NSW Ombudsman reports (www.ombo.nsw.gov.au)		
Report/submission	***Background***	***Key findings/recommendations***
Work with a specific focus on Aboriginal people and communities		
OCHRE Review Report, October 2019	Since July 2014, we have had legislative responsibility under Part 3B of the *Ombudsman Act 1974* for monitoring and assessing designated Aboriginal programs. The first program we are responsible for oversighting is OCHRE, the NSW Government's plan for Aboriginal affairs, which was launched in April 2013. Since we began monitoring OCHRE we have made over 85 visits to 37 different communities across NSW.	Our report included a focus on accountability arrangements and how the NSW public service should be strengthened to better serve Aboriginal people. In particular, we highlighted how accountability arrangements for Aboriginal affairs across NSW Government agencies may be simplified and strengthened, and how the NSW public sector should be supported and authorised to work differently with Aboriginal communities, as required by OCHRE. The Government has supported or supported in principle 68 of the 69 recommendations.
Special report to Parliament: Fostering economic development for Aboriginal people in NSW, 2016	This report was intended to inform the development of the Aboriginal Economic Prosperity Framework. The recommendations in the Ombudsman's report were informed by over 10 years of working closely with Aboriginal people to resolve problems with government service delivery, in some of the most disadvantaged communities in NSW.	This report set out observations from our research and consultations with Aboriginal leaders and the business community. We set out what we believed were the key elements of the reforms required to achieve tangible success in developing Aboriginal economic capacity in NSW. These included building a strong framework for Aboriginal economic development and addressing the key barriers to Aboriginal people successfully participating in the economy.
Responding to Child Sexual Assault in Aboriginal Communities - A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, 2012	Justice James Wood, Commissioner at the Special Commission of Inquiry into Child Protection Services in NSW, recommended that the NSW Ombudsman be given specific authority to audit the implementation of the NSW Government, *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities* (a five year plan released in 2007).	This report outlined the findings and recommendations from our audit of the implementation of the *Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities*. The report focussed on the need to: • improve the capture and use of data in identifying and responding to 'at risk' children • improve staffing capacity in high need locations particularly in relation to key services such as, child protection, health and education • meet the demand for counselling for child victims and their families

	Part 6A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* provided that the Ombudsman must prepare and provide a report to the Minister for Aboriginal Affairs by 31 December 2012 on the audit of the implementation of the Interagency Plan. During the audit we conducted 495 separate meetings involving more than 2,000 people and regularly engaged with the Aboriginal Child Sexual Assault Ministerial Advisory Panel and members of the Coalition of Aboriginal Peak Bodies.	• provide better access to forensic medical examinations for children • improve the criminal justice response to child sexual abuse • provide effective, holistic treatment to all children who display sexually abusive behaviours • manage sex offenders in the community • support place-based service delivery to tackle disadvantage in high need Aboriginal communities.
Special report to Parliament: Addressing Aboriginal disadvantage – the need to do things differently, 2011	This report was one of three interim reports arising in the context of our role to audit the Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities. The timing of the report was in large part due to the NSW Government's decision to establish a Ministerial Taskforce on Aboriginal Affairs in August 2011. The Taskforce examined ways to improve the overall wellbeing of Aboriginal people, starting with strategies to significantly improve educational and employment outcomes. They also looked at the related issue of improving service delivery to Aboriginal communities and the accountability mechanisms needed to make this happen. We prepared the report outlining our findings and observations from our auditing work so far to help inform the Taskforce's deliberations.	The over-riding theme of this report was the urgent need to establish a stronger accountability framework for addressing Aboriginal disadvantage at a state-wide level, including: • strong leadership and governance arrangements • integrated decision-making at all levels about local service planning, funding and delivery to ensure resources are more effectively utilised • more rigorous and meaningful data collection, analysis and public reporting on progress made against key indicators at a local community and state-wide level • a statutory agency to provide independent scrutiny of the steps taken to implement the government's approach to addressing Aboriginal disadvantage and the outcomes achieved. Importantly, the report emphasised the need for government to build meaningful partnerships with Aboriginal communities and, in doing so, give practical recognition to Aboriginal people exercising responsibilities consistent with their right to self-determination. It also stressed the importance of taking bold approaches to the priority areas of education, building economic capacity, and protecting vulnerable children in Aboriginal communities.
Special report to Parliament: Inquiry into service provision to the Bourke and	In 2007 we received a complaint from the Brewarinna Aboriginal Community Working Party (ACWP) raising concerns about the adequacy of the response of Community Services to vulnerable children and their	This report examined the provision of community and child protection services in Bourke and Brewarrina, in particular, the adequacy of the response to vulnerable children in these communities. While the report focused on the experiences for the Bourke and Brewarrina communities, its

Brewarrina communities, 2010	families. We worked closely with the ACWPs in Brewarinna and Bourke, as well as local service providers and government agency staff to explore improved caseworker presence and service delivery in NSW. Other significant concerns about 'at-risk' families were raised with us, including from community leaders in Bourke and Brewarinna and we decided to inquire into and review the delivery of community services to these two communities. This report was published in the context of our audit responsibilities in relation to the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities.	recommendations were relevant to rural and regional communities across the State to rural and regional communities across the State. Our inquiry demonstrated that simply directing additional funds to more Aboriginal programs is not the solution. Rather, what is needed is to rebuild the service system to achieve a more targeted response to those individuals and communities most in need of assistance and support. Among other things, our recommendations focused on the need to: address chronic staff shortages in high need locations; build the capacity of the Aboriginal service sector; and develop an 'intelligence-driven' approach to child protection practice to identify those children and families most at risk. We also recommended establishing effective local leadership and governance arrangements to drive service improvements and measure ongoing performance.
Special report to Parliament: Improving service delivery to Aboriginal people with a disability, 2010	This review was carried out under section 11(1)(c) of *the Community Services (Complaints, Reviews and Monitoring) Act 1993*. Its objectives were to examine the practical initiatives taken by Ageing, Disability and Home Care (ADHC) to meet the goals set out in ADHC's Aboriginal Policy Framework and Aboriginal Consultation Strategy, and to assess whether these initiatives have resulted in better access for Aboriginal people with a disability to the services they and their carers need. Our findings and recommendations were informed by consultations with over 460 stakeholders.	Overall, our review confirmed that ADHC was strongly committed to improving outcomes for Aboriginal people. To build further on this commitment, we identified a number of areas where ADHC should focus its efforts, including: • raising awareness of services among Aboriginal people • consulting ore effectively with local Aboriginal communities to inform the planning and delivery of services • implementing a flexible service model • undertaking more robust assessment and monitoring of the willingness and ability of mainstream and Aboriginal organisations to provide services to Aboriginal communities • establishing an improved model of accountability. The three Western region directors of Community Services, Department of Education and Communities and the NSW Police Force who participated in our project saw firsthand the benefits of this approach. Their own joint analysis of the 48 children in our review helped to clarify risks and prompted them to work together to achieve a range of positive outcomes. They also: recognised the need for streamlined, effective and accountable governance

		structures; emphasised the benefits of agencies coming together to share select information on priority families; and indicated that the existing local governance structures to facilitate this type of work needed to be rationalised to overcome duplication and fragmentation.
Submission: Inquiry into the high level of involvement of Indigenous juveniles and young adults in the criminal justice system, 2010		The submission canvassed: • the importance of early identification of risk • police strategies to divert young offenders from the criminal justice system • alternative pathways for young people • young people in the adult correctional system • healing programs.
Review of the impact of Criminal Infringement Notices on Aboriginal Communities, 2009	In 2002 a Criminal Infringement Notice (CIN) scheme was introduced in 12 trial locations. The CIN scheme enables police to issue penalty notices to adults who appear to have committed a limited range of offences, mostly relating to minor incidents of offensive conduct, offensive language and larceny/shoplifting. Our report, *On the Spot Justice? The Trial of Criminal Infringement Notices by NSW Police* (2005), concluded that CINs were largely successful in providing police with an easy, additional way to deal with minor offences. We recommended changes, including measures aimed at reducing the risk of 'unintended and undesirable consequences such as net-widening', especially in smaller towns and those with sizeable Aboriginal populations. Following the trial, the CINs scheme was extended state-wide on 1 November 2007. Parliament required the Ombudsman to review the expanded scheme, including how the provisions impact on Aboriginal and Torres Strait Islander communities.	Our review found that CINs can divert petty offenders away from being arrested, charged and brought before the courts therefore there are diversionary benefits. There are also savings for police, courts and others involved in the judicial process. However, there are also risks associated with the use of CINs. These include risks of net increases in sanctions, in that some offenders may be issued with CINs in circumstances where previously they would have been warned or cautioned, risks that recipients might not court-elect or request an internal review despite having strong grounds to do so, and risks that recipients may simply ignore the penalty notice and become entrenched in the fines enforcement system – thereby incurring further debts, sanctions and an increased likelihood of becoming involved in secondary offending. Our review has found that these pitfalls are particularly acute for Aboriginal people. The number of CINs issued to Aboriginal people had grown significantly since the scheme was extended state-wide, with Aboriginal suspects accounting for 7.4% of all CINs issued, much higher than would be expected for a group that makes up just over 2% of the total NSW population. We also found that Aboriginal people are less likely to request a review or elect to have the matter heard at court, and that nine out of every 10 Aboriginal people issued with a CIN failed to pay within the time allowed, resulting in much higher numbers of these recipients becoming entrenched in the fines enforcement system.
Special Report to Parliament: The implementation of the	The Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal,	While we found evidence of good work to implement the JGOS principles in some areas and a large number of committed individuals, we found little

joint Guarantee of Service for People with Mental Health Programs and Disorders Living in Aboriginal, Community and Public Housing, 2009	Community and Public Housing (JGOS) was developed in recognition that people with mental health problems frequently experience difficulties accessing housing, disruption to tenancies and reduced capacity to maintain housing. For these reasons, mental illness has been identified as one of the typical pathways into homelessness. This report detailed the findings of a comprehensive, 18-month investigation into the implementation of the JGOS. Our findings and recommendations were informed by extensive consultations, interviews and surveys with over 460 stakeholders.	evidence to demonstrate that the JGOS was achieving systemic improvements and were unable to conclude that the overall implementation of the JGOS had been effective. We identified several weaknesses in the JGOS agreement and governance arrangements, including inconsistencies and a lack of accountability mechanisms and systems to support the effective implementation of the JGOS. We identified four key areas that would need to be addressed should the agencies decide to maintain the JGOS: the JGOS agreement and resources; the practical implementation of the JGOS; systemic issues that have impacted on implementation; and the JGOS governance and accountability arrangements.
Supporting the carers of Aboriginal children, 2008	A range of research activities informed the preparation of the report. This included: • surveys of 100 authorised carers of Aboriginal children • consultations with peak bodies • consultations with representatives from six Aboriginal out-of-home care services providers and two non-Aboriginal providers	This report examined issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them to provide quality care. The report also examined issues which specifically relate to Aboriginal children and the carers who take on responsibility for providing them with a home and healthy upbringing. The report included detailed observations and suggestions for improvement. The report highlighted the need for: • appropriate supports for carers • clear consultation processes • addressing deficiencies in the collection of data • developing, implementing and monitoring appropriate and consistent cultural support planning processes. In November 2007, the Special Commission of Inquiry into Child Protection Services in NSW was announced. The report was provided to the Commission of Inquiry for its consideration.
Special report to Parliament: Working with local Aboriginal communities – Audit of the implementation of the NSW Police Aboriginal	We audited 14 police local area commands across the state to look at how well police were implementing their NSW Police Aboriginal Strategic Direction. Consultation involved more than 1500 community members, representatives from over 300 government	This report was intended to inform the public and to provide guidance to police about the key issues they need to address to ensure ongoing improvements in Aboriginal-police relations. We also sought to acknowledge some of the better examples of police and Aboriginal leaders coming together in an attempt to improve their relationship and deal with some of the tough issues in their communities.

Strategic Direction 2003-2006, 2005	agencies and local area commanders, senior officers and specialist liaison officers from the commands we audited.	It was clear from our audits that there is a direct link between police building a strong relationship with the local Aboriginal community and successfully making inroads into reducing crime and Aboriginal people's contact with the criminal justice system. Further, that police cannot bring about change on their own. What is needed is a commitment from community leaders and all relevant government agencies to work together to come up with practical solutions to tackle crime and underlying social problems.
Report	***Background***	***Key findings/Recommendations***
Broader work with a strong Aboriginal focus		
Special Report to Parliament: Asbestos: How NSW Government agencies deal with the problem, 2017	Many people in Aboriginal communities live in dwellings constructed of fibro asbestos containing material (ACM). Some of those buildings are more than 50 years old, and many are in poor repair. In recognition of this issue, the report contained a chapter on Asbestos in Aboriginal communities.	We were unable to identify any studies into asbestos-related diseases in Aboriginal communities in NSW and concluded that research in this area may be warranted, given the amount of residual ACM within these communities, and the historic exposure to asbestos in mines and from various government building/demolition programs.
Discussion Paper: Public Interest Disclosures Act 1994 - Local Aboriginal Land Councils, 2017	Questions had been raised about whether Local Aboriginal Land Councils (LALC) fall under the *Public Interest Disclosures Act 1994* (PID Act). The discussion paper was published to clarify the application of the PID Act and, if necessary, assist the NSW Ombudsman and the Public Interest Disclosures Steering Committee to develop recommendations for legislative or administrative reform.	
Special Report to Parliament: NSW Ombudsman Inquiry into behaviour management in schools, 2017	This report examined the complex area of behaviour management of students in NSW schools. As part of this inquiry, we considered it important to examine some of the significant issues involved in meeting the needs of Aboriginal students who have a disability and/or additional support needs.	Chapter 6 of the report considered engaging Aboriginal students with behaviour support needs. This discussed: • risk factors associated with disengagement from school • Our previous recommendations about addressing school non-attendance and keeping children and young people engaged in education • Progress by the department to better engage and support Aboriginal students.
Submission: Inquiry into service coordination in		Key issues highlighted in this submission included:

communities with high social needs, 2015		• place-based models of service planning, funding and delivery are an integral part of improving the identification of, and response to, vulnerable families and high needs communities • the growing recognition that effectively identifying and responding to the needs of high risk families requires sophisticated and collaborative service practices, and a service system that drives such practices • the need to strengthen information sharing by agencies, particularly in relation to child protection risks.
Policing intoxicated and disorderly conduct: Review of section 9 of the Summary Offences Act 1988, 2014	In 2014 the Ombudsman completed a review of the operation of the offence of continuing to be intoxicated and disorderly in public (section 9 of the *Summary Offences Act 1988).* This section provides for police to issue a person with an on-the-spot fine or charge the person for continuing to be intoxicated and disorderly after the person has already been given an opportunity to comply with a formal move on direction from police. An issues paper was also published in 2012.	The review found that the new powers impacted on vulnerable groups who are already over-represented in the criminal justice system. During the first 12 months of the new intoxicated and disorderly offence, 40% (196) of all fines and charges for this offence were issued to marginalised groups – mainly Aboriginal people and/or people who are experiencing, or who have a recent history of, mental illness. The report made 17 recommendations, with several aimed at strengthening NSW Police Force training and guidance for officers.
Review of a group of school-aged children from two Western NSW towns (Confidential report), 2012	In 2012 we finalised a confidential report after completing a review of a group of 48 school-aged children in two Western NSW towns. The review aimed to demonstrate how existing agency information holdings could be used to better identify and respond to children at risk. This review fed into our audit of the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities	The report found that in towns where resources are scarce and there are comparatively high numbers of vulnerable children and families, agencies need efficient and effective ways to collectively identify those at greatest risk. Information held by the NSW Police Force (NSWP) and Department of Education and Communities (DEC)– which identifies high-risk domestic violence offenders and victims, repeat young offenders and children at risk – and the ongoing tracking of school attendance and suspensions carried out at school level are examples of readily available 'analysis' which not only informs the day-to-day business activities of these agencies, but is essential to building a common picture of risk.
Submission of NSW Ombudsman: Wood Special Commission of Inquiry into	In November 2007, the NSW Government established the Wood Special Commission of Inquiry into Child Protection Services in NSW to undertake a review of the	We made submissions in relation to: • the Children's Court • Oversight agencies • Privacy and exchange of information

Child Protection Services, 2008	child protection system. We provided the Wood Inquiry with a number of submissions.	• Mandatory reporting • Out of home care • Assessment and early intervention and prevention • Young people at risk • Interagency cooperation – overcoming challenges to service delivery • Responding to issues of serious child protection and neglect in Aboriginal communities
Report	***Background***	***Key findings/Recommendations***
Work relating to death reviews		
Review of suicide clusters and evidence-based prevention strategies for school-aged children, 2019	The Child Death Review Team (CDRT) commissioned the Australian Institute for Suicide Research and Prevention to review existing research, and to examine existing strategies in NSW that aim to prevent youth suicide, and that are in place to reduce risk and promote healing after a suicide death. The report is under section 34H Community Services (Complaints, *Reviews and Monitoring) Act 1993.*	The CDRT reviewed the individual circumstances of a number of linked suicide deaths in regional NSW in 2015 and 2016. We determined that there was a need to understand more about risk factors that might relate specifically to cluster suicides, such as the role of social media, and what more might be done in prevention, and response. This report sets out what is known about suicide clusters among school-aged children, and examines current policy frameworks. The report finds that the prevention and postvention strategies in place in NSW for schoolchildren are in line with what is considered current best practice, and that NSW seems to be taking the right steps in this area. In terms of preventing suicide clusters, however, more research is needed.
The role of child restraints and seatbelts in passenger deaths of children aged 0-12 years in NSW, 2019	This report reviewed the deaths of 66 children aged less than 13 years who died as passengers in vehicle crashes in NSW between 2007-2016. The review was conducted by Neuroscience Australia.	The report concluded that just over half of the 66 children who died in crashes over the 10-year period 2007 – 2016 were not properly restrained in the vehicle. Moreover, the lack or inappropriate use of seatbelts or restraints played a primary role in the death of almost one-third of the children. In other words, many of the deaths could likely have been prevented if the children had been properly buckled up. Like many of our reviews, the report showed that the likelihood of death as a passenger was greater for Aboriginal and Torres Strait Islander children, children whose families lived in the most disadvantaged areas of the state, and children living in remote areas. The report made six recommendations, including that:

		• Regular monitoring of child restraint practices across NSW should be introduced, particularly in areas of socio-economic disadvantage and outside major cities. • Measures to increase restraint use should be developed and implemented. • Greater attention should be given to identifying and implementing measures to reduce misuse through restraint design and product standard requirements – and to removing barriers to vulnerable population groups accessing restraint fitting programs and services. • Current legislative controls over minimum restraint use should be maintained, alongside wider dissemination of information on best practice for restraining children – particularly children over the age of seven. Dissemination strategies must ensure these messages reach and are understood by those sectors of the community most in need. The recommendations have been endorsed and adopted by the CDRT and we will monitor how agencies progress their implementation.
Spatial analysis of child deaths in New South Wales, 2018	In 2016, we engaged the Australian Institute of Health and Welfare to undertake geospatial analyses of the 8,657 deaths of children that occurred in NSW between 2001 and 2015. This was to help understand the geographic distribution of child deaths in NSW, and how this may vary by cause of death and the characteristics of geographic areas.	The report found that overall, the child mortality rate in NSW has been in decline. Across the nearly 90 geographic areas analysed, the report finds that no area in NSW saw a significant increase in its child mortality rate over the period examined, and there was a significant decline in 18 areas. Additionally, the differences in mortality rates between areas has narrowed over time. These are reassuring findings confirming that the number and rate of child deaths is being reduced throughout NSW. The analysis also examined variations in child mortality by area level characteristics. The analysis enumerated the increased likelihood of a child dying in our state if they live in a disadvantaged area, and specifically, if they live in an area characterized by high poverty, low school engagement, overcrowded housing and childhood developmental vulnerability.
Childhood injury prevention – Strategic directions for coordination in New South Wales, 2017	A scan of childhood injury and disease prevention infrastructure in NSW was completed in 2015. The scan confirmed that there is a need for stronger leadership and coordination to deliver further improvements in childhood injury and disease prevention in NSW. This	The findings were a synthesis of issues identified through a rapid review of the literature and a series of expert stakeholder interviews. The literature review specifically focused on coordination mechanisms used within Australia and in several other countries where examples of advances in childhood injury prevention efforts were evident. This literature review was

	report (building on earlier work) explored strategic options for coordination in childhood injury prevention.	supplemented by a focused stakeholder consultation. Stakeholders were predominantly located across Australia but included several representatives from other countries perceived as leaders in the coordination of childhood injury prevention. The key components of a coordinated approach to childhood injury prevention include: • Policy leadership • Data and information systems • Research and knowledge translation networks • Coalitions, collaborations and partnerships.
Reporting of fatal neglect in NSW, 2016	The Australian Institute of Family Studies was contracted by the NSW Ombudsman to conduct a review of the definition and reporting practices of fatal neglect. The research project has three components: • a literature review and analysis of fatal neglect with a focus on definitions of fatal neglect and approaches of reporting fatal neglect in child death review reports, in Australia, and internationally • a review and analysis of the Ombudsman's reporting of neglect-related reviewable child deaths since 2002 • advice regarding strengths and weaknesses of current approaches to defining and reporting neglect related deaths and issues for consideration in the reporting of neglect-related deaths in the context of optimising strategies to prevent reviewable child deaths.	this review found that the NSW Ombudsman approaches to the review of fatal neglect within Reviewable Death Reports, and all child deaths in the CDRT reports are consistent with international best practice in the context of a prevention focused approach. However, in order to support the public health purpose of the reviews further, the following amendments could be implemented: • rather than identify deaths in the CDRT as due to neglect, report them in the context of preventability associated with modifiable risk factors • in the CDRT report of all child deaths prevention of deaths could be considered in terms of supervisory neglect and neglect through failure to provide a safe environment for children without explicitly identifying deaths as neglectful • in the Reviewable Deaths report, due to the similarities between abuse and neglect at the severe end of the spectrum, consider all deaths where a wilful and knowing act has contributed to the death of a child as 'maltreatment related' to enable reporting rather than separating abuse from neglect.
Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-2014	This report was commissioned by the CDRT to: • describe child deaths in NSW from diseases for which a vaccine is currently available in Australia, over the period 2005 to 2014	The report found that deaths in children from potentially preventable infectious diseases continue to occur in NSW, particularly in young infants. This report made six recommendations concerning immunisation and vaccination and one regarding enhancing data collection.

	• provide recommendations to improve prevention of child deaths due to vaccine-preventable diseases.	
Submission to the Independent review of swimming pool barrier requirements in NSW, 2015	The CDRT submission identified a number of issues learnt during the Team's work over many years in relation to swimming pool drowning deaths.	Issues canvassed included: • the integrity of child resistant pool barriers • mandatory council inspection programs • exemption from compliance requirements • issues associated with portable pools • gate and latch mechanisms.
A scan of childhood injury and disease prevention infrastructure in NSW, 2015	the CDRT commissioned the Centre for Health Service Development at the Australian Health Services Research Institute, University of Wollongong, to undertake an independent preliminary scan of childhood injury and disease prevention infrastructure in NSW. This report is the result of that work.	The report reflected the approach taken to describe childhood injury and disease prevention infrastructure in NSW by: • defining key concepts • summarising the policy framework nationally and within NSW • identifying the major existing sources of data and information relevant to childhood injury and disease prevention • reviewing key stakeholders • exploring existing mechanisms of coordination.
Drowning deaths of children (private swimming pools) 2007-14, 2015	The report contained information from the NSW register of child deaths.	Issues canvassed in the report include the age and gender of children who drowned, information about the swimming pools where they drowned, child resistant barrier faults and supervision of children.
Special Report to Parliament: Causes of death of children with a child protection history 2002-11, 2014	This report outlines the findings from research undertaken by the CDRT into the causes of death of children with a child protection history over the 10-year period 2002-2011.	The research identified that children with a child protection history have a higher rate of death from certain causes, including sudden unexpected death in infancy, and unnatural causes, such as fire and assault.
Issues paper: Child deaths: Low Speed Vehicle Run-Over fatalities of young children 2002-2011	The CDRT undertook a review of the circumstances of the deaths of the 24 children in order to improve understanding of why these incidents happened, and what might help to prevent similar tragedies in the future.	The Team was concerned that the number of low speed vehicle run-overs has not declined over the last decade and noted that prevention strategies should consider three key areas: • changes to vehicle design so that reversing visibility is improved; • modifications to housing design, including separation of driveways and garages from play areas; and • raising public awareness of the dangers of low-speed run-overs and methods to prevent them.

Report for the NSW Child Death Review Team on Measuring Socioeconomic Status, 2012	The CDRT sought advice from a recognised expert in the field on appropriate options for measuring and reporting socioeconomic status in relation to children whose deaths are subject to review by the Team.	
Swimming Pools Act 1992 review: CDRT submission, 2012	In order to inform this submission, and to provide relevant information to the Swimming Pools Act review, CDRT and reviewable death information relating to children who drowned in private swimming pools in the past five years (2007 – 2011) was analysed.	
Report	***Background***	***Key findings/Recommendations***
Detention and custody		
Managing use of force in prisons: the need for better policy and practice, 2012	This report brought together the work of two investigations into use of force. It detailed the problems and deficiencies identified and the progress made by Corrective Services NSW (CSNSW) to remedy them and concluded with a summary of the significant amount of work which CSNSW still needed to do.	The report made recommendations about a range of issues include: • policies, procedures and reviews • training • data collection and analysis • CCTV.
Special Report: Kariong Juvenile Correctional Centre – Meeting the challenges, 2011	Kariong Juvenile Correctional Centre housed some of the most challenging and troubled adolescent boys and young men in the NSW criminal justice system. This report detailed our investigation into the operation of the Behaviour Management Program at Kariong Juvenile Correctional Centre which determines almost every aspect of an inmate's day to day life and calls for significant changes.	The report concluded that changes needed to be made in the following key areas: • evaluation of the effectiveness of the Behaviour Management Program in achieving its stated objectives • clarification of the objectives of any management program at Kariong • inmate management procedures for Kariong that take into account the needs of its particular inmate population – adolescent boys and young men aged between 16 and 21 years old.
Children (Criminal Proceedings) Amendment (Adult Detainees) Act Review, 2005	The *Children (Criminal Proceedings) Amendment (Adult Detainees) Act 2001* commenced in January 2002. The objective of the Act was to limit the age to which young people can remain in juvenile custody. The Act provided that a juvenile offender convicted of a serious children's indictable offence must not remain in juvenile custody beyond the age of 18 unless the court	Our review included gathering statistical data, examining court documentation, speaking with young people affected by the Act and examining their files, interviewing key policy and operational staff within the Departments of Juvenile Justice and Corrective Services and reviewing relevant policies and procedures.

	finds special circumstances to justify otherwise, or the non-parole period expires within six months of the offender's 18th birthday. In addition, no individual may remain in juvenile custody beyond the age of 21 years and six months. The NSW Ombudsman was charged with monitoring the operation and effect of the Act for a period of three years from its commencement.	We found that the *Children (Criminal Proceedings) Amendment Act 2001* had not reduced the number of serious young offenders over the age of 18 years detained in juvenile justice centres. Since its commencement, the court has overwhelmingly found that there are special circumstances to justify the majority of serious young offenders remaining in juvenile custody for a period beyond their 18th birthday. The report included eight recommendations.
Review of the Crimes (Administration of Sentences) Amendment Act 2002 and the Summary Offences Amendment (Places of Detention) Act 2002, 2005	The *Crimes (Administration of Sentences) Amendment Act 2002* and the *Summary Offences Amendment (Places of Detention) Act 2002* commenced in 2003. Among other things, the legislation: • increased the powers of correctional officers to stop, detain and search people or vehicles that are 'in or in the immediate vicinity of' a place of detention • authorised correctional officers to use dogs, and reasonable force, when stopping, detaining and searching people and their vehicles • created new penalties for not complying with a direction given by a correctional officer in relation to the stop, detain and search powers, and for failing to produce anything detected in a search when requested to do so by a correctional officer • • permitted the seizure and destruction of property brought unlawfully into a correctional centre	The report made 35 recommendations, including to amend legislation and policies to provide greater clarity around the powers of officers and the safeguards that apply when powers are used. Recommendations were also made in relation to training, use of drug-detection dogs and record keeping.