Submission No 122

Attachment 1

INQUIRY INTO ELDER ABUSE IN NEW SOUTH WALES

Organisation: Ombudsman New South Wales

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Senate Standing Committees on Community Affairs
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Senate Inquiry into violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability

We welcome the opportunity to provide information to the Committee to assist its inquiry into the critical area of preventing, and effectively responding to, violence, abuse and neglect of people with disability in institutional and residential settings.

Our submission has been informed by:

- our extensive work and consultations with people with disability and the broader disability sector, including through our complaints, inquiry and review functions
- our work in relation to the new NSW disability reportable incidents scheme
- our experience in, and results from, the NSW employment-related child protection reportable conduct scheme over the past 16 years, and
- our extensive work and consultations with Aboriginal communities, including Aboriginal people with disability and disability service providers.

To assist the Committee, we have provided links to relevant documents, including our disability reportable incidents scheme guidelines, and the national Disability Complaints Commissioners' document on the minimum safeguards they consider need to be in place under the NDIS.

The attached comments are provided for your consideration. If you have any questions, please contact Kathryn McKenzie, Director Disability, on [redacted] or email [redacted]

Yours sincerely

Bruce Barbour
Ombudsman

27 April 2015

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner

27 April 2015

1. Our role in relation to services and supports for people with disability

Under the NSW *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the responsibilities of our office include a range of key functions targeted at improving the delivery of services to people with disability in NSW, including:

- receiving and resolving complaints about disability services, and assisting people with disability to make complaints
- reviewing the pattern and causes of complaints about disability services, and making recommendations to improve how services handle and resolve complaints
- monitoring and reviewing the delivery of disability services, and making recommendations for improvement
- inquiring into matters affecting people with disability and disability services, and reviewing the situation of people with disability in residential care
- reviewing the causes and patterns of the deaths of people with disability in residential care, and making recommendations to reduce preventable deaths, and
- oversighting and coordinating the Official Community Visitor scheme.

On 3 December 2014, the NSW *Disability Inclusion Act 2014* came into effect. The new legislation amended the NSW *Ombudsman Act 1974* to include Part 3C 'Protection of people with disability' ('Part 3C'). Part 3C comprises a scheme for the reporting and oversight of the handling of serious incidents – including abuse and neglect – involving people with disability in supported group accommodation.

All of our functions apply to the NDIS trial site in the Hunter region of NSW.

2. The NSW Ombudsman's disability reportable incidents scheme

Part 3C is the first – and only – legislated scheme in Australia for the reporting and independent oversight of serious incidents involving people with disability in supported accommodation.

2.1 Background

We have consistently expressed the view that considerable work is required across the disability sector to prevent, and effectively respond to, abuse, neglect and exploitation of people with disability. In March 2012, we wrote to the then Director-General of the Department of Family and Community Services (FACS), noting the need to establish a system for reporting serious incidents in disability services – including allegations of assaults and neglect, and other critical incidents. We also advised that such matters ought to be subject to active oversight.

Our discussions with FACS at that time were prompted by our analysis that:

- there were inconsistent reporting requirements across the sector, depending on whether the person with disability resided in supported accommodation operated by FACS or a non-government provider, or in an assisted boarding house
- there was no independent oversight of these matters (outside of complaints to our office)

- there was no comprehensive picture of the extent of abuse, neglect and/or exploitation of people with disability in disability services, and
- there was a paucity of guidance for disability services in relation to responding to serious incidents, particularly client-to-client assaults and decisions relating to reporting to Police.

We also noted that, while there is a comprehensive reporting and oversight system in place in relation to alleged serious workplace child abuse incidents under Part 3A of the Ombudsman Act, there was no comparable system in place in relation to serious incidents involving 'vulnerable' adults with disability.

We identified that the disability reforms in NSW[1] provided a valuable opportunity to develop a comprehensive framework for preventing, and effectively responding to, abuse, neglect and exploitation of people with disability. In our view, a reporting and oversight system is an important and necessary component of such a framework, and fundamental to enabling a genuinely person-centred approach to supports.

In proposing a reporting and oversight system, we were informed by the UN *Convention on the Rights of Persons with Disabilities* (UNCRPD), including Articles 12, 14, 15 and 16. This includes obligations on States Parties to:

- 'take all appropriate measures to prevent all forms of exploitation, violence and abuse'[2] (and, in order to prevent such abuse, shall ensure that, among other things, 'all facilities and programmes designed to serve persons with disability are effectively monitored by independent authorities'[3]), and
- 'put in place effective legislation and policies … to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.'[4]

Our proposal was also informed by current adult safeguarding systems in Australia, and by international comparisons with Canada, the United Kingdom and the United States. As part of developing our proposal, we also consulted with a range of local peak disability service delivery and advocacy agencies.

In our proposal, we noted that the purpose of developing a system for the reporting of serious incidents and oversighting agency handling of such incidents is twofold: to ensure that responses to serious incidents are timely and appropriately managed within a rights-based framework; and to identify systemic issues for the prevention of serious incidents.

2.2 Part 3C of the Ombudsman Act

Part 3C of the Ombudsman Act requires our office to keep under scrutiny the systems of FACS and funded providers for preventing, handling, and responding to reportable incidents in disability 'supported group accommodation'.[5] Disability supported group

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[1] Including *Stronger Together*, *Stronger Together 2*, and the review of the *Disability Services Act 1993*

[2] United Nations *Convention on the Rights of Persons with Disabilities*, Article 16(2)

[3] *Ibid*., Article 16(3)

[4] *Ibid*., Article 16(5)

[5] Section 22(1) of the Disability Inclusion Act defines supported group accommodation as: 'premises in which:
(a) a person with disability is living in a shared living arrangement (whether short-term or permanently) with at least one other person with disability, other than an arrangement in which one or more of the

accommodation includes any accommodation where at least two people with disability are living together (with some exceptions[6]) and support is provided on-site (including respite services).

Part 3C requires and enables the Ombudsman to:

- **receive and assess notifications** concerning reportable allegations or convictions
- **scrutinise agency systems** for preventing reportable incidents, and for handling and responding to allegations of reportable incidents
- **monitor and oversight** agency investigations of reportable incidents
- **respond to complaints** about inappropriate handling of any reportable allegation or conviction
- **conduct direct investigations** concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable incident or conviction
- **conduct audits and education and training** activities to improve the understanding of, and responses to, reportable incidents, and
- **report on trends and issues** in connection with reportable incident matters.

Within 30 days of becoming aware of a reportable allegation or reportable conviction, the Secretary of FACS, or head of a funded provider, must give the Ombudsman notice of the allegation and/or conviction.

Under Part 3C, a reportable incident involves any of the following:

(a) an incident involving any of the following in connection with **an employee of FACS or a funded provider and a person with disability** living in supported group accommodation:

  (i) **any sexual offence** committed against, with or in the presence of the person with disability,

  (ii) **sexual misconduct** committed against, with or in the presence of the person with disability, including grooming of the person for sexual activity,

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persons with disability is living with a guardian of the person or a member of the person's family who is responsible for the care of the person, and

(b) support is provided on-site:

  (i) for a fee, or

  (ii) whether or not for a fee if the support is provided as respite care.'

Under section 9(1) of the *Disability Inclusion Regulation 2014*, premises are prescribed as 'supported group accommodation' to the extent that the premises are premises in which on-site support (whether or not as respite care) is provided by:

(a) the Secretary under s25 of the Act, or

(b) an eligible entity provided with financial assistance by the Secretary under s29(1) of the Act.

[6] Under section 22(3) of the Disability Inclusion Act, supported group accommodation does not include an assisted boarding house, or other premises, or a type of premises, prescribed by the regulations not to be supported group accommodation. Under section 9(2) of the Disability Inclusion Regulation, premises are prescribed not to be supported group accommodation 'if:

(a) the premises are not under the control, direction or management of a disability service provider, or

(b) support provided on-site for a fee in the premises is substantially under the control, direction or management of either or both of the following:

  (i) one or more of the people with disability living at the premises,

  (ii) a guardian or member of the family who is responsible for the care of a person with disability who is living at the premises.'

(iii) **an assault** of the person with disability, not including the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated under workplace employment procedures,

(iv) **an offence under Part 4AA of the NSW *Crimes Act 1900***[7] committed against the person with disability,

(v) **ill-treatment or neglect** of the person with disability, or

(b) an incident involving an **assault of a person with disability living in supported group accommodation by another person with disability** living in the same supported group accommodation that:

(i) **is a sexual offence**, or

(ii) **causes serious injury**, including, for example, a fracture, burns, deep cuts, extensive bruising or concussion, or

(iii) **involves the use of a weapon**, or

(iv) **is part of a pattern of abuse** of the person with disability by the other person, or

(c) an incident occurring in supported group accommodation and involving a **contravention of an apprehended violence order** (AVO) made for the protection of a person with disability, regardless of whether the order is contravened by an employee of FACS or a funded provider, a person with disability living in the supported group accommodation or another person, or

(d) an incident involving an **unexplained serious injury** to a person with disability living in supported group accommodation.

2.2.1 Initial data

Between 3 December 2014 and 3 April 2015, we were notified of 170 reportable incidents:

- 100 (59%) involve allegations of employee to client incidents
- 58 (34%) involve allegations of client to client assault
- 10 (6%) involve allegations relating to unexplained serious injury, and
- 2 involve allegations of the contravention of an AVO.

Employee to resident reportable allegations

Of the 100 notifications relating to employee to client conduct:

- 42 (42%) involve allegations of physical assault[8]
- 28 (28%) involve allegations of sexual assault or sexual misconduct[9]

[7] Section 4AA of the Crimes Act includes fraud and other similar offences. It includes where a person, by any deception, dishonestly obtains property belonging to another or obtains a financial advantage or causes any financial disadvantage.

[8] Allegations include that staff: pushed residents, causing fall and bruising; slapped; grabbed and pulled hair; bent arm back; hit with box; burned with cigarette lighter; dragged across floor causing carpet burns; used cold water in shower; threatened to bend fingers back; punched in face; hit on shoulder; and threw glass of water in face.

- 25 (25%) involve allegations of ill-treatment and/or neglect,[10] and
- 5 involve allegations of fraud.[11]

Two notifications have resulted in employees being charged with criminal offences.

Client to client reportable allegations

Of the 58 notifications relating to client to client conduct:

- 18 (31%) involve allegations of assault resulting in serious injury[12]
- 18 (31%) involve allegations of assault involving the use of a weapon[13]
- 14 (24%) involve allegations of assault that is part of a pattern of abuse,[14] and
- 8 (14%) involve allegations of assault involving a sexual offence.[15]

Two notifications (involving assault resulting in serious injury) have resulted in clients being criminally charged.

Unexplained serious injury

The 10 unexplained serious injuries reported include fractures, extensive bruising, and burns.

Contravention of AVO

In both of the notifications we have received concerning the contravention of an AVO, the allegations related to breach of the AVO by another person with disability living in the same supported group accommodation.

The effectiveness of the disability reportable incidents scheme relies on comprehensively capturing, analysing and publicly reporting on the data, including patterns, trends and outcomes. (Further information on our work in this regard is provided in section 2.4.6).

2.3 Areas that require attention

While the disability reportable incidents scheme is new, we have handled matters relating to abuse, neglect and exploitation of people with disability for many years, primarily

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[9] Allegations include that staff: sexually assaulted residents; touched resident's penis; pulled resident's pubic hair; tickled resident and touched breasts; slept in bed with resident; and had inappropriate personal relationship with resident.

[10] Allegations include that staff: withheld food; inappropriately used restrictive practices to manage behaviour; locked resident outside for extended period of time and deprived of food and water; failed to connect or flush enteral nutrition tube; and left residents unsupervised for an extended period of time.

[11] Allegations include that staff stole money and other items from residents.

[12] Allegations include that residents: punched resident in the head, causing concussion; hit with chair, causing deep cuts; and choked, pushed and punched, causing extensive bruising.

[13] Allegations include that residents: threatened to hit other residents with a broom, butter knife, piece of wood, and other objects; and struck residents with remote control, DVD cover, and metal cup.

[14] Allegations include that residents: hit/struck resident on multiple occasions; pinched resident on multiple occasions; punched and bit resident on two separate occasions; and attempted to choke resident and on another occasion verbally abused and threatened to kill same resident.

[15] Allegations include that residents: made resident touch penis; sexually assaulted residents; and tried to get other residents to touch genitals.

through our complaints, inquiry, and review functions.[16] The need to take comprehensive action to prevent and effectively respond to serious incidents in disability service settings was also consistently reported by the NSW Community Services Commission, which merged with our office in 2002.[17] In 1997, the Commission and Audit Office of NSW reported that, in relation to large residential centres:

> Incidents are inconsistently defined, reported, monitored, analysed and are generally not well managed. The largest category of injury to residents is reported to result from resident to resident aggression. The risk factors are poor staff to resident ratios, resident mix, number of residents in the centre, configuration of accommodation, the effectiveness (or existence) of behaviour intervention plans and the centres ability to identify and implement preventative strategies.[18]

Our analysis of recent matters has continued to identify many of the above factors as well as important additional areas that warrant attention in relation to supported accommodation.

2.3.1 Pre-placement planning and decisions

The consequences for residents when pre-placement planning and decisions are flawed or poorly implemented is a common theme in the matters raised with our office about allegations of serious incidents involving people with disability in supported accommodation. We have identified multiple matters that have raised questions about the adequacy of the work undertaken to:

- clearly identify the support needs, risks and preferences of individuals through comprehensive assessment and consultation
- appropriately match individuals to available accommodation vacancies and existing residents, and
- adequately plan and support the transition process.

The matters have exposed instances of inadequate responses to individuals with specific support needs, including those who have not received appropriate support to address known risks and vulnerabilities. Importantly, we have noted several matters where critical aspects of the person's support needs, history and circumstances were documented but not adequately considered or taken into account in the placement decisions. This has included decisions that resulted in, for example, a victim of sexual assault being accommodated with the alleged perpetrator of the offence.

In some cases, family members, advocates or Official Community Visitors have raised concerns about the placement decision-making and planning process. These include the adequacy of work undertaken by services prior to placement decisions to ascertain and

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[16] See, for example, our reports More than board and lodging - the need for boarding house reform - Special report to Parliament October 2011; NSWOmbudsman-Annual-report-2013-2014.pdf (pp92-98); Full-Annual-Report-2012-2013.pdf (pp95-102); and NSWOmbo_AR_11_12_Web.pdf (pp88-94).

[17] Relevant reports include Community Services Commission, 1995, *The Lachlan report: exclusionary time-out or solitary confinement?*; Community Services Commission, 1998, *The Lachlan Inquiry: an assessment of the standard of care at the Lachlan Residential Centre and progress since the 1995 investigation*; and Community Services Commission, 1997, *Suffer the Children: the Hall for Children report: final report of an inquiry by the Community Services Commission into the quality and standard of care at the Hall for Children, a non-governmental residential service for children and adults with disabilities*.

[18] Audit Office of NSW and Community Services Commission, 1997, *Performance audit report: large residential centres for people with a disability in New South Wales*, pvi

enhance the compatibility of residents, and to identify key risks and the strategies/controls required to manage risks. We have received complaints or been notified of these types of issues after individuals have sustained significant injuries as a result of reasonably foreseeable assaults by other residents.

2.3.2 Post-placement management

Our analysis of matters involving serious incidents has identified the need for more comprehensive planning and associated strategies to be put in place as part of the transition of individuals into their new accommodation arrangements. More thorough work of this kind should be seen as integral to protecting the rights of people with disability, and to minimising the likelihood of assaults and other serious incidents.

In particular, the matters have demonstrated the importance of:

- developing a workplace culture that actively promotes and supports the prevention of violence and abuse
- providing clear guidance to staff about the support needs of, and risks to, each individual and the strategies required to address these issues
- involving relevant professionals (such as skilled behaviour clinicians) in developing and regularly reviewing each individual's support needs/risks and related strategies
- staff promptly implementing the recommendations of professionals in relation to current and emerging risks, and
- providing effective staff supervision and support to identify and address emerging issues and to reinforce key messages about the prevention of violence and abuse.

Our handling of matters relating to serious incidents in disability accommodation services has raised concerns about the adequacy of action taken by some services to prevent violence and abuse from occurring and recurring. In particular, we have identified matters where we could find no evidence of action taken in response to:

- escalating behaviour
- concerns and recommendations of professionals regarding the capacity of an individual to provide informed consent to sexual activity
- a lack of guidance for staff about the challenging behaviour of individuals and the support required to minimise their behaviour and/or its impact (such as a behaviour support plan)
- identified inadequate staffing levels to provide the necessary appropriate support
- identified concerns about an individual's predatory behaviour
- clear evidence of the incompatibility of residents and requests by residents to move, and
- the use of restricted practices without authorisation.

2.3.3 Response to serious incidents

Matters brought to our office have raised concerns about the ability of some disability accommodation services to recognise, manage, and effectively respond to serious incidents (including incidents of abuse, neglect and unexplained injuries).

a) Recognition and rapid response

It is important that staff are able to recognise abuse and other serious incidents in order to provide an appropriate and effective response. We see a need for improved guidance for staff, related training and monitoring, and broader cultural change across the sector.

It is also vital that we achieve a more sophisticated understanding of, and response to, abuse and neglect across disability accommodation services. In this regard, it will be critical for the sector – and other key stakeholders – to consider the adequacy of the existing policy and procedural guidance for residents, staff and families. In addition, the sector needs to ensure that staff are adequately trained in relation to effectively implementing relevant policy, and there needs to be appropriate systems in place to monitor and review compliance with key policies.

It is also important that services:

- make appropriate inquiries to ascertain what has occurred (for example, in relation to unexplained injuries) and to collect initial evidence
- ensure the immediate and ongoing safety and welfare of individuals, including clearly identifying the current risks and how they will be managed (such as through exploring alternative accommodation options for the victim or perpetrator), and
- obtain timely medical assistance/review for victims, including those with unexplained serious injuries.

However, it is essential that even this early response does not prejudice any potential police inquiry. (Our current work to provide guidance to disability services in relation to the initial and early response to serious incidents is discussed in section 2.4).

b) Reporting and communication

We have identified the need for improved practice in disability supported accommodation in regard to both internal reports and reports to relevant external parties, when a serious incident occurs.

In particular, we have noted a lack of clarity and consistency in the internal reporting of serious incidents, exemplified by reports that have not included details of the injuries sustained, the nature of the incident, or the proposed action to prevent recurrence. In some cases, it has not been clear what action, if any, has been taken in response to the incident/s reported. These deficiencies in practice raise questions about internal oversight and review of these reports from both an individual and a systems perspective.

Common issues of complaint relate to (where appropriate) family members not being informed of the incidents, including assaults and serious injuries; and delays in families being advised.

c) Process and practice; critical legal issues

Our work shows that one of the key reasons disability accommodation services do not report serious incidents – including sexual and other assaults – to police, or the police decide not to investigate, is due to a perception that the perpetrator, the victim or any witnesses with disability, lack the capacity to understand what has occurred, and/or to provide reliable evidence.

We have highlighted the need for clarity and improved guidance to ensure that:

- serious incidents are reported to police in a timely way
- services have a sound understanding of the investigative process and their role
- appropriate action is taken to ascertain whether perpetrators have, in a legal sense, the requisite capacity
- people with disability receive appropriate support to maximise their capacity to provide a statement and give evidence
- appropriate support is provided to victims, perpetrators and witnesses with disability – including being linked in with relevant services, such as sexual assault services, and the NSW Criminal Justice Support Network, and
- residents who are the victims of physical or sexual assault are provided with clear advice about their rights, including their right to make a complaint.

More broadly, a well-established, appropriate and effective working relationship must be developed between disability accommodation services and police to support improved practice in responding to serious incidents involving people with disability.

d) Review of existing guidance and practice

Our analysis in relation to serious incidents has identified the need for services to improve their risk management – and broader management responses – to these matters.

We would emphasise the need for serious incidents, including physical or sexual assaults, to result in the immediate review of the circumstances of individuals, and the adequacy of current staff practice and available guidance (where relevant). In particular, we would emphasise the importance of services being in a position to:

- rely on effective or appropriate strategies to manage risks, and
- ensure that staff awareness and support of sexual activity between residents occurs in the context of residents providing informed consent.

It is important that the response to serious incidents involves a prompt and comprehensive review of existing risk and behaviour management strategies, as well as relevant policy and procedures. There is also a need to ensure that the response to serious resident-to-resident sexual and physical abuse includes a review of client compatibility and relationships; and that services involve relevant professionals in providing any necessary assessments and reviews.

2.4 Current areas of work

While the information in this submission primarily concerns the disability reportable incidents scheme, it is important to recognise that a significant amount of our work is focused on preventative and developmental strategies, including training of disability support staff. Disability reportable incidents, and the issues and trends we identify through the scheme, help to inform improvements in the disability sector and the practice of service providers. Some current examples of this work are provided below.

2.4.1 Best Practice Working Group

Many of the issues that have emerged from our handling of complaints relating to alleged abuse, neglect and exploitation of people with disability are challenging, complex, and not

easily resolved in the short-term. Early on, we recognised that addressing these issues – and achieving tangible and sector-wide improvement and cultural change – would require a partnership approach, with the involvement of disability leaders and key subject-matter experts within and outside of the disability sector.

Ahead of the commencement of the disability reportable incidents scheme, we established a Best Practice Working Group to inform the development of the scheme and to start working through the known challenges, service and practice gaps, and complex issues. A list of the current members of the Best Practice Working Group is provided at Annexure 2.

As part of the discussions of the group, we have developed a schedule of the key issues, current and planned strategies, and areas of responsibility. Among other things, the schedule includes issues relating to:

- the need for a comprehensive policy and practice framework for preventing and effectively responding to abuse, neglect and exploitation of people with disability
- pre-placement planning, assessment of risk, client matching and compatibility
- staff screening and recruitment practices
- availability of, and access to, relevant clinicians and expert advisors (including psychologists, behaviour support clinicians and mental health clinicians)
- assessing the capacity of individuals to consent to sexual activity
- reducing the use of restrictive and restricted practices, and improving practice in relation to their use, consent and authorisation
- support for victims with disability, and
- the criminal justice response to people with cognitive impairment.

2.4.2 Education and training on preventing and responding to serious incidents in disability services

Since 2012, we have run workshops with disability services' staff on responding to serious incidents, including abuse and neglect, in a disability service setting. The training provides practical advice to enable staff to understand:

- how to identify and respond to abuse, neglect and other serious incidents
- the systems and processes that contribute to a 'client-safe' environment
- the fundamental principles and strategies for conducting an investigation, and
- the responsibilities of key agencies, including the NSW Police Force, FACS, and the NSW Ombudsman.

In the past year, we have delivered 35 workshops to approximately 720 staff of disability services. In terms of course participant levels of satisfaction with the training, we note that, from a sample of 150 evaluations completed by participants in 2014:

- 100% would recommend the workshop to others
- 99.3% rated the workshop overall as good/excellent
- 99.3% rated the presenter as good/excellent
- 97.9% rated the content as good/excellent
- 90.3% rated the resources as good/excellent, and

- 96.5% agree/strongly agree that they feel confident they can implement what they have learnt in the workplace.

Since the commencement of Part 3C, we have also provided a modified version of the workshop for direct care staff, focused on identifying, responding to and reporting incidents; and the broader requirements relating to supporting people with disability in supported accommodation.

In addition, in the lead-up to, and post, the commencement of Part 3C, we have been implementing a range of other strategies to raise awareness of the disability reportable incidents scheme and the responsibilities of disability services, including:

- having direct contact with the majority of the 127 disability supported group accommodation services in NSW to explain the scheme and provide advice on specific matters
- publishing a guide for services on Part 3C on our website (Guide for services: Reportable incidents in disability supported group accommodation)
- presenting at stakeholder forums, including the NDS state conference, and
- meeting with other key stakeholders and representatives, including advocacy and peak disability organisations, the Disability Council of NSW, the Board of NDS, and the NSW Police Force.

2.4.3 Development of guidance for disability services on the initial and early response to serious incidents

Direct care staff play a critical role in the initial stages of responding to a serious incident – and their actions at that point can either assist or adversely affect any subsequent investigation. In this context, we have commenced work on a project to develop clear guidance for disability support workers on the early action they need to take in response to a serious incident. The tools will comprise:

- best practice guidelines for an initial and early response
- a ready-reckoner document for disability support workers to quickly refer to immediately after a serious incident, and
- additional information for inclusion in the 'Handling serious incidents in disability services' training for disability support workers delivered by Ombudsman staff.

The project is being informed by consultation with a range of key stakeholders, including police, disability service providers and support workers, advocates, and practitioners. We anticipate completing this work in the second half of this year.

2.4.4 Empowering people with disability and their supporters

To date, the primary focus of our communication and education strategy relating to Part 3C has been on supported group accommodation services and their staff. However, it is critical that people with disability living in supported group accommodation are provided with the necessary information and assistance to enable them to understand their rights, and what to do when things aren't okay.

In partnership with members of our Part 3C Best Practice Working Group, including the NSW Council for Intellectual Disability and the Intellectual Disability Rights Service, we are currently exploring the need for a program to inform and educate people with disability

(and their families, advocates and other supporters) in relation to Part 3C, and their right to live free from violence, abuse and neglect.

For many years, our office has run workshops for people with disability on '*The Rights Stuff*' – aimed at helping them to understand their rights as consumers of disability (and other) services, and how to complain and speak up. In conjunction with FACS and other parties, we are currently revising the workshop scope and materials to ensure that it includes an appropriate focus on freedom from abuse and what to do in relation to serious incidents. As part of this work, we will be linking in with the capacity-building workshops run by My Choice Matters[19] directly with people with disability and their supporters.

2.4.5 Working with the NSW Police Force to improve the response to serious incidents involving people with disability

Our work has highlighted the importance of building capacity in the Police Force to effectively respond to serious incidents involving people with disability (whether victim, offender or witness). The recent matters we have handled have pointed to the need to work collaboratively with police and disability services staff to ensure that:

- appropriate action is taken to support people with disability (particularly intellectual disability) to give evidence
- people with disability in contact with police have access to a support person
- the police response to reports of serious incidents involving people with disability in supported accommodation is timely and appropriate, and
- people with disability are not unnecessarily brought into contact with the criminal justice system due to inadequate risk management or behaviour support, or inappropriate policy requirements.

Improving practice and guidance in this area is one of the priorities of the Best Practice Working Group. As indicated in Annexure 2, the group includes representatives from the NSW Police Force, including the Assistant Commissioner with responsibility for the Vulnerable Communities portfolio. To facilitate a partnership approach to this work, our office has seconded a Detective Inspector in the NSW Police Force, Anthony Holton, to the role of Director of our Disability Reportable Incidents unit for a two-year period.[20]

Our actions will be informed by, and seek to replicate where appropriate, the significant work that has been done as part of our employment-related child protection reportable conduct scheme under Part 3A of the Ombudsman Act,[21] including:

- the development of agreed Standard Operating Procedures (SOPS) that clearly outline the responsibilities of local police in providing practical support to agencies responding to allegations of reportable conduct under the Part 3A scheme
- work underway to develop a *Protocol to Reduce the Criminalisation of Children and Young People in Residential Out-Of-Home Care*,[22] and

[19] My Choice Matters works with people with disability and their families to live their life their way and get the most out of the changing disability system. In particular, the work is focused on helping people with disability to develop and grow their skills in choice, value and control: http://www.mychoicematters.org.au/.

[20] Anthony's background includes experience working with vulnerable persons, including substantial experience in the child abuse squad.

[21] An overview of our reportable conduct scheme under Part 3A is provided in Annexure 3.

[22] Among other things, the protocol aims to reduce the frequency of police involvement in responding to less serious incidents of challenging behaviour by children/young people living in residential out-of-home care;

- holding a one-day forum for staff of Aboriginal out-of-home care agencies and police officers from across NSW aimed at: strengthening understanding of their respective responsibilities in responding to reportable allegations under Part 3A; developing relationships; and identifying practical ways to effectively work together at a local and state-wide level.[23]

Annexure 3 of our submission provides further information about the significant work undertaken, and outcomes achieved, in our Part 3A area that provides a useful indicator for what may be accomplished under Part 3C. We note that the Royal Commission into Institutional Responses to Child Sexual Abuse should be well placed to provide the Senate Committee with an independent view of the relative strengths of the reportable conduct scheme.

2.4.6 Data collection, analysis and reporting

There is a paucity of accurate and comprehensive data relating to serious incidents – including abuse, neglect and exploitation – involving people with disability in institutional and residential care settings. Among other things, gaining an accurate picture of the incidence and nature of the matters required to be reported under Part 3C and the response to them, on an individual and systemic basis, will be important in:

- informing the nature and scope of the safeguards necessary under the NDIS
- guiding the broader policy and practice response to systemic issues, and
- enabling this office to monitor and assess the extent of change and service improvement following the introduction of Part 3C.

We are undertaking substantial work to ensure that the data system for Part 3C enables us to accurately record, track and report on pertinent factors, including but not limited to:

- key demographic details – particularly gender, age and cultural status
- service providers (government and NGO)
- disability and other support needs of the residents involved (whether alleged victim or subject of allegation), including communication and behaviour support
- the nature and adequacy of risk management, investigative and other action taken in response to the serious incidents
- support provided to residents involved, and
- issues arising from individual matters.

In addition, we are exploring IT solutions to streamline and simplify the notification process for disability services. In this regard, we are currently looking at mechanisms to support the electronic lodgement of notification forms (with potential automatic population of our data system).

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promote the safety, welfare and wellbeing of children and young people by improving relationships, communication and information sharing at a corporate level and between local police and residential out-of-home care services; and enhance police efforts to divert young people from the criminal justice system by providing police with better information about the supports provided to individual children or young people who have committed criminal offences.

[23] The forum was held on 4 December 2014, and involved 160 participants from across NSW. Forum participants reached agreement on a range of key commitments, including the identification of a senior contact officer in each Police Local Area Command and Aboriginal OOHC agency to facilitate the efficient and effective exchange of information between police and agencies.

On a longer-term basis, we are also exploring options for building on the existing online complaint reporting system developed by Orima for the Office of the Disability Services Commissioner in Victoria, and adapted by FACS for use in NSW.[24] If this initiative is successful, then there is the potential to make available nationally a reasonably sophisticated and integrated complaints and reportable incident IT system at a very low cost. With the transition to the NDIS, there are obvious benefits in developing and implementing a system of this kind.

3. Opportunities and lessons from the NSW Ombudsman's employment-related child protection reportable conduct scheme

The development and implementation of the disability reportable incidents scheme has largely been modelled on the employment-related child protection reportable conduct scheme that has operated in our office since 1999, under Part 3A of the Ombudsman Act. An overview of the Part 3A reportable conduct scheme is provided at Annexure 3.

While we recognise that there are important points of differentiation between the two reporting and oversight schemes, we consider that the Part 3A reportable conduct scheme is a useful indicator of what can be achieved, over time, through the Part 3C disability reportable incidents scheme. In particular:

- the audit and other work we undertake to keep agency systems under scrutiny
- the breadth of the activities we undertake to raise awareness and knowledge of the reportable conduct scheme among agencies, and to support employers to meet their obligations under the scheme
- the intersection of our reportable conduct function and the Working With Children Check (WWCC) in NSW – including 'notifications of concern' to the Children's Guardian, and
- the use of our CS CRAMA monitoring, inquiry and review functions in combination with our Part 3A role to identify systemic issues relating to the out-of-home care and broader child protection systems.

Importantly, our office's operational practice in relation to Part 3A has evolved over time. The significant changes that we have made in relation to how we identify, and act in response to, critical information associated with employment-related child protection reportable conduct matters provides a useful guide for the Committee as to what may be possible under Part 3C.

4. Areas for specific consideration

4.1 The need for improved screening of potential employees in the disability sector

It is of vital importance to ensure that, wherever practical, those individuals in the community who engage in inappropriate behaviour or take advantage of vulnerable people are prevented from working in care-focused roles in the disability support system. As we move to a model where people with disability can exercise greater control and

[24] We note that Western Australia has developed its own complaints reporting technology based on the same parameters as Victoria and NSW, and New Zealand is also looking at adopting the tool.

choice over their lives, it will be essential to ensure there is an appropriate workforce to enable and support participants to exercise and enjoy their full complement of rights. The importance of a highly skilled workforce that has the capacity to appropriately support people with disability cannot be overstated.

We support the introduction, via legislation, of a comprehensive system for screening people engaged to support people with disability. The development of such a system should be informed by existing screening systems: for example, the Working With Children Check system in the *Child Protection (Working With Children) Act 2012* (NSW); the *Working With Vulnerable People (Background Checking) Act 2011* (ACT); and the *Disability Services Act 2006* (Qld).

However, consistent with the right of people with disability to exercise control over their own lives, we would have significant concerns about any system that did not allow for people with disability to seek limited work or 'engagement' exemptions for those individuals who are barred, in circumstances where the person with disability demonstrates that the granting of the exemption would serve to promote (and not prejudice) their rights.

4.1.1 Establishment and role of a database relating to completed employment proceedings

In our view, significant findings from any legislated 'reportable incident' scheme should feed into any legislative system for screening individuals who are applying to work with vulnerable people with disability. In considering this issue, we believe that a relatively low cost and effective IT solution – and related practice framework – could be developed that would provide for probity screening that involves both consideration of criminal matters and significant adverse employment findings.

4.2 Information sharing

We consider that relevant information sharing provisions are a necessary component of an effective safeguarding system, including a reportable incident scheme. In our view, the provisions should address the following issues:

4.2.1 Providing information to victims

Firstly, the system should allow for the provision of information by agencies to victims, their families and guardians. For technical legal reasons, this area has been a weakness in relation to the operation of our Part 3A scheme. After having raised our concerns about the need to guarantee that, under both our Part 3A and Part 3C functions, agencies have a legal right to provide appropriate information to victims, we understand that legislation in NSW will be introduced this year to deliver this outcome.

4.2.2 Exchange of information between agencies

Secondly, we believe that a disability reportable incidents scheme should allow for provision of information for the purposes of enabling the Secretary or principal officer of a funded agency to provide to, and receive from, other funded agencies and public authorities, information that relates to the promotion of the safety of people with disability in connection with responding to a reportable allegation or conviction under Part 3C.

In this regard, it is important to note that, until the introduction of the information sharing provisions in Chapter 16A of the NSW *Children and Young Persons (Care and Protection)*

Act 1998, employing agencies found themselves in the invidious position of having legislative responsibility for responding to reportable conduct under Part 3A, but without having the right to obtain the necessary information to allow them to make informed investigative and risk management decisions. While we do not believe that it is consistent with the rights of people with disability who are adults to be affected by a provision as broad as Chapter 16A,[25] from our extensive experience we are nevertheless convinced that it will be essential that agencies dealing with abuse allegations under this scheme have the ability to exchange information consistent with their legislative obligations and existing common law duty of care responsibilities.

In relation to Part 3C, the NSW Government opted to test the new scheme in relation to the need for information exchange provisions. We are currently collating case studies from pertinent Part 3C matters that will assist the NSW Parliament in considering the adequacy of the current information exchange regime.

Interstate exchange of information

In past reports highlighting the value of the information exchange provisions in the child protection area, we have noted that it is important to acknowledge the challenges that still exist in relation to the interstate exchange of information. For example, in our submissions to the Royal Commission, we have advocated for a nationally consistent approach to information sharing provisions. Against this background, it is vital to consider these cross-border information exchange challenges in the context of the need to develop national disability complaints and reportable incidents schemes.

4.3 Restrictive interventions

Our work points to the need for consistent legislative requirements to be introduced relating to the use of restrictive interventions.[26] In particular, our reviews of the deaths of people with disability in residential care have highlighted systemic problems with the use, and regulation, of restrictive practices across residential services, including:

- failure to follow policy in relation to the use of psychotropic medication for some people in disability services, and
- the frequent use of psychotropic medication as a primary behaviour management strategy.[27]

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[25] The key principles underpinning Chapter 16A are:

1. agencies that have responsibilities relating to the safety, welfare or wellbeing of children or young people should be able to provide and receive information that promotes the safety, welfare or wellbeing of children or young persons
2. those agencies should work collaboratively in a way that respects each other's functions and expertise
3. each such agency should be able to communicate with each other so as to facilitate the provision of services to children and young persons and their families
4. because the safety, welfare and wellbeing of children and young persons are paramount:
    1. the need to provide services relating to the care and protection of children and young persons, and
    2. the needs and interests of children and young persons, and of their families, in receiving those services

take precedence over the protection of confidentiality or of an individual's privacy.

[26] Encompassing both restrictive and restricted practices.

[27] NSW Ombudsman, 2011, *Report of Reviewable Deaths in 2008 & 2009, Volume 2: Deaths of people with disabilities in care*, pp21-22; and NSW Ombudsman, 2013, *Report of Reviewable Deaths in 2010 and 2011, Volume 2: Deaths of people with disabilities in care*.

Our monitoring of the implementation of our recommendations in relation to these issues has underscored the need for requirements in this area to have legislative force. The quality assurance systems have limited scope in relation to restrictive interventions and behaviour support requirements. There is no overarching system or regulatory regime to ensure that the use of restrictive interventions in relation to people with disability in residential care upholds their rights and meets relevant requirements.

We consider that there is a need for a nationally consistent legislated approach relating to the use of restrictive interventions to increase accountability and transparency, and to ensure that the rights of people with disability are upheld. We note the framework and requirements outlined in the Disability Act 2006 (Vic), including the provisions concerning:

- the functions and responsibilities of the Office of the Senior Practitioner, including to:
    - visit and inspect any premises where disability services are being provided, see any person, and obtain information from services
    - authorise, investigate, audit and monitor the use of restrictive interventions
    - direct a service to discontinue or alter a practice, procedure or treatment to a person with disability
    - publicly report on the use of restrictive interventions, and
    - develop guidelines and standards, and provide education, training, information and advice on restrictive interventions and on the rights of people subject to such interventions
- sanctions for breaches of the legislation
- provision for external merits review of decisions to use restrictive interventions, and
- the involvement of an independent person to explain the intended restrictive intervention, its use and the person's rights; and to identify and report where the person does not understand the 'what and why' of the restrictive interventions, and where the legislative requirements are not being met.

4.4 The importance of independent persons

4.4.1 Official Community Visitors

The Official Community Visitor (OCV) scheme in NSW plays an important role in preventing and responding to abuse, neglect and exploitation of people with disability in residential care. The OCVs are independent, Ministerial appointees who conduct visits – including unannounced visits – to people with disability in the full-time care of disability accommodation providers.

Among other things, the OCVs can confer alone with any resident or staff member; inspect documents relating to the operation of the accommodation service; and provide the relevant Minister and the Ombudsman with advice or reports on any matters relating to the conduct of the service. Our office coordinates the OCV scheme and provides support to the Visitors.

OCVs have played a significant role in relation to many of the disability abuse-related matters that have been handled by our office, including:

- identifying and raising concerns about the actions by services to prevent serious

incidents (including placement decisions)

- identifying and reporting serious incidents and systemic issues relating to abuse and neglect with services and our office (including assaults, inappropriate use of restrictive practices, and neglect)
- receiving information from residents, family members and staff about issues of concern, and
- monitoring the progress of actions by services to address critical issues.

We have achieved substantial change and improved outcomes for people with disability as a result of the close link between the OCV scheme and our office's complaints functions – particularly in relation to matters concerning violence, abuse and neglect in residential care. These matters have benefitted from the separate but complementary functions we perform: notably, the ability of Visitors to identify incidents of abuse and neglect and the associated impact on individual residents, and to act to raise and resolve the issues as independent persons; and the powers and ability of our office to progress these matters on an individual and/or systemic basis when escalated by the Visitors.[28]

4.4.2 Individual advocacy

Our office has seen the benefit of individual advocacy for people with disability, particularly for people without an informal support network, or where the person and their informal supports need assistance to raise and resolve concerns locally and at an early point. Advocates have been effective in bringing matters relating to abuse and neglect to our attention on behalf of individuals with disability, both within and outside of institutional and residential settings.

In our view, it will be important to ensure that individual advocacy continues to be available for people with disability (and their families/friends/carers) to access as required. The disability reforms provide a valuable opportunity to consider the necessary role and scope of individual advocacy (and advocacy more broadly) in the new funding and support arrangements. In this regard, it is worth noting the model of advocacy and assistance provided under New Zealand's National Health and Disability Services Advocacy Service, which provides a combined visiting, advocacy and complaints approach (outlined in Part 3 of the NZ *Health and Disability Commissioner Act 1994*).

[28] In progressing new disability support arrangements nationally, it is worth considering the role of 'independent persons' more generally, and how this support and oversight may best be legislated and managed to ensure that people with disability have maximum choice and control; that their rights are being upheld; and support is provided where required. In particular, we believe that there is likely to be an important and increasing role for independent persons where the person with disability does not have an informal support network, or where there are higher levels of vulnerability and/or risk involved. In the shift to individualised funding and support arrangements, there would be merit in considering the use of independent persons who could:
1) visit people with disability in the community (where the planning process identified this need) to talk about their living and support arrangements; assist the person to understand and exercise their rights and options; support them to resolve matters of concern; and alert authorised agencies where the person requires formal assistance, such as in relation to abuse or neglect;
2) discuss proposed restrictive interventions (and the person's rights) with the person with disability who is directly affected, and report where the person does not understand or legislative requirements are not being met; and
3) assist/support decision-making with people with disability – particularly where the person does not have an informal support network.

4.5 Aboriginal and Torres Strait Islander people with disability

The comments in this part of our submission are made against the background of our long history of working to improve outcomes for Aboriginal people in NSW. Our Aboriginal Unit was established 18 years ago and since then, has helped Aboriginal people from all over NSW to resolve complaints about a wide range of issues. Our office has also delivered more than 15 major reports and submissions addressing concerns raised by Aboriginal communities about the quality of service delivery (these documents are available on our website).

Our 2010 report to Parliament, *Improving service delivery to Aboriginal people with a disability*, resulted in the (then) Department of Ageing, Disability and Home Care significantly reforming the way it delivers services to Aboriginal people and strengthening its governance mechanisms for driving and measuring improved performance in this area. While our review focused on disability services provided within the community (such as personal care, community transport and carer support), some of our findings are relevant to the Senate Committee's consideration of issues relating to the particular situation of Aboriginal and Torres Strait Islander people with disability in institutional and residential settings.

Most notably, our consultations highlighted the low take-up of disability services by Aboriginal people and their preference for privately caring for family members with disability within the extended family/community rather than accessing more formal types of care or support. The feedback we received indicated a number of contributing factors, including limited awareness of available services; an inability to relate to the concept of disability and/or variable understandings about what constitutes a disability; a belief that there is a cultural obligation to care for a person with disability within the family; stigma and shame associated with the disability 'label'; and significantly, fear and mistrust of institutions arising from a collective legacy of negative experiences including forced removal and abuse.

The above factors, at least in part, may also explain the relatively small numbers of Aboriginal people living in residential care settings in NSW and the limited number of Aboriginal organisations providing this type of care. However, it is likely through the NDIS transition (and related capacity building and community education initiatives), that the uptake by Aboriginal people of disability services will increase over time, including the numbers of Aboriginal people living in a residential setting. While it is vital to respect the individual preferences of Aboriginal people with disability and their families, it is also important that they have a genuine choice when making decisions about their care and support needs. In order to attract Aboriginal clients, organisations need to demonstrate they are responsive to the particular needs of Aboriginal people with disability and their families. This requires mainstream agencies and organisations to take practical steps (such as recruiting Aboriginal staff, building relationships with local Aboriginal communities, embedding flexibility in service provision to meet identified needs) to build community trust in their capacity to deliver appropriate services to Aboriginal people.

It is particularly important in light of historical events, that organisations have (and are seen to have) effective strategies in place for preventing and responding to allegations of abuse and neglect. A very practical way to demonstrate this might involve being prepared to provide transport assistance to family members to facilitate their ongoing relationship and involvement with the individual in care – a known protective factor – given how often limited transport options is cited as a barrier to accessing services for people living in regional and remote areas.

Providing genuine choice to individuals and their families also requires building the capacity of the Aboriginal service sector to deliver disability services to Aboriginal people who cannot or would prefer not to access a mainstream organisation. Our work in oversighting the out-of-home care (OOHC) sector in NSW, which has been undergoing significant expansion over recent years following recommendations from the Special Commission of Inquiry into Child Protection Services in 2008, has highlighted both the importance of working closely with new and expanding organisations to build their capacity, and the resource-intensive nature of this work. It is likely that the disability sector will experience similar rapid expansion as a result of the NDIS reforms. If stronger demand in the future leads to an increase in the number of Aboriginal-specific disability services – a direction we would welcome – it will be important to ensure that these services are adequately supported to effectively prevent and respond to abuse and neglect.

The number of Aboriginal OOHC care agencies in NSW has more than doubled during the transition of responsibility for the care of children in foster or authorised kinship care from the government to the non-government sector. In the context of this rapid expansion, strengthening the overall governance and ability of Aboriginal agencies to identify and adequately respond to allegations of child abuse will remain a priority for us over coming years.

We have undertaken a range of activities in recent years to support Aboriginal OOHC agencies to meet their legislative obligations in relation to child protection and to improve the way they respond to allegations and complaints that are relevant to the context of disability service provision – these activities have included:

- developing tailored training programs on handling reportable child abuse allegations delivered at the agency premises and arranging for the involvement of local police – whose responsibility to investigate child abuse at times intersects with the OOHC agencies' responsibility to investigate allegations against their employees
- regularly attending meetings with the peak body representing Aboriginal OOHC agencies (AbSec) to highlight child abuse notification rates – this awareness raising drive led to a significant increase in notifications to our office, and
- hosting a state-wide conference in December 2014 in partnership with AbSec, which brought Aboriginal OOHC agency staff together with senior and local police personnel, and representatives from the Child Abuse Squad, to build working relationships and gain a better understanding of each other's respective responsibilities in relation to protecting children from abuse, and to discuss practical ways of working together at a local level.

It will be necessary for this type of work to form part of any capacity building program undertaken with the Aboriginal disability sector to ensure that organisations have the expertise required to meet their obligations under Part 3C of the Ombudsman Act (or relevant legislation in other jurisdictions), including identifying, risk-managing and investigating allegations of abuse, neglect and exploitation.

5. NDIS safeguards

In April 2013, and to inform Commonwealth, State and Territory discussions, Disability

Complaints Commissioners from across Australia[29] developed an agreed document on the minimum safeguards they consider ought to be in place under the NDIS: Safeguards and the NDIS. A copy of the document is provided at Annexure 1.

Many of the agreed minimum safeguards have been discussed in this submission as they are important in preventing and effectively responding to abuse, neglect and exploitation, including:

- development of a comprehensive national framework for preventing, identifying and effectively responding to abuse, neglect and exploitation of people with disability
- a requirement to report critical incidents, particularly in the context of high risk service settings (with oversight of the handling of matters by an independent oversight body/ies)
- the introduction of a consistent national system for screening people engaged to support people with disability under the NDIS
- regulation and effective oversight of the use of restrictive interventions, and
- Community Visitors.

However, the Commissioners' document does not include a significant additional safeguard that is currently in place in NSW – the reviewable disability deaths function, prescribed by the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, and conducted by our office since 2002.[30] In addition to its core purpose of reducing the preventable deaths of people with disability in care (including deaths that may be neglect-related), the function has enabled the identification of important factors associated with violence, abuse and neglect in residential settings, including:

- inappropriate use of restrictive interventions, including chemical restraint
- patterns of abuse between residents
- poor reporting and response to critical incidents
- poor development and implementation of behaviour support strategies, and
- failure to implement the recommendations of expert health and behaviour practitioners.

In the context of the NDIS, it will be important to consider the potential need for a reviewable deaths function to, among other things, identify any links between the participant's death and the support provided (or not provided) – including support to prevent or address violence, abuse and neglect.[31]

[29] The Disability Complaints Commissioners group encompasses NSW, Victoria, South Australia, Western Australia, Northern Territory, ACT, New Zealand, and the Australian Disability Discrimination Commissioner. Queensland and Tasmania do not currently have Disability Complaints Commissioners.

[30] This function was not included in the Commissioners' safeguards document as our office is the only agency in Australia with responsibility for reviewing the deaths of all people with disability in residential care (including assisted boarding houses). Against this background, and despite its importance, we did not consider it likely that the function would be adopted as part of the NDIS Quality and Safeguards Framework.

[31] The reviewable deaths functions of the Ombudsman's office complement, but do not replace, the functions of the State Coroner.

5.1 Scope and operation of key safeguards relating to abuse and neglect

Overall, we support a consistent national approach to safeguards under the NDIS. However, in relation to the reporting and oversight of the handling of disability reportable incidents, there are important State and Territory-based systems that also need to be considered. In our experience, the effective operation of reportable conduct schemes – and the timely and targeted action the oversight agency needs to take to facilitate positive outcomes for individuals – requires local knowledge and relationships. Importantly, a crucial component of our work in both the Part 3A and Part 3C reportable conduct schemes involves searching and analysing information on the databases of state-based organisations – Police and FACS – and extensive negotiations with NSW Police, in connection with the identification and investigation of crimes under the NSW Crimes Act.

We note that State/Territory arrangements will also need to be considered in relation to the regulation and oversight of restrictive interventions, given that substitute decision-making authorities and tribunals are inherently State/Territory-based organisations.

The disability reforms, and development of the NDIS Quality and Safeguards Framework, provide a useful opportunity to consider the scope of key existing safeguards.

5.1.1 Scope of a disability reportable incidents scheme

In identifying a potential initial target group for the disability reportable incidents scheme, we observed that there is considerable consistency across jurisdictions in relation to those adults with disability who are considered to be vulnerable. In relation to serious incident reporting systems, vulnerable adults with disability are generally deemed to be those who meet two requirements:

- they have been abused or neglected, or are at risk of abuse or neglect, *and*
- as a result of their disability, they need support to safeguard their own rights, seek assistance, complain and/or care for themselves.

In this context, we proposed that NSW should introduce a reporting system that focuses on serious incidents involving any person living in residential care. However, we are acutely aware that it is not only people with disability in supported group accommodation who are at risk of, and vulnerable to, abuse, neglect and exploitation. Indeed, in our extensive discussions with the providers of disability supported group accommodation that are included in the current scope of Part 3C, we have received consistent feedback that:

- they welcome the introduction of the disability reportable incidents scheme, and are keen to receive feedback and guidance on best practice in preventing and responding to serious incidents, and
- they consider the scope of the scheme should be broader, to include day programs, and drop-in support arrangements.

Our proposal also recommended that assisted boarding houses be included in the scope of the disability reportable incidents scheme. However, this accommodation setting is not currently within the Part 3C scheme, due to the separate reporting requirements associated with assisted boarding house residents under the NSW *Boarding Houses Act 2012* and the NSW *Boarding Houses Regulation 2013*. Given the support needs and vulnerability of many people with disability in assisted boarding houses, and the absence of independent oversight of reporting in this area, we believe that further consideration

may need to be given to whether these residents should be included in any future reporting scheme.

5.1.2 Scope of a Community Visitor scheme

In NSW, the OCV scheme is currently limited to accommodation services in which a person with disability is in the full-time care of the service provider, and assisted boarding houses. We note that submissions to the NSW Law Reform Commission's 1999 review of the (then) *Community Services (Complaints, Appeals and Monitoring) Act 1993* indicated support for expansion of the jurisdiction of the OCV scheme to include people with disability living in 'some of the more flexible arrangements for supported accommodation, such as those people living in private or rented accommodation who receive significant support, or those living in accommodation which is provided by a service provider but leased in the name of the resident.'[32]

There was also some support for the jurisdiction to extend to, inter alia, people with disability not living in visitable services who directly request access to a Visitor. The Law Reform Commission's view at that time was that the jurisdiction should not be extended, because the focus of Visitor Schemes in other contexts is on monitoring publicly-funded services, and on those in the full-time care of the services visited.

Against the background of the vital role Visitors play in helping to prevent and appropriately respond to abuse, neglect and exploitation of people with disability in residential care, we believe that there would be merit in considering the scope for expanding the OCV scheme to potentially include other kinds of care arrangements that will emerge under the reform agenda.[33] For example, people living in private accommodation and receiving full-time disability support; and people in private living arrangements that may expose them to high levels of risk. However, any expansion of the scheme to these areas would need to be informed by the wishes of people with disability who live in these settings.

5.2 Opportunities and risks

It is important to recognise that the transition to the NDIS and individualised funding arrangements present significant opportunities to address many of the longstanding and endemic issues that create and perpetuate unsafe accommodation and support environments for people with disability. For example, there are opportunities to:

- move away from services 'placing' individuals in accommodation vacancies and making the critical decisions about who lives where and with whom
- change staff culture and the way in which supports are provided, and
- heighten the awareness and response of people with disability, their supporters, support providers, and the broader community in relation to abuse, neglect and exploitation.

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[32] Law Reform Commission (1999) *Report 90 – Review of the Community Services (Complaints, Appeals and Monitoring) Act 1993 (NSW)*, section 4.53.

[33] We note that the Victorian Community Visitors Disability Board expressed concern in its 2010/11 Annual Report that Visitors were unable to visit people on Individual Support Packages. The Board noted that, while visiting people with individualised funding in private homes had never been within the ambit of the Community Visitor's role, work was needed to clarify the status of situations where people live together independently with 'pooled' packages.

However, there are also some substantial risks and challenges that need to be taken into account as part of the planning process for transition to the NDIS. Some of the issues that have been canvassed by our Part 3C Best Practice Working Group are illustrative in this regard, including:

- the access to, and availability of, expert clinicians to assess and provide clear guidance and assistance to people with disability, their supporters, and support providers at critical junctures – for example, expert assessment of an individual's capacity to consent to sexual contact; and expert (and timely) assessment, guidance and review of behaviour support needs
- access to emergency accommodation and support options, and
- access to the expert advice, clinical leadership and multidisciplinary assistance that is currently provided by FACS' Clinical Innovation and Governance Unit – including coordination and management of the Community Justice and Integrated Services Programs; and delivery of specialist behaviour intervention guidance.

Annexure 1

Safeguards and the NDIS

In July 2014, the Commonwealth, State and Territory governments began consultations to inform the development of a Consultation Regulatory Impact Statement to seek community input on the development of a national disability safeguards and quality framework. Set out below are the minimum safeguards the Disability Complaints Commissioners[34] agree should form part of a national quality and safeguards framework for people with disability under the National Disability Insurance Scheme (NDIS).[35]

The Commissioners recognise the importance of dignity of risk and its central role within a person-centred service system based on choice and control, and they welcome the NDIS's commitment to enabling participants to exercise their rights not just in planning and managing their supports, but in their wider lives as well.

Within this context, the Commissioners recognise that each person with disability faces different risks and different levels of vulnerability. This can be for a range of reasons, including the impact of a person's disability, the extent of their informal and formal support networks, the type of support required and the setting in which its delivered, and the availability of appropriate supports in the local community.

Any national safeguards system must, therefore, take a sophisticated and proportionate approach to managing risk. It should not duplicate the responsibilities of other independent community or mainstream oversight and safeguarding bodies[36] but instead work with them to promote the rights of people with disability to speak up and access the same range of protections available to the rest of the community.[37] Such an approach acknowledges that not all people with disability will require the same level or type of protection, and a person's level of vulnerability may vary from setting to setting, or change over time.

A proportionate safeguards framework supports service providers by identifying the characteristics of particular services or settings where people with disability will benefit from a more structured approach, enabling providers to direct their resources and expertise effectively.

Independent oversight and analysis of the data gathered through the different functions of the safeguarding framework (including complaints, critical incidents reports, inquiries, reviews and monitoring) provides valuable feedback about the evolving disability market. This will assist people with disability, service providers and the NDIS by providing evidence of the quality of services and outcomes.

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[34] The Disability Complaints Commissioners group encompasses NSW, Victoria, South Australia, Western Australia, Northern Territory, ACT, New Zealand, and the Australian Disability Discrimination Commissioner. Queensland and Tasmania do not currently have Disability Complaints Commissioners.

[35] This paper updates the previous paper *Safeguards and the NDIS*, published in April 2013. The minimum safeguards outlined in this document are in addition to those relating to quality frameworks and standards for registered and other support providers.

[36] Examples include consumer protection bodies, health care complaints authorities, public guardianship and trustee agencies, etc.

[37] All governments have a responsibility to improve the reach and effectiveness of all complaints mechanisms under the National Disability Strategy (*Areas for future action 2.6*).

One of the acknowledged benefits of the NDIS is the drive to develop a nationally consistent approach to disability service delivery. It will take time to build such a system, and any proposed safeguards framework must be adaptable enough to work with the current jurisdictional differences while also driving the shift to a single national approach. The framework will also need to be responsive to any new challenges or risks that emerge from the developing disability sector.

Against the background of our work in the disability sector over many years, and following discussion and agreement with people with disability, the Commissioners strongly believe that NDIS participants and potential participants should have access to the minimum safeguards set out below.

The success of a new system of safeguards is dependent on the needs of people with disability being recognised in the design of the system. A new safeguards function will need to be equipped with disability expertise and resources to ensure that information is provided through a range of communication methods, and navigation of the system is accessible for people with varying abilities.

We also recognise the critical related need for a solid strategy to support the development and provision of safeguards. In this regard, the Commissioners are keen to work with Commonwealth, State and Territory governments and people with disability on a robust set of arrangements for the delivery of the necessary safeguards.

1. **Independent oversight**,[38] consisting of a body(ies) with:
    - Complaint handling and investigative powers to:
        - receive, resolve[39] and investigate complaints
        - conduct 'own motion' inquiries and investigations[40]
        - assist people with disability to make complaints, and
        - review the pattern and causes of complaints, identify systemic issues for service improvement, and make recommendations to improve the handling and resolution of complaints.

      Central to these functions is the need to:
        - include the provision of information, education, training and advice about matters relating to complaints and complaint handling
        - establish a nationally consistent complaints reporting system, requiring the prescribed reporting of key information about complaints to the independent oversight body(ies),[41] and

[38] Concerned with supports funded by the NDIS, and people with disability who receive, or are eligible to receive, supports funded by the NDIS.

[39] Including the resolution of complaints at a local level, and through alternative dispute resolution.

[40] 'Own motion' inquiries should be able to be conducted in relation to matters about which a complaint could be made.

[41] In this regard, we refer to the provisions of s105 and s106B of the *Disability Act 2006* (Vic), requiring services to provide an annual report to the Disability Services Commissioner, including information about the number, type, and the outcome of complaints. NSW has adapted the Victorian online reporting system and included quality framework recording for use in its own sector, and WA has developed its own complaints reporting technology based on the same parameters as Victoria and NSW.

- include legislative provisions to ensure protection of complainants from any detrimental action (or threat of detrimental action) linked to a complaint.

- Legislative responsibilities to conduct ongoing reviews into the effectiveness of aspects of the NDIS (ie: monitoring, review and inquiry functions).[42]
- Responsibility for promoting access to advocacy and supported decision-making.

Service providers' actions would be assessed against the relevant standards, in the expectation that these would vary according to the type of support. Where the complaint is best dealt with by a mainstream complaints handling body, for example, a consumer affairs regulator, the complainant would be assisted in making contact with the proper body.[43]

The analysis of complaint data collected through a national reporting system will identify systemic weaknesses that can pose a risk to participants and the sustainability of the NDIS, allowing these to be addressed proactively.

2. Safeguards to prevent and effectively respond to abuse, neglect and exploitation – including:

- development of a comprehensive national framework for preventing, identifying and effectively responding to abuse, neglect and exploitation of people with disability
- a requirement to report critical incidents,[44] particularly in the context of high risk service settings [with oversight of the handling of matters by an independent oversight body(ies)]
- the introduction of a consistent national system for screening people engaged to support people with disability under the NDIS, using a comprehensive clearance and bar model[45]
- the introduction of an 'unconscionable conduct' (or exploitation) offence,[46] and
- regulation and effective oversight of the use of restrictive interventions.[47]

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[42] See the NSW *Community Services (Complaints, Reviews and Monitoring) Act 1993* (and related provisions in the NSW *Ombudsman Act 1974*).

[43] It will be important for people with disability to be provided with support throughout the complaints process, where necessary.

[44] See Part 3C (Protection of people with disability) of the NSW *Ombudsman Act 1974*.

[45] This model is largely consistent with the probity checking arrangements in place in the ACT and Queensland under the *Working With Vulnerable People (Background Checking) Act 2011* (ACT), and the *Disability Services Act 2006* (Qld). However, these systems would be enhanced by ensuring that adverse findings from the proposed critical incidents reporting system are factored into the screening (and related risk management) system.

[46] The creation of an offence for exploiting people with disability would serve as a 'safety net' for all service delivery arrangements, including those that will fall outside of the safeguards proposed for providers registered under the NDIS.

[47] Restrictive interventions include chemical, mechanical and physical restraint, and seclusion. The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, endorsed by the Disability Reform Council in March 2014, identifies accountability as a guiding principle and specifies this should be supported by transparent reporting mechanisms. These include: detailed independent monitoring; access to independent processes for complaints, or review and appeal of decisions to use restrictive practices; analysis of trends to evaluate the effectiveness of the strategies and identify any increased reliance on the use of restrictive practices.

3. Community Visitors

At a minimum, we consider that Community Visitors should be available to people with disability living in residential care funded under the NDIS, given their relative vulnerability.[48] Among other things, Community Visitors perform a critical role in independent monitoring, resolution of complaints and emerging issues, and advocacy support.[49]

4. Public Guardian/ Public Advocate

We would expect that the national system would incorporate the best aspects of the public guardian/ public advocate roles, in the context of a person-centred approach.[50]

5. Disability Advisory Council(s)

We recognise the importance of an advisory council(s) that represents people with disability.

[48] There would be merit in committing to ongoing dialogue between relevant stakeholders regarding the scope for expanding the Community Visitor scheme to potentially include other kinds of care arrangements that will emerge under the reform agenda. We consider that there is also likely to be an important and increasing role for 'independent persons' more generally under the NDIS, particularly where the person with disability does not have an informal support network, or where there are higher levels of vulnerability and/or risk involved. For example, the use of independent persons who could: visit people with disability in the community, where the planning process identifies this need; discuss proposed restrictive interventions (and the person's rights) with the person with disability and report where the person does not understand or legislative requirements are not being met; and provide supported decision-making assistance.

[49] It is worth noting the model of advocacy and assistance provided under New Zealand's National Health and Disability Services Advocacy Service, which provides a combined visiting and advocacy approach (outlined in Part 3 of the NZ *Health and Disability Commissioner Act 1994*.)

[50] Important aspects include supportive and substitute decision-making, investigating complaints or allegations that a person is under inappropriate guardianship or is being exploited or abused or in need of guardianship, and promoting the development of the ability and capacity of persons with disability to act independently. We note the approach outlined in the Victorian *Guardianship and Administration Bill 2014* and the introduction of a 'supportive guardian' function.

Annexure 2

Part 3C Best Practice Working Group – Membership List

Name	Organisation	Title
Steve Kinmond	NSW Ombudsman	Deputy Ombudsman/ Community and Disability Services Commissioner
Anthony Holton	NSW Ombudsman	Director, Disability Reportable Incidents Division
Carol Berry	NSW Ombudsman	Principal Project Officer, Practice Reform, Disability Reportable Incidents Division
Meredith Brown	NSW Ombudsman	Principal Investigator, Disability Reportable Incidents Division
Kathryn McKenzie	NSW Ombudsman	Director, Disability
Denis Clifford	NSW Police	Assistant Commissioner
Karen Clogher	NSW Police	Inspector, NWM Region Project Officer
Denise Bennett	NSW Police	Inspector
Tracy Wright	Ageing, Disability and Home Care	Executive Director, Large Residential Centres & Specialist Supported Living/Statewide Services
David Coyne	Ageing, Disability and Home Care	Executive Director, Clinical Innovation and Governance
Michelle Henwood	Ageing, Disability and Home Care	Manager, State-wide Behaviour Intervention Team, Clinical Innovation and Governance
Peter Goslett	Ageing, Disability and Home Care	Director, Policy and Practice Clinical Innovation and Governance
Alison Chung	Ageing, Disability and Home Care	Acting Manager, Behaviour Support, Clinical Innovation and Governance
Matt Frize	Ageing, Disability and Home Care	A/Manager, Clinical & Case Work Services Community Justice Program
Grant Marley	Ageing, Disability and Home Care	Director, Professional Conduct, Ethics and Performance
Jacqui Astolfi	Ageing, Disability and Home Care	Director, Operational Support
Julie Brown	Ageing, Disability and Home Care	Principal Project Officer, Operational Support
Janet McNeill	Ageing, Disability and Home Care	Senior Project Officer, Strategic Change
Harriet Ketley	Department of Justice	Policy Manager, Justice Policy
Stephen Kilkeary	Department of Justice	Victims Services
Geoffrey Tremelling	Legal Aid, NSW	Civil Outreach Solicitor
Cain Beckett	Disability Council of NSW	Chair
Scott Holz	National Disability Services	State Manager
Tony Pooley	National Disability Services	Sector Engagement Manager
Dr Bruce Chenoweth		Senior Developmental Psychiatrist
Dr Tom Tutton	Autism Spectrum	Principal Behaviour Consultant

	Australia	
Amanda Wood	Real Disability Care	Principal Psychologist
Ariana Kenny	Ability Options	Executive Leader Clinical Services
Jim Simpson	NSW Council for Intellectual Disability	Senior Advocate
Janene Cootes	Intellectual Disability Rights Service	Executive Officer
Associate Professor Leanne Dowse	University of New South Wales	Chair in Intellectual Disability and Behaviour Support
Ben Fogarty		Barrister, Denman Chambers
Mark Clayton	Sunnyfield	Executive General Manager
Lauren Murray	Life Without Barriers	Director of Operations NSW & ACT
Suzanne Punshon	National Disability Insurance Agency	Director Engagement and Funding
Leigh Budden	National Disability Insurance Agency	Assistant Director Engagement

Annexure 3

The NSW Ombudsman's employment-related child protection reportable conduct scheme

Our employment-related child protection jurisdiction commenced in May 1999, when a system was established for the Ombudsman to oversee the handling of allegations of a child protection nature against employees of government and certain non-government agencies.[51]

Our jurisdiction involves overseeing the handling of child abuse and neglect allegations that are made against employees[52] of more than 7,000 government and non-government agencies.[53] The scheme was – and remains – a unique and unprecedented jurisdiction, not least because of the oversight it brings to both government and non-government organisations in their handling of child protection concerns and the conduct of their employees (including volunteers).

Following the 2013 Victorian Parliamentary Inquiry into the handling of child abuse by religious and other organisations, a decision was made to establish a reportable conduct scheme in that state. Our office has been providing ongoing advice to Victorian agencies to support the establishment of the new scheme.

Part 3A of the *Ombudsman Act 1974* requires and enables the Ombudsman to:

- **receive and assess notifications** concerning reportable allegations or convictions against an employee
- **scrutinise agency systems** for preventing reportable conduct by employees, and for handling and responding to allegations of reportable conduct and convictions
- **monitor and oversight** agency investigations of reportable conduct
- **respond to complaints** about inappropriate handling of any reportable allegation or conviction against employees
- **conduct direct investigations** concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable notification or conviction
- **conduct audits and education and training** activities to improve the understanding of, and responses to, reportable allegations, and
- **report on trends and issues** in connection with reportable conduct matters.

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[51] The scheme was established following recommendations arising from the Wood Royal Commission into the NSW Police Service.

[52] In this context, an 'employee' is defined broadly as including: any employee of the agency, whether or not employed in connection with any work or activities of the agency that relates to children, and any individual engaged by the agency to provide services to children (including in the capacity of a volunteer).

[53] The NSW Solicitor-General recently clarified the reach of our jurisdiction and advised us that '[O]n its face the notion of "substitute residential care" in the care of children would appear to extend to any arrangement where an organisation has the care and control of children of a kind that would otherwise be provided by parents and caregivers, were a child in his or her place of residence.' This advice has greatly increased the number of agencies and individuals deemed to fall within our employment-related child protection jurisdiction. We are currently working with organisations in the recreational camping and youth sectors, together with religious and other volunteer organisations, which run camps falling within the scope of this advice.

All public authorities are subject to the requirements of Part 3A if the reportable conduct arises in the course of a person's employment. Some public authorities are 'designated agencies' and also need to notify reportable allegations if they arise from conduct that takes place outside of employment.[54] Some non-government agencies are also subject to Part 3A requirements and must notify reportable allegations that arise both within and outside of employment.[55] It is worth noting that historical allegations of child abuse only fall within our employment-related child protection jurisdiction if the involved individual is an 'employee' of a relevant agency at the time when the allegation becomes known by the head of agency.

What is notifiable to the Ombudsman?

When an allegation of 'reportable conduct' is made against an employee of relevant government and non-government agencies – including non-government schools, approved children's services and agencies providing substitute residential care – the head of agency is required to notify the Ombudsman of any reportable allegations or convictions involving their employees as soon as practicable and, the 'notification' must be made in any event, within 30 days of the head of agency becoming aware of the allegation or conviction.

Section 25C requires the head of agency to 'make arrangements within the agency to require employees of the agency to notify the head of agency of any such reportable allegation or conviction of which they become aware. We encourage agencies to notify us at the earliest possible opportunity, whether by way of formal notification or initially through telephone contact, so that we can play an early role in guiding agencies through their initial response.

Section 25A of the Ombudsman Act defines a 'reportable allegation' as an allegation of reportable conduct against a person or an allegation of misconduct that may involve reportable conduct.

Section 25A of the Ombudsman Act defines 'reportable conduct' as:

(a) Any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence), or

(b) Any assault, ill-treatment or neglect of a child, or

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[54] Under s25A of the Ombudsman Act, designated government agency means any of the following:
(a) the Department of Education and Training (including a government school) or the Department of Health,
(a1) a Division of the Government Service (or a part of a Division of the Government Service) prescribed by the regulations for the purposes of this definition,
(b) a local health district within the meaning of the *Health Services Act 1997*,
(c) any other public authority prescribed by the regulations for the purposes of this definition.

[55] Designated non-government agency means any of the following:
(a) a non-government school within the meaning of the *Education Act 1990*,
(b) a designated agency within the meaning of the *Children and Young Persons (Care and Protection) Act 1998* (not being a department referred to in paragraph (a) of the definition of ***designated government agency*** in this subsection),
(b1) an approved education and care service within the meaning of the *Children (Education and Care Services) National Law (NSW)* or the *Children (Education and Care Services) Supplementary Provisions Act 2011*,
(c) an agency providing substitute residential care for children,
(d) any other body prescribed by the regulations for the purposes of this definition.

(c) Any behaviour that causes psychological harm to a child,

whether or not, in any case, with the consent of the child.

The section also specifies that reportable conduct does not extend to:

(a) conduct that is reasonable for the purposes of discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards, or

(b) the use of force that, in all circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures, or

(c) conduct of a class or kind exempted from being reportable conduct by the Ombudsman under section 25C of the Act.

Our role in keeping agency systems under scrutiny

We primarily fulfil our section 25B requirements to scrutinise agencies' systems through our ongoing oversight and monitoring of reportable conduct matters; by conducting direct investigations, as well as our through our intelligence gathering activities. These activities are complemented by our keep under scrutiny function. Our ability to undertake auditing activities is dependent on other competing demands on our resources, such as taking a proactive role in overseeing the handling of the high volume of serious reportable conduct matters involving criminal allegations.

Under section 25B of the Ombudsman Act, the Ombudsman is required to keep under scrutiny the systems that agencies have in place for preventing reportable conduct, as well as the systems for handling and responding to reportable allegations (including allegations which are exempt from notification) and convictions, involving employees of designated government or non-government agencies, or other public authorities. Audits are one way for the Ombudsman to review such systems. Audits of agencies may be conducted independently of the investigation and monitoring role of the Ombudsman.

The purpose of an audit is generally to assist an agency to improve its systems and practices for providing safe environments for children in its care. It is also to identify and promote good practice across agencies. The Ombudsman does this by assessing the policies and practices within an agency, and providing it with advice about the good practice we identify and areas for improvement. Our audits might also identify the need for training – we discuss this area of our work below.

Our education and training role

The Ombudsman employs a range of strategies to raise awareness and knowledge of the reportable conduct scheme among designated agencies, including non-government schools, and to support employers to meet their obligations under the scheme. These strategies include:

- publishing on our website a range of factsheets and practice updates for employers
- providing direct telephone advice to employers
- delivering employment-related child protection training to staff of agencies falling within the reportable conduct scheme, including workshops on responding to child protection allegations against employees and handling serious allegations

- providing targeted information sessions to build the capacity of specific sectors/agencies, particularly those that are 'new' to our jurisdiction[56]
- regularly meeting with agencies to discuss emerging systemic or practice issues, and convening 'case conferences' to discuss individual investigations
- hosting stakeholder forums[57]and giving presentations at conferences and seminars,[58] and
- providing detailed feedback to the agencies we audit under section 25B of the Ombudsman Act.

The intersection of our reportable conduct function and the Working With Children Check

The allegation-based system that triggers a notification under Part 3A of the Ombudsman Act complements the new Working With Children Check (WWCC) system. In June 2013, we were required to commence a legislative function to support the WWCC.

In determining whether an investigation into a reportable allegation has been properly conducted, and whether appropriate action has been taken in response, we check to see whether, as required under the *Child Protection (Working with Children) Act 2012*, relevant misconduct findings have been notified to the Children's Guardian.

In this regard, under section 35 of the Working with Children Act, reporting bodies are required to notify the Children's Guardian of findings of misconduct in relation to:

1. Sexual misconduct committed against, with or in the presence of a child, including grooming of a child.
2. Any serious physical assault of a child.

In addition, Schedule 1, Clause 2A of the Act, enables the Ombudsman to make a 'notification of concern' to the Children's Guardian if we form the view, as a result of concerns arising from the receipt of information by our office in the course of exercising our functions, that '*on a risk assessment by the Children's Guardian, the*

[56] For example, in February this year we provided a workshop to the NSW Department of Education's Early Childhood Education and Care Directorate as part of our ongoing work in building capacity in the approved children's services sector. The 20 participants included Regional Managers, staff responsible for approving children's services providers and staff taking inquiries. We held a similar forum for newly accredited out-of-home care agencies in August 2014. In addition, in 2013 we convened a roundtable discussion with large out of school hours (OOSH) providers, the Department of Education and the OOSH peak body to discuss strategies for improving the child protection knowledge and capability of that sector.

[57] For example, to coincide with the 10-year anniversary of the introduction of the reportable conduct scheme in 2009, we held a major two-day symposium bringing together expert practitioners to discuss the unique issues arising from the investigation of reportable allegations and convictions. Over 320 delegates attended the symposium. In June 2013, we hosted an employment related child protection forum on the risk management of employees where there is evidence of risk to children but where this evidence is not sufficient for the person to be charged or dismissed. The forum, which was attended by approximately 100 people, had a particular focus on the challenges involved in handling cases of sexual misconduct, where behaviour may constitute a crossing of professional boundaries, but is not found to be grooming or another sexual offence under the law.

[58] For example, we addressed attendees at the NSW Family Day Care 2013 professional networking and development forum.

Children's Guardian may be satisfied that the person poses a risk to the safety of children'.[59] It is also important to note that this clause is not limited to matters arising from the exercise of our functions under Part 3A; if sufficient concerns arise from information which we have received from exercising *any* of our wide-ranging functions, we can refer the matter to the Children's Guardian.

Both section 35 referrals and Schedule 1, Clause 2A referrals by our office trigger a 'risk assessment' by the Children's Guardian in relation to whether the involved individuals pose a risk to children. Under this function, the information we supply to the Children's Guardian about individuals who may pose a risk to children triggers formal risks assessments by the Children's Guardian of that person's suitability to work with children.[60] Through this function, we have helped identify individuals of concern whose histories would not have been scrutinised under the WWCC processes if not for the information we have supplied.

Furthermore, under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, our office – and other agencies – can also refer information to the Children's Guardian to assist her in developing profiles of individuals where there is some information indicating possible emerging risk.

We routinely provide information to the Children's Guardian under Chapter 16A to inform its administration of the WWCC. (In this regard, it is worth noting that many of our Chapter 16A referrals relate to persons for whom a risk assessment trigger already exists, but we hold additional relevant information that may not be known to the Children's Guardian). This practice recognises that our office does not hold or have access to every piece of information about an individual that may be relevant to a WWCC risk assessment. Similarly, the information held or that is otherwise accessible by the Children's Guardian about persons applying or being verified for child-related work can be complemented in significant ways by the Ombudsman's holdings.

Since the commencement of Schedule 1, Clause 2A, our office has provided a significant number of notifications of concern to the Children's Guardian, and has exchanged critical risk-related information under Chapter 16A.

Our role in monitoring and reviewing the delivery of community services

It is also important to stress that our reportable conduct jurisdiction is informed, and enhanced by, our broader functions under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA). These functions include (but are not limited to) the following:

- Promoting and assisting the development of standards for delivering community services, and educating service providers, clients, carers and the community generally about those standards.
- Monitoring and reviewing the delivery of community services and related programs, including making recommendations for improvement in the delivery of community services and promoting the rights and best interests of service users.
- Inquiring, on our own initiative, into matters affecting service providers, visitable services and persons receiving or eligible to receive a community service.

[59] *Child Protection (Working with Children) Act 2012*, Schedule 1, Clause 2A

[60] These referrals are known as Notifications of Concern.

- Receiving, assessing, resolving and investigating complaints and working with agencies to improve their complaint handling procedures.
- Reviewing the situation of individual children or groups of children in out-of-home care.
- Reviewing the causes and patterns of child deaths and identifying ways in which these deaths could be prevented or reduced.

Our dual Part 3A and CS-CRAMA oversight functions have been in place for over 12 years (following the merger of the Community Services Commission with the Ombudsman's office in 2002). Our combined jurisdiction assists us in identifying systemic issues that specifically relate to the out-of-home care system, as well as those which intersect with the broader child protection system.

Following a decision by the Ombudsman in 2010 to integrate our employment-related child protection oversight and our community services monitoring and review role, we have been able to better identify, and seek to address, a range of systems issues impacting on the broader child protection system.

Evolution of our operational practice in relation to Part 3A

Much of our early work was largely targeted at establishing the framework for the implementation of the reportable conduct scheme across NSW – including an extensive education and support program involving more than 7,000 agencies – which focused on raising awareness of agencies' notification obligations; assisting them to establish child protection systems; and building their investigative capacity.

Over time, many of the agencies we oversight have increased their competency in handling reportable allegations. As a result, over the past five years we have been able to develop a more streamlined, outcome-focused approach to the oversight of agencies' investigations. We have entered into extensive negotiations with a range of sectors in relation to strengthening child protection knowledge and practice, supported by 'class or kind' determinations that exempt relevant agencies from having to notify us of less serious forms of alleged reportable conduct.[61] For example, we have entered into 20 class or kind determinations with various government agencies, dioceses, non-government organisations and independent school peak bodies.

As a result of this sector development work, we have been better placed to focus on initiatives aimed at refining and improving our own practices – as well as those of agencies within our jurisdiction – in connection with the handling of reportable conduct involving criminal allegations. In large part due to the effect of our class or kind determinations, matters involving serious criminal allegations now make up a significant proportion of our work. For example, we currently have 112 open matters concerning individuals who have been charged with criminal offences relating to children. In addition, we have a further 169 open notifications that either are, or have been, the subject of a police investigation but where charges were not, or have not yet, been laid.

Changes to our operational structure and business practices

[61] Sexual offences and sexual misconduct allegations must be notified to our office and are not included in any of our class or kind determinations.

In 2010, and as a result of a broader office restructure, the Deputy Ombudsman and Community and Disability Services Commissioner introduced a suite of staged reforms, which included changes to the Part 3A operating structure and business processes. It is important to note that these reforms took place against the background of new information sharing provisions in October 2009 (Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*) following recommendations stemming from the Special Commission of Inquiry into Child Protection Services.[62] Chapter 16A has provided significant scope for our office and other prescribed bodies to proactively share risk-related information to promote the safety, welfare and wellbeing of children.

Another important feature of our work involves our direct access to FACS' database, KiDS, and the NSW Police Force's database, COPS. Our access to both systems enables us to gain insights into risks relating to individual children that were previously not apparent to us – and that often went beyond the reportable conduct allegation being oversighted – and to identify intra and inter agency practice weaknesses, including a failure by agencies to proactively share information. Our direct access to these databases has allowed us to identify and address problems with individual cases as well as systems weaknesses in areas such as:

- carer probity screening
- potential gaps in the WWCC relating to police intelligence holdings, and
- problems caused by the existence of multiple civilian profiles on the COPS system (known as CNIs).

In establishing systems for preventing and responding to reportable allegations, we were initially managing a high volume of notifications from a relatively inexperienced and diverse range of agencies that needed significant guidance and support. Because of this, our ability to strategically target our resources and undertake significant proactive work was very limited.

By substantially reducing the volume of notifications that we receive each year through various class or kind determinations, we have been able to concentrate our efforts on improving our analysis of, and response to, serious reportable conduct matters through:

- repositioning our strategic focus towards more active monitoring of more serious, higher risk allegations
- increasing the proportion of investigators at a senior level in our employment-related child protection division, and
- increasing the level of practical support to agencies responding to allegations of serious reportable conduct.

Particular initiatives to support agencies in responding to allegations of serious reportable conduct

[62] In our 2008 submission to the Special Commission of Inquiry into Child Protection Services in NSW (Submission-to-Child-Protection-NSW-Commission.pdf), we outlined problems associated with the privacy laws that inhibit the effective exchange of information between agencies about child protection matters. We proposed a specific legislative solution that would enable the ready flow of information between agencies to promote the 'safety, welfare and wellbeing of children and young people.' His Honour Justice Wood adopted our proposal and recommended the introduction of new information sharing provisions in his final report on the Inquiry. In October 2009, Chapter 16A of the Children and Young Persons (Care and Protection) Act came into effect.

We have implemented a range of policy and practice changes in recent years to ensure that we add value to agency investigations in practical ways, and that we identify and address inhibitors to good practice.

Key initiatives that we have undertaken to support agencies in responding to allegations of serious reportable conduct include:

- Taking an increasingly proactive role in relation to serious allegations, including substantially increasing our 'in-house' access to Police and FACS databases in order to obtain a holistic understanding of the prevailing risks in particular matters and to better inform our assessment of any action that may be required. We have also played a role in remedying data integrity issues identified through our direct access to the COPS and KiDS databases.
- Since our new legislative function under the WWCC commenced in June 2013,[63] we have made 449 referrals of information to the Children's Guardian, including 28 Notifications of Concern, 284 Chapter 16A referrals, and 149 responses to Notices issued under section 31 of the *Child Protection (Working With Children) Act 2012*.
- Engaging with Police on a frequent basis in relation to significant reportable conduct matters (this approach played an important role in prosecutions involving multiple victims), and having a much greater emphasis on engaging with Police in relation to taskforces. We play an active role in facilitating police/agency contact and in briefing police on relevant holdings and possible avenues of inquiry, particularly when agencies are less experienced in handling reportable conduct and interacting with Police.
- Reaching an agreement with the Police Commissioner in 2009 regarding Standard Operating Procedures (SOPS) that clearly outline the responsibilities of local police in providing practical support to agencies responding to allegations of reportable conduct under the Part 3A scheme – these SOPS are attached (see Annexure 4).
- Revising our reportable conduct definitions in August 2010, prompted in large part by the difficulties agencies were facing in investigating, and making appropriate findings in relation to alleged sexual misconduct. Our revised definition makes it clear that, in addition to sexually explicit comments or behaviour, sexual misconduct can include boundary breaching behaviour, such as an inappropriate and overly personal or intimate relationship with, or conduct towards, a child or young person. The revised guidelines have allowed employers to be able to pursue broader lines of inquiry and examine the nature of inappropriate relationships without the need to establish 'grooming'.
- Reviewing the range of findings available to agencies and allowing agencies, in appropriate circumstances, to find that an allegation is 'not sustained – [due to] a lack of evidence of weight', rather than 'false'. The finding of 'false' is now reserved for cases where there is compelling evidence to demonstrate that an allegation is untrue, rather than simply a lack of evidence of weight.

[63] Under section 35 of the *Child Protection (Working with Children) Act 2012*, reporting bodies are required to notify the Children's Guardian of findings of misconduct in relation to: 1) sexual misconduct committed against, with or in the presence of a child, including grooming of a child; and 2) any serious physical assault of a child. In addition, Schedule 1, Clause 2A of the Act enables the Ombudsman to make a 'notification of concern' to the Children's Guardian if we form the view, as a result of concerns arising from the receipt of information by our office in the course of exercising our functions, that '*on a risk assessment by the Children's Guardian, the Children's Guardian may be satisfied that the person poses a risk to the safety of children*'.

- Promoting and strengthening the mechanisms for greater interagency collaboration and information exchange, including actively promoting and using Chapter 16A in relation to reportable conduct matters.
- Developing two new training packages to help agencies improve their responses to allegations made against their employees. Since establishing a cross-office community education and training unit in late 2009, we have delivered 73 child protection workshops to more than 1,400 stakeholders.[64]

The work of the Serious Reportable Conduct Team

The Serious Reportable Conduct Team in the Part 3A area is headed by the Director, Employment-Related Child Protection, and is comprised of a team of senior investigators who work collaboratively with investigation and support staff to ensure timely responses to high risk notifications and enquiries. The Team was established 18 months ago and, since that time, has developed and refined its processes for ensuring that information relating to serious reportable allegations – or children otherwise identified as being at-risk – are responded to quickly and as comprehensively as possible.

Our most experienced investigators regularly liaise with senior police from local area commands and the Child Abuse Squad in relation to investigating serious reportable allegations. We routinely refer detailed briefings to police, which has resulted in the commencement and/or enhancement of police investigations and the preferment of criminal charges. Generally, referrals of information to police are in the form of briefing documents and are usually released in accordance with Chapter 16A of the Care and Protection Act.[65]

A Director from the Ombudsman's executive management team is the central contact point for our office and police, and in many cases, she liaises directly with the relevant Commander in the first instance to facilitate the necessary exchange of information.

We also work closely with FACS, the Children's Guardian and employers to ensure that important child protection information is appropriately shared and managed to mitigate risks to children. Increasingly, we fulfil this important role at an early stage in our oversight of matters. We have quarterly liaison meetings with both agencies to track the progress of systemic issues identified through our oversight.

To facilitate the efficient and consistent identification of (and responses to) risk, the Team established an Intelligence Group. The establishment of the Intelligence Group was driven by a number of factors, including:

- the unique position our office is in to contribute to identifying child protection risks through our direct access to the policing and child protection databases combined with our own reportable conduct holdings – this access provides us with a 'helicopter' view of critical information which is not readily accessible to other agencies, and

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[64] Our introductory workshop, *Responding to child protection allegations against employees*, provides an overview of employer obligations under the Ombudsman Act, and covers the steps involved in the investigation process, risk assessment and risk management. Our advanced training course, *Handling serious child protection allegations against employees,* is designed for senior management and investigators and focuses on how to handle allegations that may involve criminal conduct, equipping participants with specialist and practical knowledge to help them deal with some of the more complex challenges associated with more serious allegations.

[65] *Children and Young Persons (Care and Protection Act) 1998.*

- the recognition that our 'notification of concern' function under the WWCC would need to be supported by strong internal intelligence systems to help us gather and analyse evidence to effectively identify individuals who may pose a risk to children at the earliest opportunity.

All new serious reportable conduct notifications and enquiries relating to children potentially being at-risk, flow through the Intelligence Group to ensure that our oversight is informed by all available relevant information. The Intelligence Group conducts a range of information checks drawing upon publicly accessible information sources, secure sources such as the KiDS and COPS databases, as well as our own holdings. When necessary, we also request information held on the Children's Guardian's WWCC database, and from other police data sources.

Triage and assessment

New matters flowing through the Intelligence Group are assessed and triaged under the guidance of the Director, who ensures that all accesses to secure databases are properly authorised and are in accordance with procedures aimed at protecting personal information.[66]

At the initial intake stage, limited checks are conducted to enable the Director to 'triage' the matter, including determining whether or not more thorough intelligence checks are warranted. Where a more in-depth intelligence check is required, the Director refers the matter to an Intelligence Group officer who creates a profile, outlining relevant information holdings and the nature of any immediate risks that need to be addressed, together with recommended action.

The initial response to a new notification will assess the adequacy of the agency's response to known risks, including whether it has undertaken an appropriate assessment of, and response to, identified risks. Where we identify that the agency has understated the level of risk, or taken inadequate action to properly manage identified risks, we prioritise telephone contact with the agency to explain our concerns and canvass potential options for strengthening the agency's risk management response. While we have no authority to direct or require an agency to take certain action to manage risks, agencies are very responsive to our suggestions. However, in circumstances when an agency inadequately responds, we will usually escalate our involvement by making more formal inquiries and requiring the agency to provide information supporting its actions and decisions around assessing and managing risks.

As part of our intelligence checks, we also aim to identify any alternative child-related work (including as a volunteer) that the person who is the subject of the reportable allegation may be involved in. Where we identify other work of this kind, we ascertain whether there are associated risks with that work and, if so, whether they are being addressed. Where any such risks are not being addressed, we take action in an attempt to ameliorate risks. For example, if police are involved in investigating the matter, we will alert police to the person's alternative employment, so that they can raise identified concerns directly with the 'other employer'. If there is no police involvement, we might facilitate the lawful provision of relevant information to the 'other employer'.

[66] This information is stored in accordance with NSW Government and our own internal information security requirements. The Ombudsman's Information and Intelligence Manager conducts audits of our staff access to internal and external databases to confirm compliance with established procedures.

If the other employer also happens to be within our Part 3A jurisdiction – we will engage directly with them about making a notification, managing risks and coordinating its response with all other involved agencies. In cases where we identify another employer but they are not within our employment-related child protection jurisdiction, and/or they are not a prescribed body for the purposes of Chapter 16A, we consider what other action can be taken such as referring relevant information to the Children's Guardian.

Facilitating information exchange

In many circumstances, the intelligence profile will recommend the need for a referral of information to appropriate authorities, including the Police, FACS and the Children's Guardian. In these cases, we contact those agencies as quickly as possible and alert them to the type of information identified. Where those agencies confirm they do not have (or have not identified) the information and that it is relevant to their investigation or inquiry, we then facilitate the provision of that information through the 'owning' agency. Approval by a senior officer is required for all external releases of information.

In relation to Part 3A cases where the employing agency and/or other relevant agencies are aware of all relevant information, and the documentation that we receive indicates they are taking appropriate action, we will *generally* have a limited direct role – for example, providing general guidance under our usual oversight practices – until the reportable conduct investigation is finalised. However, where we have identified that the reportable allegations have been, or should have been, reported to Police and/or FACS, we make it a priority to obtain up-to-date information about the status of the matter, including obtaining information directly from COPS and KiDS. This is a priority so that we can ensure that the employer agency is not taking action that may compromise the Police/FACS response, and that Police and FACS are responding appropriately.

Once we have established that appropriate reports have been made and the employer agency is aware of what action it should and should not be taking while a criminal or child protection response is underway, our investigators will consider all relevant available information and identify any gaps in information being used to inform any criminal or child protection response.

Our office is often the only agency with access to all relevant information about a particular matter, and in these circumstances, we will take a more active role to ensure information is shared with appropriate parties and acted on accordingly. We are regularly in a situation where we are required to liaise with relevant parties immediately to facilitate information exchange, requiring us to continually reassess other operational priorities.

Identifying and addressing data integrity issues

We take action to remedy data integrity issues whenever they come to our attention. For example, we have developed a 'multiple CNI register' to log and refer to police examples of persons with multiple civilian profiles (CNIs) in cases where a failure to link the CNIs would potentially result in critical information relevant to employment screening not being identified and/or a pattern of potentially high risk behaviour not being identified by police investigations.[67]

We also on occasion identify police events or cases that have linked the wrong person as the person of interest (POI), whether through human error or because of identity

[67] It should be noted that this process pre-dated our function in connection with the current WWCC.

confusion. In these cases, we have taken steps to ensure the incorrect POI is removed from the record and the correct POI is linked.

Similarly, we are frequently in the position of identifying holdings within the KiDS system where FACS either did not identify (or would not have identified) the involved person when conducting a check on the subject person, because the person had not been linked to the relevant child's record. In these cases, we have raised our concerns with FACS and have requested that it take steps to ensure the relevant records are linked.

While these case-by-case data remediation efforts are resource-intensive, this work is given priority due to the potential significant impact data discrepancies can have on identifying and responding to child protection risks. (More broadly, we have highlighted the need for FACS to address this issue from a systems perspective).

Referring matters to Police

On receipt of information about reportable allegations, our immediate priority is to assess whether the information meets the threshold for a report to FACS and/or Police and, if so, establishing whether or not this has already occurred. The timely reporting of criminal allegations to Police – and where appropriate, the reporting of risk of significant harm (ROSH) concerns to FACS – are essential to ensuring that any criminal and/or child-protection response, are not compromised.

Our new operating environment has enabled us to further strengthen our already strong, professional relationship with the NSW Police Force, and our shared commitment to ensuring child sex offenders are identified and prosecuted.

We also work closely with employers who have not recognised their responsibility to refer matters to the police, guiding them through this process and ensuring that their workplace response to matters does not compromise any police investigation. Increasingly, we fulfil this role at an early stage of our oversight of matters – because of the imperative to act promptly when children are at risk.

Since 2009, we have raised concerns about matters where FACS had not reported criminal child abuse allegations to police. In response to an investigation that we conducted last year concerning FACS' response to a report about a teacher alleged to have sent a sexually explicit text message to a child, FACS has acknowledged that their policies for reporting such criminal allegations to police are inadequate. They have told us they are developing improved policies and procedures to guide frontline staff on when and how to refer matters to police. We are pleased that FACS has made this commitment, but believe it is essential that practice in this critical area improves as soon as possible.

Where we identify that reporting obligations have not been met, we triage the matter for urgent/priority action. This will generally involve making telephone contact with the relevant agency to: provide advice about the need to make reports to FACS and/or Police; provide guidance on the type of information it should include in such reports; and to emphasise to the agency that it may need to suspend any response to the reportable allegation pending clearance from those agencies.

We closely monitor the agency's compliance with our advice until we are satisfied that the relevant authorities are aware of the matter and that the agency understands how it should proceed. In addition to maintaining contact with the agency about its compliance, we confirm via the Police or KiDS database that the reports have been made and that an

appropriate level of information was included in the reports to enable those agencies to assess what, if any, action they should take.

When we identify through the Police or KiDS database that one or both of these agencies intends to take action on a matter, we will often maintain ongoing dialogue with the employing agency, to ensure it does not hinder or inadvertently compromise the child-protection or criminal response.

We also identify matters where it appears that Police or FACS have determined not to take any action in response to an employer's report, in circumstances where we have reason to believe that action is warranted. This can often be a result of the report failing to clearly articulate the criminal conduct. In such cases, we might guide the employer to provide further information to Police and/or FACS; we may initiate direct dialogue with Police or FACS; or we might coordinate and facilitate an interagency meeting to promote a thorough exploration of the relevant evidence and investigative options.

Finally, it is generally the role of the employing agency to report criminal allegations to Police and ROSH matters to FACS. The Ombudsman's involvement generally revolves around identifying reporting failures; liaising with relevant parties to remedy problems with the response to matters; and monitoring compliance with required actions. However, we will frequently make reports directly to Police and/or FACS. This includes in cases that involve technical legal and/or evidentiary issues; where there is no other agency currently involved in the particular matter; or where the matter requires urgent action.

Annexure 4

Police Standard Operating Procedures (SOP) – Employment related child abuse allegations

Purpose[68]

To give guidance to police responding to employment related criminal child abuse allegations against employees of agencies responsible for the provision of services to children and young people.

Procedures

As an employing agency is unable to conduct its own investigation until Police have either rejected the matter or completed their investigation, it is important that the employing agency is kept informed of the police investigation and any action that can be undertaken by the agency while Police are conducting their own investigation.

The following procedures outline some of the key issues to be addressed when responding to employment related criminal child abuse allegations.[69]

- In cases where the Local Area Command (LAC) decides that the matter should be referred to the Joint Investigation Response Team (JIRT), JIRT procedures should be followed. The employing agency must be notified within **48 hours** of transfer and provided with the contact details of the JIRT officer.
- If the matter was not referred to the LAC by the employing agency and the LAC is aware that the subject of the allegations is engaged in child related employment, then the LAC should notify the employer of the criminal allegations as soon as practicable to enable the employing agency to take appropriate risk management action.
- In cases where the Police referral is made by any source other than Community Services, the LAC should, as soon as practicable, confirm with the employing agency or other reported whether the matter has been reported to Community Services (and in the case of an agency referral, if not, why not).
- The LAC is to make a decision to accept or reject the investigation as soon as practicable, preferably within two business days, and advice the agency.
- If the matter will be investigated by Police, the employing agency should be provided with:
    - the contact details of the investigating officer,
    - expected timeframes for updates,
    - advice as to whether the employee can be advised of the nature of the allegations,
    - advice as to whether the employee can be informed of the Police investigation, and
    - any known information relating to the safety, welfare or well being of a particular child or young person/s if the investigating officer believes that the provision of the information would assist the employing agency to manage any risk to such persons

[68] Full details of the legislative scheme, including definitions are at Appendix 1.

[69] It should be recalled that in all interactions with children and young people their safety, welfare and wellbeing is of paramount concern to police.

that might arise in the agency's capacity as employer of the subject of the allegations.

Prior to providing such advice, Police will usually need to discuss these issues with the employing agency, to assist both parties to reach a shared understanding as to how best to protect the investigative process, while at the same time enabling the employer to fulfill its statutory and other common law responsibilities.

- If the LAC is unable to make a decision about whether to proceed with an investigation within two business days, the employing agency is to be contacted by a police officer from the LAC as soon as practicable after the expiry of the second business day for the purpose of informing the employing agency when it is likely to make such a decision.
- When an investigation is discontinued prior to the laying of charges, the investigating officer, or his or her nominee, is to inform the employing agency within **48 hours** of making the decision to discontinue the investigation. The investigating officer, or his or her nominee, is to provide information relating to the safety, welfare or well being of a particular child or young person/s if he or she reasonably believes that the provision of the information would assist the agency:
    a) to make any decision , assessment or plan, to initiate or conduct any investigation, or to provide any service, relating to the safety, welfare or well-being of the child or young person/s.
    b) manage any risk to the child or young person/s that might arise in the employing agency's capacity as an employer.
- For all matters the subject of ongoing investigation and/or prosecution, Police should provide an agency with regular updates on the progress of the investigation or prosecution. Police and the employing agency should reach and agreement as to the frequency of these updates.

Appendix 1

The Legislative Scheme

Part 3A of the *Ombudsman Act 1974* (the Act) relates to the Ombudsman's workplace child protection jurisdiction. The Ombudsman oversights designated and non-designated employers' handling of reportable allegations against their employees. Reportable allegations constitute sexual offences, sexual misconduct, assault, ill-treatment, neglect and behaviour that causes psychological harm to children.

Designated employers include both government and non government agencies who are required to notify the Ombudsman of allegations arising in the course of their employee's work and non-work life.

Non-designated employers include all other government agencies (such as NSW Police Force) who are only required to report to the Ombudsman reportable allegations made about their employees that arise in the course of their employment with their agency.

Relevant section of *Ombudsman Act 1974* No 68

Part 3A Child protection

25A Definitions

(1) In this Part:

child means a person under the age of 18 years.

designated government agency means any of the following:

(a) the Department of Education and Training (including a government school), the Department of Community Services, the Department of Health, the Department of Sport and Recreation, the Department of Juvenile Justice or the Department of Corrective Services,

(b) an area health service within the meaning of the *Health Services Act 1997*,

(c) any other public authority prescribed by the regulations for the purposes of this definition.

designated non-government agency means any of the following:

(a) a non-government school within the meaning of the *Education Act 1990,*

(b) a designated agency within the meaning of the *Children and Young Persons (Care and Protection) Act 1998* (not being a department referred to in paragraph (a) of the definition of designated government agency in this subsection) or a licensed children's service within the meaning of that Act,

(c) an agency providing substitute residential care for children,

(d) any other body prescribed by the regulations for the purposes of this definition.

employee of an agency includes:

(a) any employee of the agency, whether or not employed in connection with any work or activities of the agency that relates to children, and

(b) any individual engaged by the agency to provide services to children (including in the capacity of a volunteer).

head of an agency means the chief executive officer or other principal officer of the agency. The regulations may specify the person who is to be regarded as the head of a particular agency for the purposes of this definition.

investigation of a matter includes any preliminary or other inquiry into, or examination of, the matter.

reportable allegation means an allegation of reportable conduct against a person or an allegation of misconduct that may involve reportable conduct.

reportable conduct means:

(a) any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence), or

(b) any assault, ill-treatment or neglect of a child, or

(c) any behaviour that causes psychological harm to a child,

whether or not, in any case, with the consent of the child. Reportable conduct does not extend to:

(a) conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards, or

(b) the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures, or

(c) conduct of a class or kind exempted from being reportable conduct by the Ombudsman under section 25CA.

Note. Examples of conduct that would not constitute *reportable conduct* include (without limitation) touching a child in order to attract a child's attention, to guide a child or to comfort a distressed child; a school teacher raising his or her voice in order to attract attention or to restore order in the classroom; and conduct that is established to be accidental.

reportable allegation means an allegation of reportable conduct against a person or an allegation of misconduct that may involve reportable conduct.

reportable conviction means a conviction (including a finding of guilt without the court proceeding to a conviction), in this State or elsewhere, of an offence involving reportable conduct.

(2) A reference in this Part to a designated government or non-government agency is a reference to a designated government agency or a designated non-government agency.

(3) A reference in this Part to a reportable allegation or a reportable conviction extends to any such allegation or conviction in respect of a matter occurring before the commencement of this Part.

Information Provision

New laws that relate to the exchange of information about children and young people commenced on **30 October 2009. Chapter 16A** of the *Children and Young Persons (Care and Protection) Act 1998* prioritises the safety, welfare and wellbeing of a child or young person over an individual's right to privacy.

Chapter 16A allows government agencies – including NSW Police – and non-government organisations (NGOs) who are "prescribed bodies" to exchange information that relates to a child's or young person's safety, welfare or wellbeing, whether or not the child or young person is known to Community Services, and whether or not the child or young person consents to the information exchange. Up until now, information exchange has generally only been possible where the information was sent to or received from Community Services.