Nine matters were dealt with as formal complaints and the remainder were resolved directly through our staff either providing information to carers or liaising with the department to resolve their concerns.

Our consultations have also included a number of Aboriginal out-of-home care providers across the state and we have actively consulted with AbSec, the peak

Aboriginal child and family agency in NSW and the Foster Carers' Association throughout the project, as well as medical practitioners involved in research trials aimed at identifying the particular health and development needs of children in out of home care. These stakeholders have indicated strong support for our project and have noted the value of documenting the needs of carers of Aboriginal children in NSW and how best to address them, as well as identifying good practice relating to case management, community consultation and cultural planning for Aboriginal children and examining how this might be replicated across the state.

We plan to provide a draft report to the Department by the end of February 2008.

Also during 2007, while our interviews were taking place, we commenced a project to conduct a review of a group of young children in out-of-home care. We decided to review the individual situations of a group of children under the age of 5 in out-of-home care. While this project did not specifically target Aboriginal children, 9 of the 49 children (or close to 20%) whose individual circumstances we reviewed were Aboriginal, and we paid careful attention to matters specific to Aboriginal children, such as whether the department had adhered to Aboriginal Placement Principles.

We focussed our reviews on the key practice areas: care planning, health screening and assessment, case management, placement support and contact and identity. We made observations in each of these practice areas. Our review also identified practice areas that, in our view, warranted improvement and we are currently awaiting a response from the department about whether the practice weaknesses identified in our report will be addressed by the department's quality review program or other initiatives.

In January 2008, we also advised DoCS that we had decided to initiate a similar group review of older children in out-of-home care. Our decision to initiate this further review took into account our findings and observations of our review of the group of children younger than 5 years, and also the particular challenges faced by older children in out-of-home care.

Our review will focus on children aged 10 - 14 years of age, who are in out-of-home care as a result of final orders made by the Children's Court allocating parental responsibility or aspects of parental responsibility to the Minister for Community Services.

DADHC Aboriginal Policy Framework

In July 2005, the Department of Ageing, Disability and Home Care (DADHC) released its Aboriginal Policy Framework that outlines strategies to increase consultation with Aboriginal communities and develop culturally appropriate services that are more accessible to Aboriginal people. We developed a project plan to monitor the Framework and consultation strategy, which included the use of information gathered by our own Aboriginal Complaint Unit staff, while conducting audits and other work in Aboriginal communities throughout NSW [29].

[29] such as our audits of the NSW Police Force's implementation of the Aboriginal Strategic Direction.

As was reported in our 2006 – 2007 annual report, we received some feedback from Aboriginal communities that raised questions about whether the framework had been implemented across all DADHC regions and also, how consultation with Aboriginal communities was informing the planning and delivery of community services.

On this basis, we wrote to DADHC requesting information about its progress towards implementing the Aboriginal Policy Framework, their consultations with Aboriginal communities and how they were ensuring that the framework was being implemented consistently across all regions.[30] DADHC responded by providing details about various activities being undertaken throughout the regions and the development of its Aboriginal Access and Equity Strategy.

We met with the Aboriginal Disability Network and the Aboriginal Community Care Gathering, which allowed us to gauge community understanding of the information that DADHC had provided us about its regional activities. We learnt that there was some level of awareness of consultation taking place within the regions, but that it was variable, and both representative peak groups reported that they had not been consulted by DADHC on the framework and as part of the consultation strategy.

We are meeting with DADHC in February to discuss the potential for the Ombudsman to audit DADHC's engagement with Aboriginal communities around disability service issues.

3.6 Promoting access to advocacy support

One of our community service functions is to promote access to advocacy support for people who receive, or are eligible to receive, community services[31]. However, it is critical that our role be distinguished from that of community sector advocacy organisations, who directly advocate on behalf of people who use community services.

As outlined in section 3.4 above, it is a key focus of our extensive community education, information and awareness activities, to promote access to advocacy support. We do this through:

- 'The Rights Stuff' toolkit and consumer workshop program, for people who use community services, their families, carers and advocates. This publication contains detailed information on the different types of advocacy and how consumers can access advocacy support and help and contains a comprehensive advocacy 'contacts' list.
- We target "intermediaries" in the sector (eg neighbourhood centres, consumer newsletters, peak agencies) with relevant information, so that they can effectively pass this information on to service users.
- Our Boarding house program "Solving Problem Right at Home" which, in partnership with the OCV scheme, has a significant emphasis on providing information and skills to residents on how to access and use advocates.

[30] We did this pursuant to our section 11 (c) function – to monitor and review the delivery of community services and related programs, both generally and in particular cases.
[31] section 11, (1) (j) Community Services (Complaints, Reviews and Monitoring) Act.

- Our public training workshops specifically address advocacy skills and resources, include training for service staff on how to advocate for and with their consumers, and how to empower clients to increase self advocacy.
- We hold forums across the community sector to provide information and seek feedback from services providers and advocates. We include information about service provider responsibilities to provide service users with access to advocacy support. These forums are specifically designed to target the 'information gatekeepers' to support their advocacy function within the community sector.
- In 2008 we will also be holding outreach forums for advocates and we will use these forums as an opportunity to discuss the most effective ways to inform consumers about our role. We also regularly meet with advocacy agencies (for example through our regular sector roundtables) to consider any information that they wish to provide to us, to discuss developments in the sector and to ensure that they are satisfied with how we are responding to any concerns or complaints that they have raised.
- As part of our complaint handling reviews, we audit services' policies and procedures, to look at how they are offering service users access to advocacy supports as part of their complaints system.

As the Committee is aware, we also administer the Official Community Visitor scheme. OCVs perform a number of important functions - they inform the relevant Ministers about matters affecting the conditions of people in care, they promote legal and human rights of residents, consider matters raised by residents, help resolve grievances and concerns of residents and they also provide information about advocacy services.

We also regularly provide advice about advocacy supports available to people who use community services, as part of our handling of complaints. We maintain a listing of up-to-date contact details of advocacy groups to facilitate our staff making such referrals.

In assessing how we may proceed with complaints, we consider the capacity of the complainant to pursue the matter independently, and also their capacity to enter into any resolution action that we may facilitate. Where necessary - and particularly in relation to people with disabilities, the aged or young people - we may refer a complainant to an advocacy organisation as a means of supporting the resolution of the complaint or to provide support to the complainant in ways that we are not able to, due to our independent role.

3.7 Facilitating immediate responses to emergency situations

The Committee's report indicates that some stakeholders had questions about how effectively we respond to immediate concerns, including that the Division '*does not take immediate action to assist vulnerable individuals whose situation is urgent*, and is less able than the Community Services Commission to provide urgent assistance with an immediate problem.[32]

Many of the complainants we deal with, the individuals and families who come to our attention through avenues such as reviews, and the people in care visited by OCVs,

---

[32] at p.11

are in vulnerable situations. Our work may indicate that a person, or persons, may be in a situation where they require prompt assistance, or are at some level of risk. In the first instance, the critical role for this office is to ensure that the relevant and responsible agencies are alert to the situation. In many cases, once appraised of such circumstances, responsible agencies respond promptly and effectively.

In general, we give priority to matters involving the most vulnerable consumers. We have developed broad structures and specific procedures to ensure that our response to identified concerns is timely and appropriate. For example, the Division:

- Accepts verbal complaints and makes verbal preliminary inquiries of agencies to ensure timely and efficient assessment of a situation, and prompt notification to agencies of a potential concern.
- Has clear procedures for making reports of risk of harm if staff have grounds to suspect children identified to them may be at risk of harm.
- Employs a range of avenues under CS CRAMA and the Ombudsman Act to facilitate prompt responses by relevant agencies, including investigations initiated of our own motion.
- Has processes in place to ensure good exchange of information with OCVs, including OCVs undertaking visits based on a request from the CSD complaints team staff. OCVs can raise any issues directly with service providers and specify an appropriate time frame for a response.

In the conduct of our work, staff are conscious of the need to respond appropriately to situations affecting the immediate safety and wellbeing of individuals.

For example, our reviews of child deaths involve examination of records relating to children who died and their families, including those held by DoCS, Health and Police. In reviewing these records, we may become aware of risk situations involving surviving siblings or other children in contact with the family. Where we identify such risks, we can bring this to the department's immediate attention through a report under section 43(3) of CS CRAMA. These reports can convey relevant information not otherwise known to an agency but relevant to facilitating a response by them, or they can suggest an appropriate course of action to ensure risk is assessed or responded to. In other situations we may contact the DoCS Child Death and Critical Reports Unit by phone, to alert them to our concerns and where appropriate, request that that unit takes appropriate action through the department's Helpline or the relevant Community Services Centre.

In the conduct of in-care reviews, we may identify issues that are impacting on the immediate care circumstances of a child. Where this is the case, we bring these to DoCS attention and ask the department for advice on any action taken in response to the issues.

For example, in our reviews of very young children in care last year, we identified issues ranging from apparent failure of DoCS to ensure provision of services arising from paediatric and developmental assessments, to child care fees not being provided to a carer. In all instances the department acted quickly to address the issues we identified.

Since the stakeholder review, we have put in place a number of additional staffing and structural changes to enable our staff to respond quickly to urgent situations that are brought to our attention. The staffing changes that we introduced were designed to:

- enhance the speed in which we are able to respond to complaints and inquiries
- improve the quality of initial information, advice and referral provided by our intake staff
- increase complaint resolution rates
- increase capacity to deal with complex complaints and initiate investigations within the CSD

The changes have also assisted in the early identification of complaints that can be appropriately referred for local resolution and investigation, and the fast tracking of matters where there are immediate and current concerns about the safety, care or welfare of vulnerable service users.

In addition to staffing changes, we have introduced a number of systems changes that are designed to ensure that significant matters – and matters requiring an urgent response – are considered by senior staff, including the Deputy Ombudsman, at a very early stage. Some of these changes include the introduction of a register of 'significant complaint matters' discussed weekly at a 'significant complaints meeting', the establishment of weekly complaints allocation meetings to ensure that all complaints are allocated for action within a maximum of 5 days of receipt, or sooner where there is an emergency situation requiring an immediate response, and the development and review of a range of internal policies and procedures.

4. Issues arising from submissions to the Committee

4.1 Summary of the issues raised in the submissions

The Committee received submissions from a diverse range of organisations and the range of issues raised in those submissions was also broad.

Set out below are the main issues - as we see them - raised in the submissions.

Positive comments about our work

We were very pleased to note that a considerable number of submissions made positive comments about the work that we do. For example, the Intellectual Disability Rights Service (IDRS) noted that there have been benefits flowing from the merger of the CSC into this office, including from our use of *Ombudsman Act* powers, and the fact that complaints can be made about issues that apply to more than one agency or about agencies that extend beyond the scope of the Act, through the work of other teams within this office.

The submission of the Disability Council of NSW noted:

> *...the Office and the CSD offer a range of mechanisms that contribute to fostering a culture of continuous improvement within human service providers...*[33]

and with regard to the merger:

> *...we believe that the senior management and staff of the Ombudsman/CSD have shown themselves committed to commendable action to protect and uphold the rights of people with disability who may feel vulnerable in their engagement with/ treatment by community service providers. We congratulate the Ombudsman / CSD for the manner in which they have managed the challenges of amalgamation and developed services and mechanisms that support and encourage people to exercise their rights ...* [34]

The submission of the Coalition of Appropriate Supported Accommodation for People with Disabilities (CASA) highlighted the importance of our role in investigating matters of systemic significance. The submission of the Multicultural Disability Advocacy Association of NSW (MDAA) made positive mention of our roundtable discussions with disability advocacy organisations, to identify and discuss issues as they arise, and the Disability Council of NSW indicated that they valued the proactive role taken by the Deputy Ombudsman to engage in community development and consultation.

The Council of Social Service in NSW (NCOSS) congratulated us on our successful systemic work and our capacity to engage government departments and community organisations to find solutions to systemic issues. NCOSS also made a number of

---

[33] Submission of the Disability Council of NSW, 25 October 2007, page 6.
[34] Ibid, Page 7.

positive comments about our work and progress since the amalgamation. These comments included positive note of initiatives such as our work with the Senior Officers Group (SOG) and the NSW Human Services Chief Executive Officer's forum and our information and awareness raising initiatives.

The submission of the Association of Children's Welfare Agencies (ACWA) listed a number of achievements of our work:

- *The non-government community services sector that we represent has a healthy respect for the making of complaints and understands the need for good complaint management processes.*
- *Both government and non-government agencies have greater insight into the systemic issues surrounding reportable deaths, particularly of children in out of home care, or those who are otherwise associated with the community services system, as defined in the legislation.*
- *Organisations providing residential care for children and young people have improved the quality of that care, often due to the scrutiny and with the support of the Official Community Visitors. This has served to complement the work of the Office for Children Children's Guardian, funding bodies and the education and support role of peak organisations such as ours.*
- *Some agencies providing poor quality care have been closed down as DoCS ceased to fund them or refer clients to them following adverse Ombudsman or Community Services Commission reviews or investigation reports.*
- *Access to community services, particularly SAAP services, has been clarified, so that any denial of access is based on proper risk assessment.*
- *The Department of Community Services has worked hard, over the last six or so year, particularly, to reform its own service delivery in child protection and out-of home care, as well as to improve its monitoring of funded or contracted services. The oversight by the NSW Ombudsman has influenced this effort.* [35]

Concerns expressed in the submissions about our work

In addition to many positive comments, a small number of submissions expressed concerns about some aspect of our work. It is important to bear in mind however, that in many instances, only one submission raised the concerns that are set out below.

The concerns related to:

- The level of feedback that we provide in relation to complaints and in particular, whether we monitor the implementation of agreements made to resolve a complaint.[36]
- Continued disappointment about the decision to amalgamate the CSC into the Ombudsman's office due to the perception that inquiries and reporting under the

[35] ACWA submission, 24 August 2007, pp 1- 2.
[36] Submission of MDAA, 23 August 2007, page 3.

Act are more private and less rigorous than when they were dealt with by the CSC.[37]

- The relatively small number of complaints made about accommodation and support services for people with an intellectual disability and low numbers of direct investigations and reviews of the circumstances of people with a disability living in care.[38]
- That there should be additional community visitors and more visits to services in the disability area. That OCV feedback should be more strategic, and more detailed information should be provided about situations where issues raised by OCVs are not resolved [39]. There should be more OCVS with CALD backgrounds.[40]
- While we have done much work to engage with the community through meetings and projects and through positions such as that of our youth liaison officer, 'there remains a gap in the engagement with the consumers at the individual and community level.' [41]

Broader concerns about the operation of the Act

A number of the submissions also raised broader concerns about the operation of the Act, that did not specifically relate to our work, such as:

- Specific factors that mitigate against people making complaints - for example issues affecting people of CALD or ATSI backgrounds and people living in regional or remote areas.[42]
- Complaints often relate to issues that are difficult to resolve - for example, no alternate service providers might be available or there may be inadequate service available due to high demand. In other cases the issues may fall between the gaps of different service systems - for example the health and community care systems.[43]
- The possiblility that increased avenues of complaint (such as the National Disability Abuse and Neglect Hotline and the Complaints Resolution and Referral Service) may lead to some people falling through the gaps of the various complaint handling bodies.[44]
- Specific issues that mitigate against the objects of the act, such as the emphasis on local resolution of complaints - for example issues affecting Aboriginal people using DoCS' complaints resolution service.[45];
- The situation of some vulnerable groups who remain outside the protections offered by the Act, such as people with disabilities living in unlicensed boarding houses.

---

[37] Submission of People with Disability (PwD), 29 August 2007, page 2.
[38] Submission of IDRS, 21 September 2007, page 3.
[39] Submission of NCOSS, page 5.
[40] Submission of MDAA, 23 August 2007, page 4.
[41] Submission of NCOSS, page 6.
[42] Submission of Carers NSW, 27 July 2007, page 3.
[43] Submission of Carers NSW, 27 July 2007, page 3.
[44] Submission of MDAA, 23 August 2007, page 2.
[45] Submission of AbSec, 25 September 2007.

Suggestions for amendments to the Act, as contained in the submissions.

Many of the submissions also provided comments about the terms of the Act and its operation, and made suggestions for possible amendment. Set out below is a summary of those comments:

Suggestions for updated processes

A number of submissions were supportive of the objects of the Act, but made suggestions for updated processes, including:

- Resourcing of local community discussions forums, creating circles of listening in local community settings, using local community cultural contexts to inform dispute resolution, engaging action researchers in community-based dispute resolution processes and engaging the community in healing and development.[46]
- Considering a new model of practice - explicit affective practice, which has emerged from the restorative justice movement.[47]
- Amendment of the Act to ensure that culturally appropriate alternate dispute resolution processes are mandated.[48]
- Creation of a tribunal or advocacy agency for making complaints.[49]

Objects of the Act

The submission of the NSW Commission for Children and Young People argued that currently, the objects of the act do not reflect all of our s 11 functions:

> *For example, section 11 of the Act gives the Ombudsman functions in standard setting, community education, inquiry and advocacy to improve service delivery in community services. These important functions are not limited to complaints or monitoring and so are outside the current objects of the Act.*
>
> *Similarly, section 36 of the Act states that, in addition to monitoring the performance of service systems, the systemic review of deaths aims to 'formulate recommendations as to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths'.*
>
> *I suggest that the objects of the Act be extended beyond complaints and monitoring to include preventing or reducing reviewable deaths and improving service delivery in community services.* [50]

Expansion of our jurisdiction

A number of submissions to the Committee argued for the expansion of aspects of our jurisdiction. In particular, a number of submissions argued for the expansion of the 'visitable service' jurisdiction to include:

---

[46] Submission of Care Connect, 23 August 2007.
[47] Submission of Goulburn Family Support Service Inc, 21 August 2007.
[48] Submission of AbSec, 25 September 2007, page 5.
[49] Submission of Bathurst Emergency Accommodation Place Inc, 13 September 2007, page 2.
[50] Submission of NSW Commission for Children and Young People, 22 August 2007, page 1.

- various foster care arrangements found in NESB communities[51]
- various informal care arrangements for older people, who are cared for in the older person's or the carer's home, so as to allow OCVs to attend these private premises[52]
- Aboriginal group homes (when they are established)[53].

The submission by the Council on the Ageing also argued for an extension of the definition of visitable service in section 8 (6) (a), from *'full-time care of the service provider'* to also include part-time care.[54]

The Disability Council of NSW also urged the Committee to consider that some vulnerable people are without the protections offered by the Act, such as people with disabilities living in unlicensed boarding houses. The Committee was asked to consider whether protections could be offered to 'all people living in circumstances where they are dependant .... on the 'community care' services of others. [55]'

Strengthening of our reporting powers

A number of the submissions to the Committee called for the strengthening of our reporting powers.

For example, ACWA argued:

> *One of the important aspects of the Ombudsman's work is the capacity to achieve systemic change, wider than the original matter under consideration, because certain reports have been published as special reports to Parliament, or have otherwise been made known to the parties involved in consultation during an inquiry, review or investigation. We believe the capacity for wide circulation of the outcomes of investigation and inquiries should be strengthened, if necessary through legislative amendment, in order that all relevant agencies providing similar services can learn and if necessary change their practices.* [56]

NCOSS also argued that there has been positive progress made since the amalgamation of the CSC into the Ombudsman's Office, however they state that there have been concerns expressed by their members representing people with disability that there is 'less openness in reporting of both the process and the findings of inquiries.'

Further, that:

> *NCOSS is conscious of the need to balance personal/organisational confidentiality and privacy with the imperatives of the public interest. Given*

---

[51] Submission of the MDAA, 23 August 2007, page 2.
[52] Submission of Council on the Ageing (NSW) Inc, page 4.
[53] Submission of AbSec, 25 September 2007, page 6.
[54] Submission of Council on the Ageing (NSW) Inc, page 3.
[55] Submission of the Disability Council of NSW, 25 October 2007, page 8.
[56] Submission of ACWA, 24 August 2007, page 2.

> *that the environment has changed dramatically since the Ombudsman Act 1974 there may be value in reviewing section 34 which dictates that no information shall be disclosed except in some circumstances, including community education function.*[57]

As outlined earlier in this submission, PwD also expressed concerns that inquiries and reporting under the Act are 'more private.'[58]

Review by Tribunal

The submissions of PwD and the Disability Council of New South Wales raised concerns about the interaction between Part 5 of the Act - concerning review by tribunal of decisions and applications to the Administrative Decisions Tribunal for reviews of decisions - and the operation of section 20 (a) of the Disability Services Act.

PwD argues that 'in practice, such appeals are not able to be made.'[59]

The Disability Council of NSW believes that:

> *...the relationship between Section 20 (a) of the Disability Services Act and Part V of CRAMA should be scrutinised, clarified and, if found unsatisfactory in some way, resolved in the interests of people with disability and their right under the Act to have access to independent mechanisms of complaint, including review and appeals of decisions.*[60]

Other specific amendments raised in the submissions

A number of submissions also made specific suggestions for legislative amendment, including:

- That the nature and form of ombudsman staff identification be specified in the Act.[61]
- that an alternate method of complaint, possibly incorporating a role similar to that of the patient representative be considered.[62]
- That the Act include specific reference to older people.[63]
- When a complaint leads to an action plan for resolution, follow up of the action plan should be mandated and time-tabled, with standards that are enforceable, moving from 'indicative guidelines to a scheme of enforceable standards.'[64]
- That the Act should reflect the Department of Ageing, Disability and Home Care as an agency covered by the legislation and the incorporation of Home Care into the department.[65]

---

[57] Submission of NCOSS, page 7.
[58] Submission of PwD, 29 August 2007, page 2.
[59] Submission of PwD, 29 August 2007, page 2.
[60] Submission of Disability Council of NSW, 25 October 2007, page 7.
[61] Submission of New Era Independent Living Centre, 15 August 2007, page 2.
[62] Submission of Sydney South West Area Health Service, 27 August 2007, page 1.
[63] Submission of COTA, page 2.
[64] Submission of NCOSS, page 3.
[65] Submission of the Minister for Ageing and Minister for Disability Services, 24 September 2007.

- The Children's Guardian also made detailed and specific suggestions concerning information exchange arrangements between this office and the Children's Guardian, with particular reference to OCV information.

4.2 Ombudman comments

As outlined above, we are very pleased to note the range of submissions to the Committee that made positive comment on our work in community services.

We also note that some submissions raised a number of specific concerns, which we have sought to address in the course of our submission to the Committee. We have not addressed each and every suggestion contained within the 40 submissions. In the case of many of the suggestions made in the submissions, it is our view that the Committee should appropriately consider the issues. However, we would be happy to respond to any specific issue not canvassed in our submission, should the Committee wish us to do so. Set out below is a brief response to the main issues of concern – as we see them - that were outlined in specific submissions.

Feedback to complainants and monitoring the outcome of complaints

In section 3.1, we have provided specific information about how we monitor agency implementation of our recommendations arising from investigations and reports to Parliament. As explained there, we closely monitor agency progress towards implementing recommendations until we are satisfied that the issues that we have identified are resolved.

In the same way, we carefully monitor the outcome of individual complaints that we have oversighted - including those where there have been agreements reached to resolve the complaint.

We note also that the Act encourages matters to be resolved locally and it is our view that this is an appropriate way forward in the vast majority of cases. Where matters are handled or resolved locally - that is directly between the consumer of the community service and the agency concerned - service users, advocates and others are able to contact us for assistance if they remain dissatisfied with the outcome of their complaint or where they believe that an agreement that was made to resolve the complaint, has not been met.

With regard to feedback to complainants, it is our policy to keep complainants informed about what we are doing in relation to their complaint, unless there is a valid reason not to do so. In practice this means that we will usually provide the complainant with a copy of our written inquiries of service providers and other correspondence, or at least provide verbal advice by telephone to explain the inquiries that we are making.

It is also Ombudsman policy to update complainants at key points of the complaint process wherever possible, such as the likely timeframe for assessing the complaint, when we have received documents we requested from the agency involved, and any reasons for delay. Once a decision about the complaint is made, we advise the complainant of our decision in writing.

Where we receive a complaint that relates to a visitable service and the OCV is not the complainant, our policy is to let the relevant OCV know that the complaint has been received, to inform their visiting. In this situation, we are required to consider what information about the complaint is appropriate and relevant to provide (to the OCV). In practice, we will usually also seek the OCVs' views at this point about the circumstances of service receivers, where we consider that this information is relevant to the complaint.

Section 3.3 of this submission provides detailed information about the findings of our client satisfaction review. As is outlined above, 74% of complainants said that we dealt with their complaint in a reasonable timeframe, 70% said that actions and decisions about their complaint were adequately explained to them and 65% felt that they were kept informed about the progress of their complaint.

Throughout 2007, and following on from the client satisfaction review and our own reviews of particular complaints, we identified complainant feedback as a priority focus and we have introduced a range of internal processes to ensure that staff provide a high and appropriate level of feedback to complainants. This will be discussed in further detail below.

Reporting of our work

As we noted in our submission to the Committee concerning the stakeholder review, it is important to acknowledge that the merger of the CSC with this office meant a shift in terms of our capacity to disclose information.

In our submission concerning the stakeholder review, we noted:

> *Section 34 of the Ombudsman Act prevents disclosure of any information obtained by the Ombudsman unless the disclosure is made in a limited number of specified circumstances. One such circumstances relates to disclosing information 'for the purposes of discharging our functions' under CS-CRAMA. While this exception to the secrecy provisions does allow this office to engage with the sector concerning aspects of our work, it is fair to say that the extent of our public disclosure of issues does not accord with what many advocacy bodies desire.* [66]

However, while there are clear limits on our capacity to disclose information, the Act does enable us to release final reports in connection with the exercise of a number of our functions. In this regard, it is important to note the range of matters on which we have reported publicly since the stakeholder review. These include our annual reports, Report of Reviewable Deaths in 2006 - volumes 1 and 2, special reports to Parliament such as our domestic violence report and our report *DADHC: Monitoring standards in boarding houses*, other documents such as our *Family Support Services Complaint Handling Review* report, discussion and issues papers such as our *Submission to the Review of the Children and Young Persons (Care and Protection) Act 1998*, and our paper concerning *Care Proceedings in the Children's Court*. All of these reports and

[66] NSW Ombudsman Submission to the Parliamentary Joint Committee, June 2006, page 5.

papers are available on our website. In other instances we release our final report to a limited audience of agencies (although in this sense it is not a public release), an example of which is our review report on the *Review of Children and Young People in out-of-home care residing in SAAP*, in 2006.

We also provide a range of information to the sector through our community education, information and awareness activities and the various meetings and roundtables that we attend.

In section 5 of this submission we have provided comments for the Committee's consideration, on possible amendments to the legislation with regard to our reporting powers.

Our work in the disability area

We agree with IDRS' observation that the formal complaints we receive about accommodation and support services for people with an intellectual disability cannot reflect the true number of issues needing to be resolved. We also agree that people with an intellectual disability are a particularly vulnerable group of consumers, and that there are often many barriers to people with intellectual disabilities making a complaint.

We have provided detailed information about the range of education, information and awareness activities that we have undertaken throughout 2007 and have planned for 2008. Many of these activities have specifically been designed to target people with disabilities, their carers and advocates and disability service providers. We have also focused on making our communication and resources more accessible for all people - including people with an intellectual disability - through the development of 'easy English' resources. We have also planned a major upgrade of the Ombudsman website and resources to meet international standards of accessibility. These measures will assist in continuing to increase the level of public recognition of our role, including in the disability area.

That being said, as outlined in our annual report, approximately one third of the formal complaints that we received in the 2006 - 2007 reporting year related to disability services - either disability accommodation services, or other support services for people with a disability and older people, funded or provided by DADHC. It is also worth noting that the vast majority of complaints concerning disability services – as in other areas of our community services jurisdiction – do not warrant formal investigation. Instead, consistent with the provisions of the Act, we attempt to resolve most of these complaints.[67].

Our 2006 - 2007 annual report[68] outlines some of our work in the disability area. To update the Committee on our work in this area since that time, the following is a brief outline of some recent developments and our plans for work in this area in 2008:

---

[67] See section 3.2 for further information about our resolution rates for complaints.
[68] pages 87 – 91.

- In January 2008 we finalised two investigations concerning the adequacy of the response of DADHC and the Hunter New England Area Health Service to the critical health issues of two people living in supported accommodation.
- We have just commenced an investigation into the conduct of DADHC, a non-government service provider, Hunter New England AHS and North Coast AHS, in relation to a man who committed suicide while a resident with the non-government service. He had been in contact with the criminal justice system and therefore DADHC's Criminal Justice Program was also involved.
- We are about to commence a project concerning DADHC residential centres, examining how well they meet the needs of individual residents. The project will involve all nine DADHC-operated residential centres, and will examine and audit the circumstances of approximately 60 residents.
- In order to respond to concerns raised with us about DADHC's re-development of institutional accommodation and the development of new accommodation models, we have recently obtained a legal opinion from senior counsel about the compliance of various accommodation models with the provisions of the *Disability Services Act 1993*. We specifically sought advice about:
    - whether the maintenance of institutions, or their redevelopment, can comply with the DSA
    - any particular challenges that would need to be met in order for compliance with the DSA to occur, and
    - the provisions of the DSA that concern 'transition plans' for services which did not comply with the DSA at the time of its introduction.

  We received this advice in December 2007 and recently held initial discussions with DADHC about the advice.
- The Reviewable Disability Deaths Team is commencing a project that examines issues for people with Down syndrome who also have dementia. This project will involve a research component, as well as review of the deaths of people with Down syndrome and dementia who lived in care.
- Since our investigation report on the Senior Officers' Group on People with Intellectual Disability and the Criminal Justice System in December 2004, we have been monitoring the progress of the SOG. We have received several progress reports that indicate that overall, progress has been slow. We are currently analysing the information received during the three years since the report, and deciding how we will report on our concerns.
- With regard to DADHC's implementation of the Aboriginal Policy Framework and Consultation Strategy.[69]
- We are currently undertaking a scoping project in relation to disability services/programs in our jurisdiction, to gain a more comprehensive overview of our disability jurisdiction and in particular, any areas that we may need to prioritise in our future work.
- We also support the work of the OCVs as is reported each year in our annual report. For example, in the 2006 – 2007, we reported approximately 2600 visits to adults with a disability in residential care.[70]

---

[69] See section 3.5.3 of this submission for further detail.
[70] See page 96 2006 – 2007 annual report.

Comments about OCV issues

With regard to the appointment of community visitors, it is important to note that OCVs can be appointed for two periods totalling six years. There are also times in which, due to changed circumstances, OCVs resign from the role. The timeframe for recruitment, appointment, induction and commencement is around twelve months.

Currently, the Office undertakes a six monthly review of OCV numbers based on a range of factors. These include, but are not limited to: location, types of services, available resources and feedback from Visitor consultation.

In 2006-07, the Office commenced the biannual recruitment of OCVs. This targets five regions of NSW with identified need for increased Visitor numbers. These were: metropolitan Sydney, Central Coast/Hunter, Illawarra, Far North Coast and Western NSW.

We held information sessions in all those regions for approximately three hundred interested community members. We received around 180 applications and interviewed 45 people. Applicants were assessed on their understanding and commitment to the sector areas; their ability to identify and resolve issues; and experience in the sectors they applied for. Our OCV information material indicates that preference will be given to people who have an Aboriginal or CALD background.

In December 2007, we recommended 12 applicants for appointment to the Minister as required under s.7 of CS-CRAMA.

In regard to recruitment of OCVs to meet specific needs, we try to recruit Aboriginal visitors or visitors with a CALD background. To assist OCVs in their work, we have also developed practice guidelines in regard to residents from CALD and ATSI communities and we offer training on related issues.

The Ombudsman allocates most services two visits per annum. The allocation of visits is higher to services for children and young people, and to services with many residents, such as large, congregate care institutions and boarding houses. From time to time, OCVs identify services that require extra allocations of either visits or hours of service.

As was reported in our 2006 – 2007 annual report, we have engaged an independent contractor to develop data classification systems, in order to better record and report on disability and out-of-home care issues identified by OCVs.

When developed, the OCV data classification system will:

- Improve the consistency of OCV reports about service issues.
- Introduce a risk prioritisation framework, enabling OCVs to identify and report service issues that:
    - impact the immediate safety, care or welfare of residents of visitable services, requiring urgent action by services

  - result in a potential risk to the safety, care or welfare of residents, requiring prompt action by services
  - affect the quality of life of residents or relate to service's systems, including policies, procedures, staff training, etc, requiring remediation over time by services.
- Enable OCVs to report service issues relating directly to the disability and out-of-home care service standards, providing opportunity to inform the accreditation and monitoring activities of DADHC, through its Integrated Monitoring Framework (IMF), and the Office of the Children's Guardian (OCG).
- Enable analysis and reporting about service issues and trends, to assist targeting of limited OCV resources to services where high needs are identified; reporting about trends and patterns in service issues to DADHC, the OCG and services; and enhance public reporting.

Engaging with consumers

This submission contains detailed information about an extensive range of activities undertaken by this office to engage the community and individual consumers, including our community education, information and access and awareness activities, our complaint handling work, our audits of indigenous issues, community meetings and consultations and our proactive project work.

When we met with NCOSS, they encouraged us to undertake rural visits and we have responded accordingly. We have benefited from the advice provided by NCOSS and other peaks over the years and we will be keen to have further discussions with them about this issue in the future.

5. The terms of the legislation

The purpose of the Committee's review of the Act is to determine whether the policy objectives of the Act remain valid, and whether the terms of the Act remain appropriate for securing those objectives.

It is our view that the policy objectives of the Act continue to remain valid and appropriate.

In this section of our submission, we have outlined some suggestions for the Committee's consideration concerning the terms of the Act and possible areas for legislative change. These areas concern specific problems or impediments associated with certain terms of the Act, however while detailing these matters below, it is our view that the broad principles of the Act remain valid.

The main areas that this office would like the Committee to consider concern:

- Official Community Visitors (Part 2)
- our reporting powers, and
- Reviews of Deaths (Part 6).

We have also provided a brief response to certain issues raised in the submission by the Children's Guardian.

5.1 Part 2 of the Act: Official Community Visitors

Power of entry and inspection of records

As the Committee is aware, OCVs are not Ombudsman staff and therefore they do not have the powers of entry to premises provided by section 17 of the *Ombudsman Act*. Section 19 of the same Act also provides for an offence of obstructing the Ombudsman, which again only applies to Ombudsman staff.

The functions of OCVs are detailed in CS-CRAMA under section 8 (1). OCVs may:

- at any reasonable time enter and inspect a place;
- confer alone with a resident or staff;
- inspect any document held at such place which relates to the operation of a visitable service;
- provide the relevant Minister and Ombudsman advice or reports on matters related to the conduct; and
- exercise any other function as prescribed by the regulations.

A number of situations have arisen in our work that have highlighted some weaknesses in the legislation, with regard to the potential enforcement of OCV's access and entry powers and also the power to inspect documents. This has particularly been the case in the licensed residential centres (LRC – boarding houses).

To assist OCVs in performing their functions under the Act, the Committee may wish to consider whether the legislation should be amended to include sanctions for

obstructing, hindering or restricting OCVs in the exercise of their functions. Section 37 (1) of the *Ombudsman Act* provides such a sanction in relation to Ombudsman staff. Should sanctions of this kind be introduced through relevant legislative amendments, we would need to develop appropriate guidelines with the OCVs to ensure that the legislative changes were accompanied by appropriate and consistent practice.

Extent of our jurisdiction

It is our view that there is currently a lack of clarity around the definition of a "visitable service", as set out in section 8 (6) (a) of the Act.

Section 8 (6) states:

> *In this section:*
>
> ***visitable service** means:*
>
> *(a) an accommodation service provided by the Department of Community Services or the Department of Ageing, Disability and Home Care, or by a funded agency where a person using the service is in the full-time care of the service provider, or ...*

However the Act contains no definition of the term "accommodation service" or "full-time care".

In June 2006, we sought senior counsel's advice about our visitable service jurisdiction and in particular, the extent of our jurisdiction and the meaning of "full-time care".

In particular, we sought advice about whether the meaning of "visitable service" extended to a range of situations including:

- The private homes of foster carers.
- The private homes of service receivers who are receiving full-time care in their own homes.
- The private homes of staff, employed or funded by DoCS, DADHC or an agency funded by DoCS or DADHC, where the staff are providing full-time care to service receivers in the staff member's home.
- The private homes of individuals who have entered into a contract with DoCS, DADHC or an agency funded by DoCS or DADHC, where these contractors or sub-contractors are providing full-time care to service receivers in the contactor's home.
- Cluster home arrangements where individuals with high needs have their own accommodation with support from centralised staff who reside on site.

We also sought advice about what constitutes "full-time" care.

We provided the following background information to senior counsel:

> ***Services currently visited***
>
> *The services currently visited by Official Community Visitors (OCVs) include out-of-home care services for children and young people provided by a designated agency (including DoCS) under the Children and Young Persons (Care and Protection) Act 1998 and residential accommodation services for adults (and children) with a disability under the Disability Services Act 1993.*
>
> *At present OCVs only visit out-of-home care (OOHC) services provided by DoCS or a funded agency in the form of group home accommodation or similar. This is accommodation provided in a home in the community where DoCS or the funded agency either owns or rents the accommodation and carers are on-site or available 24 hours a day when the resident is at home or a substantial part of the day.*
>
> *The accommodation services currently visited by OCVs are typically group home types of accommodation and large residential centres that are either owned or leased by the department or the funded agency.*
>
> *Visitors do not currently visit private homes such as the private homes of foster carers, or of people with a disability who are receiving care and support in their own homes.*
>
> *Disability accommodation services are often provided in the form of a group home or a large residential centre (such as DADHC's Metro Residences at Westmead (formerly Marsden), Rydalmere and Lachlan centres).*
>
> *The types of out-of-home care services currently visited by OCVs are also in often in the nature of a group home or a larger accommodation centre where children reside cared for and supported by staff employed by the agency (ie DoCS or a funded agency).*
>
> *The group home model of accommodation is accommodation – usually a free-standing house – in the community where a group of between 2 to 6 people live supported by staff who are employed to provide care and support for the residents – either 24 hours a day 7 days a week or for a lesser period (eg while the residents are at home).*
>
> *Large residential centres are in essence, institutional accommodation. Care and support are provided under the medical model of care and carers are usually qualified nursing staff. It is often the case, that people with disabilities that have high and complex needs are accommodated in large residential centres.*
>
> *The nature of accommodation services provided can range from those that provide minimal support to those that provide care and support 24 hours a day,*

7 days a week. An example of a minimal support service is a block of units where 6 to 7 residents live supported by one or more carers who provide support to all of the residents (that is, no live in support provided in each unit – care and support is shared). Residents of such a service would be relatively high functioning. An example of a 24/7 supported service is a high needs unit at the Lachlan large residential centre (operated by DADHC), where residents have high and complex needs – including significant disabilities and complex medical needs. In this case it is essential that staff are on duty 24 hours a day, 7 days a week – nursing staff and/or other disability workers work round the clock to provide the care and support for these residents.

Current criteria for determining whether a service is 'visitable'

For the purpose of determining whether a service is visitable or not, this office uses the following criteria:

(a) Is the service an accommodation service that provides staff support for at least 20 hours a week?

(b) Are the residents in long term (ie more than 2 months) care?[71]

(c) Does the service provider own or rent the building?

(d) Is the service provided or funded or licensed by DADHC or DOCS.[72]

We also noted the changing landscape of accommodation service provision – particularly in the disability area – and noted that the introduction of flexible and innovative models of accommodation arrangements have raised questions about whether particular services remain visitable – or will remain so in the future.

Some examples of such arrangements might be a situation where:

- A house is rented (or purchased) in the name of one or more of the residents. That is, the residents or service receivers are the tenants under a Residential Tenancy Agreement (or owners). Carers employed by the funded agency, provide full-time support to the residents (while they are at home) in their own rented home.
- The family of a resident purchases a house where their family member lives along with another person or persons with a disability. Carers employed by DADHC or a funded agency provide full time support to the residents in this home.
- Staff are employed by a funded agency to care for service receivers in the staff's member's own home.
- Staff employed by a funded agency are requested by the agency to rent accommodation in the staff's member's name – and the staff member will then reside in this accommodation with the service receivers that they are caring for.

[71] Points (a) and (b) constitute this office's working definition of a person being "in the full time care" of a service provider.
[72] Extracted from our Brief to advise.

- Individuals enter into contracts with a service provider to provide accommodation and care to specified service receivers – these may be children or adults with a disability. Often such accommodation and care is provided in the contractor's own home.
- A person enters into a contract with a funded agency to reside with the service receiver in the service receiver's own home and provide care and support for that person on a full time basis.

As background information for our request for an advising about the meaning of the term "full-time care", we noted:

> *From the legislation, it is not entirely clear what "full time care" means and, as stated above, this term is not defined in the Act. For instance does 'full time care' mean that the care must be provided 24 hours a day, seven days a week, or does less care satisfy the definition? Would care constituting an average of 20 hours per week (which may be supplemented by an on-call service when staff are not there) constitute full time care?*
>
> *In discussions with OCVs, a number of visitors have expressed the view that a person with a disability who receives 20 or more hours of accommodation support would not be able to maintain themselves and their tenancy without this level of support. That is, this level of support is necessary for the person to be able to live in the community – the implications being that the person is not capable of living independently.*[73]

With regard to disability accommodation, we noted also the operation of the Disa*bility Services Act* - a principle of which is that no single organization providing services, should exercise control over all or most aspects of the life of a person with a disability. This means that service receivers will typically receive services from more than one service provider.

The crux of the advice that we received was that senior counsel thought a "visitable service" was one where board and lodging is provided to an individual user who occupies that bed or uses that lodging and no other provider is responsible for the care of that person. This would include respite or short-term care.

If this advice is correct, a number of models of care would be outside the visitable service jurisdiction that arguably Parliament may have intended to be within jurisdiction. An example is a situation where a service provides 24 hour a day support to people living in group homes where the (residential tenancy) lease is in the names of the service receivers and in that sense, the service is not providing the accommodation.

The advice would also suggest that a number of private home situations – for example the situation where a service receiver receives full time care in the private home of a staff member employed or funded by DoCS or DADHC, or an agency funded by either department – fall within the visitable service jurisdiction.

---

[73] extracted from our Brief to Advise.

It is this office's view that there would be benefit in Parliament considering the sorts of arrangements that are considered as appropriately falling within the visitable service jurisdiction, having regard to the changing landscape of service provision.

We note that a number of submissions have called for an expansion of our OCV jurisdiction. Such an approach would allow for the consideration of the issues raised in those submissions.

5.2 Our reporting powers

A number of the submissions called for greater reporting of our work.[74] We have a number of important community services functions that are contained in section 11 of the Act. However, at present, a number of these functions do not have a reporting power linked to them under the Act. These include our functions contained in section 11 (1):

> *(c) to monitor and review the delivery of community services and related programs, both generally and in particular cases,*
>
> *(d) to make recommendations for improvements in the delivery of community services and for the purpose of promoting the rights and best interests of persons using, or eligible to use, community services,*
>
> *(e) to inquire, on his or her own initiative, into matters affecting service providers and visitable services and persons receiving, or eligible to receive, community services or services provided by visitable services.*

On the other hand, functions such as:

> *(l) to review the situation of a child in care or a person in care ...*
>
> *(m) to review the systems of service providers for handling complaints under section 13,*
>
> *(n) to review the causes and patterns of reviewable deaths under Part 6 and identify ways in which those deaths could be prevented or reduced,*

do have clear reporting powers associated with them.

The work that we do in carrying out our community service functions is clearly of broad interest, and in many cases, the wide dissemination of our work would be of considerable benefit to the sector. The submissions also highlight that the sector is keen for our work to be reported more broadly.

We have the power under the *Ombudsman Act* to make public reports in relation to all of our work – for example, by way of a special report to Parliament. However, special reports to parliament are not always the most appropriate way of promoting our community services work. For example, while the subject matter might be of broad

---

[74] see page 30-31 of this submission for background.

sector interest, it may not warrant Parliament's consideration.

There are strong grounds for keeping the work we carry out in response to individual complaints under the secrecy provisions provided by section 34 of te *Ombudsman Act*. Generally, complaints from individuals should be able to be made and resolved in private. Not only does this protect individual complainants, but it also allows agencies the subject of complaints to be more resolution focused in their response to complaints. However, if an individual complaint warrants public exposure then the Ombudsman is entitled to make a special report to Parliament.

On the other hand, when exercising our other functions under CS-CRAMA, we are generally examining issues of broad community interest. For this reason, we would support the Committee considering whether the Ombudsman should be given greater discretion to release information about our work, when exercising these other functions, both during and at the completion of matters.

5.3 Aspects of the legislation concerning Part 6: Reviews of Deaths

Application of section 35 (1) (f) and (g)

Section 35 (1) (f) of the Act provides for the review of the death of:

> *...a person (whether or not a child) who, at the time of the person's death, was living in, or temporarily absent from, residential care provided by a service provider and authorised or funded under the 'Disability Services Act' 1993 or a residential centre for handicapped persons ...*

The term 'residential care' is not defined in the Act, however a 'residential centre for handicapped person' is defined under section 4, and refers to a residential centre licensed under the *Youth and Community Services Act 1973,* namely a licensed boarding house.

This office has understood the term 'residential care provided by a service provider' to mean accommodation provided by a service provider - owned or leased in the name of the service. Therefore if the person was in accommodation in their own name, we have generally considered that their death is not reviewable.

It may be helpful for the term 'residential care provided by a service provider' (under section 35 (1) (f)) to be defined in the Act, to avoid uncertainty regarding what is, and what is not, 'residential care'.

Section 35 (1) (g) provides for the review of the death of:

> *a person (other than a child in care) who is in a target group within the meaning of the Disability Services Act 1993 who receives from a service provider assistance (of a kind prescribed by the regulations) to enable to person to live independently in the community.*

This section concerns the reviews of deaths of people with disability who are receiving assistance within the community to live independently - as distinct from

people in 'residential care', in section 35 (1) (f).

However, there is currently no service provider assistance that is prescribed within the regulations. This means that it is somewhat unclear how section 35 (1) (g) is to operate.

It is our view that Parliament should clarify the types of 'service provider assistance' that it is intended that section 35 (1) (g) should encompass.

Section 36 (1): Systemic review of deaths

Section 36 (1) of the Act outlines our functions with regard to the systemic review of deaths of children at risk of harm, children in care of other persons in care. It is our view that this very important aspect of the legislation, which explains our function with regard to reviewable deaths, could be made clearer by highlighting the objective of our work.

In this regard, the Committee may wish to consider whether re-drafting of the section may be beneficial. To assist the committee, set out below are suggestions for re-drafting section 36 (1) (b) and (d).

Possible re-drafting of 36(1)(b):

- To formulate recommendations as to policies and practices that may be implemented by government and service providers to assist in the prevention or reduction of the deaths of children at risk due to abuse or neglect; children in care, correctional centres, detention centres or lock ups; and persons in residential care,

- To formulate recommendations as to policies and practices that may be implemented by government and service providers to assist in minimising risks to the safety and welfare of children at risk due to abuse or neglect; children in care, correctional centres, detention centres or lock ups; and persons in residential care.

Possible re-drafting of 36 (1) (d):

- To undertake research or other projects for the purpose of formulating strategies to assist in reducing or removing risk factors identified through review of the deaths of children at risk due to abuse or neglect; children in care, correctional centres, detention centres or lock ups; and persons in residential care.

Section 38 (1): Provision of information and assistance to the Ombudsman

It is our view that there is currently some ambiguity associated with our power to obtain documentation from members of the Child Death Review Team, necessary to perform our reviewable deaths function.

We note that section 38 (1) provides that certain specified persons – including the Commissioner for Children and Young People – have a duty to provide us with full and unrestricted access to records that are under that person's control, to which we may require access for the purpose of exercising our reviews of deaths function under Part 6.

We note also that pursuant to the *Commission for Children and Young People Act 1998,* the Child Death Review Team is a committee of the Commission for Children and Young People, of which the Commissioner for Children and Young People is the convenor (section 45 C).

It is our view that it should be placed beyond doubt that members of the Child Death Review Team have a duty to provide the Ombudsman with information and assistance relevant to our Part 6 function.

This might occur by introducing to section 38 (1), a subsection (i) - specifying 'members of the Child Death Review Team'. Such an amendment would reflect the drafting of section 39 of the Act – concerning information to be provided by Ombudsman' – which separately lists the Commissioner for Children and Young People and the Child Death Review Team as bodies which the Ombudsman may provide information or copies of documents to.

An alternate course of action might be to amend section 45 U (c) (iv) of the *Commission for Children and Young People Act 1998.* That section concerns confidentiality of information and indicates that the Convenor of the Child Death Review Team may disclose information for the purpose of:

> *(iv) providing information to the Ombudsman concerning the death of a child that is relevant to the exercise of any of the Ombudsman's functions...*

This section could be amended so that the Convenor of the Child Death Review Team may disclose information relevant to our death review function generally, rather than only concerning the death of a particular child.

Reviewable deaths annual report

Section 43 (1) of the Act requires the Ombudsman to prepare an annual report on our work under Part 6 for the preceding 12 months. Section 43 (2) specifies what our annual report is to include.

We note that the legislation is neither prescriptive nor limiting, allowing for a range of approaches to annual reporting. This is a positive aspect of the Act, and we do not seek any change in that respect. However, we would like to outline to the Committee some of our future plans for our annual reporting.

Over five years of reviewing deaths, this office has released four annual reports, as required by section 43(1) of CS CRAMA. Since 2006, the reports have been released in two separate volumes: Child deaths and disability deaths.

The focus of the four annual reports has been to present and analyse broad systemic issues in child protection and disability services that we have identified through our reviews. The issues identified have remained largely consistent from year to year.

The systemic recommendations that have arisen from our work will take time to implement. In order to reflect the reform environment in both DoCS and DADHC, until agency actions are implemented, recommendations are updated or re-focused each year to ensure they are current and reflect the work agencies have done.

In forthcoming years, we intend to focus strongly on how agencies are responding to the systemic issues identified through reviews over the past four years, and to the subsequent recommendations we have made. Additionally, we will explore in greater detail specific issues or areas of concern that warrant close attention. For example, in 2008, our child deaths annual report will focus on the abuse and neglect deaths of children who were not known to DoCS. Our disability deaths annual report will give close consideration to a vulnerable group identified in our 2007 report, people with Down Syndrome and dementia. It is our view that this approach will add further value to our work.

5.4 Issues raised in the submission of the Children's Guardian

The submission of the Children's Guardian focuses on two main areas – the relationship between the jurisdictions and the information exchange arrangements between this office and the Children's Guardian. The following comments relate to the Children's Guardian's submission concerning information exchange arrangements.

As has been noted in the submission, this office entered into a Memorandum of Understanding (MoU) with the Children's Guardian in 2004, which principally concerns the exchange of information. We have agreed to a process to review the current MoU.

The Children's Guardian has made suggestions for legislative change to further facilitate information sharing. To assist the Committee in its consideration of the issues raised by the Children's Guardian, we make the following comments.

This office can, and does, refer complaints information to the Children's Guardian. The updated Memorandum of Understanding will further facilitate this process.

We have noted that the Children's Guardian is keen to receive information from OCV reports prepared by our office. The Children's Guardian has noted that OCV information would be useful in determining whether to accredit an agency, or whether to attach particular conditions to an accreditation.

The submission noted:

> *While the Children's Guardian has powers under the 1998 Act that would enable it to require designated agencies with OCV Reports, it would be preferable if the Ombudsman were to provide the Children's Guardian with*

> *appropriate information from OCV reports to place that information in proper context.*
>
> *Dealing with the Ombudsman, rather than directly with individual OCVs, would provide for a consistent approach as to how OCV information should be interpreted and how it might appropriately be used in Children's Guardian decision making.*[75]

On this basis, the submission asks the Committee to consider amending the Act to allow the Ombudsman, at our discretion, to provide information collected by the OCVs to the Children's Guardian, where that information is relevant to their functions.

It is our view that this is a matter that should appropriately be considered by the Committee. However, we note that the Children's Guardian can currently build access to OCV Reports into its accreditation processes by requesting them from the agencies involved. The Committee may consider that obtaining OCV reports from the agency concerned may provide a greater level of fairness to the agency, as they would have an opportunity to respond to any issues or concerns raised by an OCV, particularly where that information may impact upon their accreditation.

It is also important to consider the possibility that the provision of OCV material to the Children's Guardian could impact on the manner in which OCVs report and the nature of the issues raised in those reports, particularly if OCVs were aware that their reports could adversely impact on accreditation decisions.

[75] Submission of the Children's Guardian, 10 September 2007, page 14.

Attachment 1.

Concerns underlying recommendations	Relevant agency developments and achievements
Improving the quality of DoCS child protection work	DoCS has implemented a quality assurance project that will include an audit of each of its local offices over a four-year period to 2010.
Improving initial risk assessment	DoCS reviews the quality of work done at the central intake Helpline.
Improving secondary risk of harm assessment	DoCS has implemented a revised policy on secondary risk of harm assessment and provided relevant training to staff.
Improving responses to risk arising from neglect	DoCS has implemented a new neglect policy and provided relevant training to staff.
Decreasing numbers of cases closed without comprehensive assessment due to competing priorities	DoCS has endorsed intake assessment guidelines that require the prioritising of high risk cases for secondary assessment.[76]
Improving responses to child protection reports from police	NSWPF are reviewing operating procedures for responding to domestic violence and child protection.[77] DoCS and NSWPF are working on a joint project to improve risk assessment procedures.
Improving responses to cases involving parental substance abuse	Child protection legislation has been amended to include Parent Responsibility Contracts. These are being used in selected DoCS offices that are also piloting a Parental Drug Testing policy. DoCS is revising training to improve staff expertise on carer substance abuse. NSW Health is working to improve services to women who use drugs during pregnancy. DoCS and NSW Health have established a protocol on information exchange regarding DoCS clients on opioid treatment. The agencies are jointly reviewing methadone-related child deaths. NSW Health has upgraded its systemic response to children presenting with methadone poisoning.
Better response to prenatal	Child protection legislation has been amended to allow exchange of information regarding an unborn

[76] The intake assessment guidelines are finalised and implementation in discussion.

[77] Police have foreshadowed a December 2007 launch of child protection policy.

reports	child, and to expand the definition of a child at risk to include prenatal reports in certain circumstances. DoCS has consulted NSW Health and developed a draft policy on responding to prenatal reports.
Improving responses to Aboriginal children and young people	DoCS has published its *Aboriginal Strategic Commitment 2006-2011* outlining plans to provide better services to Aboriginal clients.
Improving responses to adolescents	DoCS is establishing an internal panel to review the suicide and risk-taking deaths of young people known to DoCS.
Better interagency child protection responses	A new edition of the *Interagency Guidelines for Child Protection Intervention* was published in 2006. The effectiveness of interagency practice under the guidelines is to be evaluated during 2007 and 2008. DoCS, NSWPF and NSW Health have reviewed the work of Joint Investigation Response Teams and revised criteria for reports of physical abuse. DoCS has memoranda of understanding with agencies including police, NSW Health and the Department of Education. An Anti Social Behaviour Case Coordination Framework is being rolled out as part of an Anti Social Behaviour Pilot Strategy, with a focus on partnerships for improving and coordinating strategies to *'reduce risks to, and anti social behaviours of, children and young people requiring multi agency intervention.'*
Improving DoCS data collection and reporting	DoCS resumed quarterly data reporting in 2005. [78]

[78] We have raised concerns about lack of capacity to fully report outcomes of DoCS work in the first three reports. The absence of aggregate information about the outcome of 47.1% of reports referred to CSC/JIRT in 2004-05 is notable.