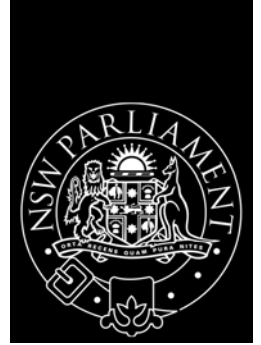


PARLIAMENT OF NEW SOUTH WALES



Committee on the Office of the Ombudsman
and the Police Integrity Commission
REPORT ON THE FOURTEENTH GENERAL MEETING
WITH THE NSW OMBUDSMAN

Together with Questions on Notice,
Transcript of Proceedings and Minutes

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Table of Contents

Membership & Staff	iii
Functions of the Committee	v
Chair's Foreword	ix
CHAPTER ONE - COMMENTARY	1
Legal professional privilege	1
Oversight powers for telecommunications interception	2
Local councils and development applications	3
Streamlining of police complaints arising from the <i>Ten Year Review of the Police Oversight System in New South Wales</i>	3
CHAPTER TWO - QUESTIONS ON NOTICE	5
NSW Ombudsman Annual Report 2005-2006	5
NSW Ombudsman Annual Report 2006-2007	6
CHAPTER THREE - ANSWERS TO QUESTIONS ON NOTICE	11
NSW Ombudsman Annual Report 2005-2006	11
NSW Ombudsman Annual Report 2006-2007	119
CHAPTER FOUR - TRANSCRIPT OF PROCEEDINGS	155
APPENDIX 1 – COMMITTEE MINUTES	171

Membership & Staff

Chair	Ms Angela D'Amore MP, Member for Drummoyne
Members	Mr Peter Draper MP, Member for Tamworth
	Mr Malcolm Kerr MP, Member for Cronulla
	Mr Paul Pearce MP, Member for Coogee
	Ms Sylvia Hale MLC
	The Hon Charlie Lynn MLC
	The Hon Lynda Voltz MLC
Staff	Ms Pru Sheaves, Committee Manager
	Ms Samantha Ngui, Senior Committee Officer
	Mr Jonathan Elliott, Research Officer
	Ms Hilary Parker, Committee Officer
	Ms Nina Barrett, Assistant Committee Officer
Contact Details	Committee on the Office of the Ombudsman and the Police Integrity Commission Parliament of New South Wales Macquarie Street Sydney NSW 2000
Telephone	02 9230 2737
Facsimile	02 9230 3052
E-mail	ombopic@parliament.nsw.gov.au
URL	www.parliament.nsw.gov.au/ombudsmanpic

Functions of the Committee

The Committee on the Office of the Ombudsman and the Police Integrity Commission is constituted under Part 4A of the *Ombudsman Act 1974*. The functions of the Committee under the Ombudsman Act are set out in s.31B(1) as follows:

- to monitor and to review the exercise by the Ombudsman of the Ombudsman's functions under this or any other Act;
- to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Ombudsman or connected with the exercise of the Ombudsman's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;
- to examine each annual and other report made by the Ombudsman, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;
- to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Office of the Ombudsman;
- to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

These functions may be exercised in respect of matters occurring before or after the commencement of this section of the Act.

Section 31B(2) of the Ombudsman Act specifies that the Committee is not authorised:

- to investigate a matter relating to particular conduct; or
- to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or
- to exercise any function referred to in subsection (1) in relation to any report under section 27; or
- to reconsider the findings, recommendations, determinations or other decisions of the Ombudsman, or of any other person, in relation to a particular investigation or complaint or in relation to any particular conduct the subject of a report under section 27; or
- to exercise any function referred to in subsection (1) in relation to the Ombudsman's functions under the *Telecommunications (Interception) (New South Wales) Act 1987*.

The Committee also has the following functions under the *Police Integrity Commission Act 1996*:

- to monitor and review the exercise by the Commission and the Inspector of their functions;
- to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or the Inspector or connected with the

Functions of the Committee

exercise of their functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

- to examine each annual and other report of the Commission and of the Inspector and report to both Houses of Parliament on any matter appearing, or arising out of, any such report;
- to examine trends and changes in police corruption, and practices and methods relating to police corruption, and report to both Houses of Parliament any changes which the Joint Committee thinks desirable to the functions, structures and procedures of the Commission and the Inspector; and
- to inquire into any question in connection with its functions which is referred to it by both Houses of Parliament, and report to both Houses on that question.

The Act further specifies that the Joint Committee is not authorised:

- to investigate a matter relating to particular conduct; or
- to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, a particular matter or particular conduct; or
- to reconsider the findings, recommendations, determinations or other decisions of the Commission in relation to a particular investigation or a particular complaint.

The Statutory Appointments (Parliamentary Veto) Amendment Act, assented to on 19 May 1992, amended the Ombudsman Act by extending the Committee's powers to include the power to veto the proposed appointment of the Ombudsman and the Director of Public Prosecutions. This section was further amended by the *Police Legislation Amendment Act 1996* which provided the Committee with the same veto power in relation to proposed appointments to the positions of Commissioner for the PIC and Inspector of the PIC. Section 31BA of the Ombudsman Act provides:

- The Minister is to refer a proposal to appoint a person as Ombudsman, Director of Public Prosecutions, Commissioner for the Police Integrity Commission or Inspector of the Police Integrity Commission to the Joint Committee and the Committee is empowered to veto the proposed appointment as provided by this section. The Minister may withdraw a referral at any time.
- The Joint Committee has 14 days after the proposed appointment is referred to it to veto the proposal and has a further 30 days (after the initial 14 days) to veto the proposal if it notifies the Minister within that 14 days that it requires more time to consider the matter.
- The Joint Committee is to notify the Minister, within the time that it has to veto a proposed appointment, whether or not it vetoes it.
- A referral or notification under this section is to be in writing.
- In this section, a reference to the Minister is;
 - in the context of an appointment of Ombudsman, a reference to the Minister administering section 6A of this Act;
 - in the context of an appointment of Director of Public Prosecutions, a reference to the Minister administering section 4A of the *Director of Public Prosecutions Act 1986*; and

in the context of an appointment of Commissioner for the Police Integrity Commission or Inspector of the Police Integrity Commission, a reference to the Minister administering section 7 or 88 (as appropriate) of the *Police Integrity Commission Act 1996*.

Chair's Foreword

This report on the Fourteenth General Meeting with the New South Wales Ombudsman was the first opportunity for the Committee to exercise its oversight role since the commencement of the 54th Parliament.

The General Meetings are a valuable tool for the Committee to perform its work of monitoring and reviewing the functions of the Office of the New South Wales Ombudsman. A number of matters arose from the Fourteenth General Meeting on which the Committee will be taking action, for example, the anomalous way in which legal professional privilege is addressed within the Ombudsman Act and discrepancies between New South Wales and Commonwealth telecommunications interception legislation.

Claims by some public sector agencies of legal professional privilege for particular documents can prevent the Ombudsman from gaining access to those documents, and the Ombudsman gave evidence that in some cases this is done to obstruct his investigations. This is an anomalous situation. The NSW Ombudsman is the only Ombudsman in Australia from whom documents can be withheld on the basis of legal professional privilege. Further, it is anomalous in terms of the Ombudsman Act, where legal professional privilege cannot be claimed in relation to Freedom of Information investigations. The Committee intends seeking an amendment to the Ombudsman Act to remove the legal professional privilege exemption in s21 of the Act.

The Committee is also concerned about the inconsistencies evident between New South Wales and Commonwealth telecommunications interception legislation. It is particularly concerning that the NSW telecommunications interception regime appears to use an obsolete warrant in the form of the Part VI warrants. It is also of concern that the NSW Ombudsman is not provided with as much information regarding warrants for telecommunications interception as his Commonwealth and interstate counterparts, for example the date and time of commencement and the duration of the interception. The NSW legislation does not require the Ombudsman to examine these particular records. The Committee will be raising these matters with the Attorney General.

Finally I would like to thank the Members of the Committee for their participation in the General Meeting and their contribution to the reporting process. The Committee's report is a consensus document which represents the bipartisan and constructive approach taken by Members of the Committee to the exercise of its oversight role.



Angela D'Amore MP
Chair

Chapter One - Commentary

- 1.1 On 18 March 2008, the Committee conducted the Fourteenth General Meeting with the New South Wales Ombudsman and his executive officers. This was the first meeting between the Committee and the Ombudsman for the 54th Parliament following the March 2007 election.
- 1.2 As part of the process of preparing for the General Meeting, the Committee sent questions on notice to the Ombudsman about matters raised in his most recent Annual Report as well as his Annual Report for 2005-2006. The answers to these questions on notice can be found in Chapter Three of this report.
- 1.3 Evidence was taken from the Ombudsman and his officers on the morning of 18 March 2008 in relation to the Annual Report for 2006-2007 as well as the Annual Report for 2005-2006. The Committee's examination also included questions about current issues relevant to the Ombudsman's jurisdiction. The commentary that follows focuses on a number of issues discussed at the General Meeting, in particular issues of legal professional privilege, oversight powers for telecommunications interception, local councils and development applications and the streamlining of police complaints arising from the *Ten Year Review of the Police Oversight System in New South Wales*.

LEGAL PROFESSIONAL PRIVILEGE

- 1.4 During his opening statement at the Committee's 14th General Meeting with the Ombudsman, the Ombudsman drew the Committee's attention to the issue of legal professional privilege. For Ombudsman in other States, Territories and the Commonwealth and the Western Australian Parliamentary Commissioner, public sector agencies cannot refuse access to documents on the basis of a claim of legal professional privilege. The Police Integrity Commission and the Independent Commission Against Corruption are not prevented from accessing any class of document. However under section 21 of the NSW Ombudsman Act, a claim of legal professional privilege can prevent the Ombudsman from gaining access to documents held by a public sector agency.
- 1.5 In an apparent anomaly within the Ombudsman Act, legal professional privilege cannot be claimed as an exemption when the Ombudsman reviews Freedom of Information applications. Section 21B of the Ombudsman Act provides for the production of documents over which legal professional privilege has been claimed as long as they relate to the FOI matter.
- 1.6 The Ombudsman previously raised this matter with the Committee during the Committee's *Ten Year Review of the Police Oversight System in New South Wales*. The Ombudsman's submission noted that there had been a number of occasions when New South Wales Police had challenged his Office's entitlement to access all information relevant to assessment of a complaint investigation. Legal professional privilege formed the basis for these challenges.
- 1.7 During the 14th General Meeting, the Ombudsman clarified his position in relation to legal professional privilege, especially in relation to a claim based on the potential criminality or liability of an individual. Mr Barbour gave evidence that legal professional privilege is not frequently used in this way. Rather, it tends to be used by

agencies who have obtained legal advice, and as a consequence argue that that material or information should not be provided to the Ombudsman. When asked if he considered the legal professional privilege exemption as a device used by agencies to block access to information that is a legitimate part of the Ombudsman's inquiries, Mr Barbour responded that while not all agencies use the provision in such a way, in a significant majority of cases where it is invoked, it is done in an attempt to prevent a more detailed examination of a particular matter.

- 1.8 The Committee cannot see that such an exemption is needed, especially when it does not apply to other aspects of the Ombudsman's jurisdiction. It is also concerning that such a provision can be, and appears to be, used by agencies to frustrate the work of the Ombudsman's Office. The Committee intends to write to the Premier and the Attorney General seeking an amendment to the Ombudsman Act to remove the legal professional privilege exemption.

OVERSIGHT POWERS FOR TELECOMMUNICATIONS INTERCEPTION

- 1.9 Under the *Telecommunications (Interception and Access) (NSW) Act 1987* the Ombudsman is responsible for ensuring that agencies¹ carrying out telecommunications interception comply with all the necessary record-keeping requirements. A judicial officer or a member of the Commonwealth Administrative Appeals Tribunal grants the warrants for telephone interception, so the Ombudsman has no role in scrutinising compliance with the approval process.
- 1.10 The Ombudsman is required to inspect agency records at least twice a year, and has the discretionary power to inspect records for compliance at any time. The inspection results are reported to the Attorney General.
- 1.11 During the 14th General Meeting with the Ombudsman, following questioning about the monitoring of B-party warrants, the Ombudsman took a question on notice regarding the inconsistencies between the NSW telecommunications legislation and that of other states and the Commonwealth, particularly in relation to Part VI warrants.
- 1.12 The Ombudsman's response to the question taken on notice stated generally that the Commonwealth and NSW legislation regarding telecommunication interception should be complementary, as envisioned by section 35 of the *Telecommunications (Interception and Access) Act 1979 (Cwth)*.
- 1.13 The response to the question taken on notice outlined five areas of inconsistency between NSW legislation and Commonwealth legislation. These areas are:
1. Amendments to the Commonwealth Act referring to a particular class of warrants as Part 2.5 warrants rather than Part VI warrants, now means that the NSW legislation is obsolete as there are no Part VI warrants in the Commonwealth Act;
 2. The Commonwealth legislation, and the Victorian, Western Australian, Tasmanian and Northern Territory legislation all require specific information relating to the warrant to be kept. NSW does not have this requirement;

¹ NSW Police Force, the NSW Crime Commission, the Police Integrity Commission and the Independent Commission Against Corruption are all agencies monitored by the Ombudsman in relation to telecommunications interception.

3. The NSW and Commonwealth legislation define 'restricted record' differently;
 4. The Commonwealth Act allows for the inspecting agency to more thoroughly examine whether breaches of the Commonwealth Act have occurred; and
 5. The Commonwealth Act provides for the exchange of information between the Commonwealth and state inspecting authorities, but there is no complementary provision in the NSW Act.
- 1.14 The Committee is concerned that these inconsistencies have been evident in the telecommunications interception legislation for a number of years. It is particularly concerning that the NSW telecommunications interception regime appears to use an obsolete warrant in the form of the Part VI warrants.
- 1.15 The Committee is also concerned that the NSW Ombudsman is not provided with as much information regarding warrants for telecommunications interception as his Commonwealth and interstate counterparts, for example the date and time of commencement and the duration of the interception. This is particularly concerning in 'named person warrants' because after the initial warrant has been issued by a judge or eligible member, the decision about which services to intercept is made by chief officer of the agency. The NSW legislation does not require the Ombudsman to examine these records. The Committee will be raising these matters with the Attorney General.

LOCAL COUNCILS AND DEVELOPMENT APPLICATIONS

- 1.16 During the 14th General Meeting, suggestions in the Ombudsman's Annual Report for 2005-2006 about how councils could reduce complaints about developments were discussed. Of particular interest to the Committee was that while the Ombudsman circulated a wide range of information to local government, a general manager would need to have read the Annual Report to access the complaint reduction suggestions. As a consequence, the Committee has written to all councils in NSW, enclosing this section of the Ombudsman's Annual Report for 2005-2006.

STREAMLINING OF POLICE COMPLAINTS ARISING FROM THE TEN YEAR REVIEW OF THE POLICE OVERSIGHT SYSTEM IN NEW SOUTH WALES

- 1.17 In 2006, the previous Committee on the Office of the Ombudsman and the Police Integrity Commission conducted a review of the police oversight system in New South Wales. 2006 marked the tenth anniversary of the new police oversight system introduced following the Wood Royal Commission into the New South Wales Police. Recommendation 6 of the Committee's Ten Year Review report was that NSW Police should consider ways to encourage the informal resolution of minor complaints at a local command level, particularly local management issues, without the involvement of complaints management teams.
- 1.18 The Ombudsman spoke of the genuine commitment of both NSW Police Force and his Office to implementing this recommendation. Both agencies have worked closely together to develop an alternative approach to handling minor complaints aimed at providing complainants and those officers the subject of complaints with fair and

Commentary

timely outcomes, as well as enabling commanders and senior officers to make better use of their resources. The Ombudsman noted that NSWPF commenced a trial of this approach in 12 local area commands on 1 August 2007. The Ombudsman's preliminary view of the trial is that where it has been applied to less serious complaints, the arrangements are proving successful. The Ombudsman stated that it was hoped that once further evaluation had been conducted, the alternative approach to handling minor complaints could be rolled out across the State. The Committee will follow the development of the trial with interest.

Chapter Two - Questions on Notice

NSW OMBUDSMAN ANNUAL REPORT 2005-2006

Dealing with unreasonable complainant conduct

What have been the outcomes of the trial of the framework for managing unreasonable complainant conduct (p36)?

Civil proceedings against police

Has there been any change to the NSW Police management of complaints made about police officers during the course of civil proceedings (p46)?

Local Government

The Office has suggested that local councils can reduce complaints made about developments where a private certifier has been the principal certifying authority by developing clear policies and procedures, training staff and educating property owners and certifiers (p 84-85). Have these suggestions been passed on to all NSW councils and have they been widely adopted?

Corrective Services

On page 95 of the 2005-2006 Annual Report you reported that the Corrective Services Commissioner challenged the Ombudsman's jurisdiction to investigate the systems the department has to prevent the disclosure of confidential information by departmental staff. Has this jurisdictional issue been resolved?

Employment –Related Child Protection

The 2005-2006 Annual Report noted your concerns about some of DADHC's investigations and that DADHC's child protection policy was not yet completed (p 118-119). Has the Department finalised their child protection policy and has the Department addressed the concerns that you raised about their investigation practices?

Protected Disclosures

There has been significant public interest in UNSW's handling of protected disclosures, particularly the treatment of whistleblowers. Given this interest and the resources expended by the Office on the investigation, could some details be provided as to why this investigation was discontinued.

Community Services

The Department of Community Services acknowledged a number of systemic deficiencies at the time of the Ombudsman's 2004 Special Report to Parliament – *Improving outcomes for children at risk of harm – a case study*. The complaints about child protection services listed in the Annual Report on page 67 indicate on-going problems with identifying and adequately assessing risk factors, failure to integrate case history and poor file documentation and record keeping.

- a) In answer to questions on notice for the Committee's Thirteenth General Meeting with the Ombudsman, you advised that DoCS had indicated that it would be conducting audits of its risk assessment model and of compliance with requirements for client

Questions on Notice

records management. Has DoCS informed the office of the outcomes of these audits?

- b) Has there been any improvement to the exchange of information between NSW Police, NSW Health and DoCS?

What were the outcomes of the Office's review (p69) of the circumstances of children and young people under the parental responsibility of the Minister for Community Services who were living in SAAP services?

Did the Office make any recommendations as a result of its study of care proceedings in the NSW Children's Court (p70)?

NSW OMBUDSMAN ANNUAL REPORT 2006-2007

Proactive projects

Can you provide the Committee with more detail on the mystery shopper audits that were conducted into DADHC customer service provision? Please include an overview of the results of the audit in your response (page 17).

Chapter 1: Corporate Governance

What were the main outcomes of the consultant's review of community service complainants and other stakeholders (page 23)?

How will the work undertaken by the independent contractor on the development of data classification systems impact on the reporting of issues identified by official community visitors (page 25)?

Can you provide the Committee with details on how the budget for the four program areas of Police, General, Child Protection and Community Services are calculated (Figure 7 on page 28)?

Chapter 4: Police

The Annual Report notes that the deficiencies identified by the Ombudsman in police investigations were remedied in 84% of cases (page 53). What happened in the remaining 16% of cases?

The auditing of 24 deficient investigations led to a change in outcome in nine matters as a result of further investigation by police (page 61). What happened in the remaining 15 cases? Were any potentially systemic issues uncovered?

Following from the Ombudsman's investigation into misconduct at the Police College in August 2006, NSW Police Force established an inquiry lead by Ms Chris Ronalds SC (page 61). One of Ms Ronald's recommendations was to establish a specialist unit for dealing with sexual harassment and discrimination. The Commissioner for Police announced the establishment of a specialist workplace equity unit in June 2007. Have NSWPF implemented the rest of Ms Ronald's recommendations?

The Annual Report notes on page 62 that NSWPF have been using the Complaint Allocation Risk Appraisal (CARA) system to determine if a complaint should be managed

locally or allocated to another command since 1 March 2007. A joint evaluation of CARA by the Police Integrity Commission, the Ombudsman and NSWPF has been planned. When will this assessment take place?

How is the implementation of electronic notification of new complaints from police progressing (page 63)?

Following the release of the Ombudsman's special report on domestic violence in December 2006, the Ombudsman made 44 recommendations to NSWPF. The Annual Report notes that NSWPF accepted the majority of the recommendations (page 64). Which recommendations were not accepted, and why? What progress is NSWPF making in implementing those recommendations that were accepted?

In relation to the Ombudsman's review of police pursuits, the Annual Report states that NSWPF accepted 23 of the 29 recommendations (page 64). What reasons were given for not accepting six recommendations? The Annual Report also notes an apparent lack of progress in implementing the recommendations. Have NSWPF given any reasons for the lack of progress? Have they moved to implement any of the recommendations?

Chapter 5: Covert Operations

The Annual Report notes at page 70 that amendments made in 2006 to the Commonwealth Telecommunications (Interception and Access) Act 1979 included provision for the interception of communications of an innocent third party known to communicate with a person of interest. They also provided for stored communications warrants which allow law enforcement agencies to lawfully access through covert means emails, SMS and voicemail messages. The Annual Report further notes that the failure over recent years to amend the Telecommunications (Interception) (NSW) Act to keep it up to date with the Commonwealth legislation means that the Ombudsman does not have the power to monitor how agencies use these new interception powers.

Are these new interception powers widely used by law enforcement agencies? Is any other monitoring of how these powers are used done by any other agency? Does the Ombudsman consider this outdated legislation to be a problem?

Chapter 7: Departments and Authorities

Many of the issues which the office has dealt with concern core business of departments and agencies eg the operation of the new structure for the Office of the Protective Commissioner; delays in dealing with applications to the Crown Lands Division of the Department of Lands; compliance with standards required to qualify for a licence (Ministry of Transport); providing comprehensive, plain English reasons for decisions (Department of Housing); delays in processing development applications (Department of Planning).

Do departments and agencies react positively to suggestions by the office for improvement to policies and procedures? Where suggested changes are made, how does the office check that improved policies and procedures are working for customers or clients?

Chapter 8: Community Services

You report that 63% of community services complaints were assessed and determined within 10 weeks (page 81). In the 2005-2006 reporting period, 75% were finalised within 10 weeks. Can you explain the main reasons for this variation in results?

Questions on Notice

In the recommendations made to community service providers following a review of their complaint-handling systems (page 83), were agreed outcomes/actions identified? And was a timeline for implementation put in place? If not would such developments be beneficial?

What was the response to the suggestion, reported at pages 84-5 in relation to the review of child protection legislation, for a forum focussing on expectations in child care proceedings?

The Annual Report outlines the first stage in a project to better understand the needs of Aboriginal foster carers and non-indigenous carers of Aboriginal children in NSW (page 85). What has been the response to the project to date and what future stages of the project have been planned?

Details are provided in the Annual Report of DoCS releasing a draft policy in March 2006 for consultation with relevant peak agencies: Assisting unaccompanied children under 16 years in SAAP youth accommodation services (page 86). Are you satisfied with the progress of DoCs to date in relation to the development of this policy?

You report that you have asked DADHC for detailed information about their plans for accommodation services, and that in the coming year you will be obtaining legal advice to inform your continued monitoring of these issues (page 88). What were the issues about which legal advice was sought?

When do you anticipate a response from DACHC in relation to your queries regarding the implementation of their strategy designed to improve services for people from CALD communities (page 89)?

What assessment has been done of the effectiveness of the child and family services education project (page 94)?

You report that in 2006-07 Official Community Visitors provided 9507 hours of services to residents, a significant increase on the 7581 hours in 2005-06, and that three new Official Community Visitors started during the year. How many hours of service to residents were provided in 2005/06 and in 2006/07 per Visitor (page 95)?

The number of visits by Official Community Visitors to services for children, young people and adults with a disability went from 109 in 2005-06 to 54 in 2006-07 (page 96, Fig 42). Can you provide some background as to the reasons for this decrease?

Chapter 10: Corrections

Our relationship with DCS is generally positive and cooperative. We try to resolve the majority of concerns brought to us quickly and at the local level, so this professional relationship is important. Staff working in centres and throughout the department generally provide us with information and respond to our questions in a timely manner. They will continue to do so as long as the most senior staff in their department encourage them to respond to us in this way and lead by example.
(page 104)

Does the office receive appropriate cooperation from senior DCS staff?

Chapter 11: Juvenile Justice

You have noted the increase in the number of young people in custody in juvenile justice centres over the past two years and the difficulties in accommodating them (pages 115-6). Is there evidence that this trend will continue and what will be the implications for the operations of juvenile justice centres and for detainees?

Chapter 12: Freedom of Information

What proportion of access to information complaints had not been determined by the agency with which the application was lodged (page 122)? When were some of these applications lodged and is it anticipated that they will be determined soon?

You report that in May 2007 you wrote to DET enclosing advice from the Solicitor General and asking DET to consider redrafting their policy on the disclosure of school accident reports (page 125). Has a response been received from DET in relation to this matter?

Chapter 13: Protected Disclosures

While being mindful of the prohibition on the Committee from reconsidering decisions made by the Ombudsman at s31B(2) of the Ombudsman Act 1974, given the inherent public interest in the disclosures made about certain University of New South Wales staff, and the amount of time spent by the Ombudsman investigating this matter, could you please explain why you decided not to report the results of your investigation.

Chapter 14: Employment-related child protection

Case Study 67 relates to an allegation made against a parent who was volunteering at an independent school (page 136). Do independent schools respond well to the work of the Ombudsman in this area?

Notifications to the Ombudsman in relation to employment-related child protection have increased by 11.7% from the last reporting period (page 136). What could be some of the reasons for this increase?

While notifications to the Ombudsman generally have increased, notifications received from independent schools have dropped by 35% (page 140). What could be the reasons for this sharp decline?

In the Ombudsman's opinion, would it be useful for the Commission for Children and Young People to conduct working with children checks on volunteers?

Legislative reviews

The Ombudsman recently tabled a report in Parliament called the Review of Emergency Powers to Prevent or Control Disorder. The Government response to the 14 recommendations was to support or implement 12. One was not supported and a section of another was not supported. Are you satisfied with the reasons provided for not supporting a reasonable suspicion test (Recommendation 7) and not supporting detailed annual reporting by the Commissioner of Police about the use of Part 6A powers (Recommendation 14 b).

Chapter Three - Answers to Questions on Notice

NSW OMBUDSMAN ANNUAL REPORT 2005-2006

1. Dealing with unreasonable complainant conduct

What have been the outcomes of the trial of the framework for managing unreasonable complainant conduct (p36)?

At this stage staff in all Australian Parliamentary Ombudsman offices have been trained in the application of the framework of management strategies for unreasonable complainant conduct initially developed by our office. An Australia-wide trial of the approach commenced on 1 May this year and will conclude on 30 April 2008. As the trial is on on-going, no results are yet available. An evaluation report of the project will be completed around August/September 2008.

As a result of wide interest in the project, the internal practice manual has been adapted to suit organisations within Ombudsman jurisdictions. This document has been published as the *Unreasonable complainant conduct: interim practice manual* and is now available for purchase from our office. A final version of the manual will be published at the end of the project.

2. Civil proceedings against police

Has there been any change to the NSW Police management of complaints made about police officers during the course of civil proceedings (p46)?

The 2005-06 Annual Report noted our investigation into the manner in which the NSW Police Force addressed allegations and findings of misconduct in civil proceedings. Our final report emphasised that there should be reliable systems to identify allegations of misconduct and that those allegations should be investigated. At the time the Annual Report was written, NSW Police Force was obtaining legal advice, and the matter was the subject of further consideration.

NSW Police Force have now introduced a system that ensures any allegations of police misconduct raised in civil proceedings that are not already the subject of formal complaint, are brought to the attention of the appropriate police command for assessment and investigation. In introducing this system, it has been specifically acknowledged that complaints should not be handled differently simply because they arise in civil proceedings.

An update of this matter is included in the 2006-07 Ombudsman Annual Report.

3. Local Government

The Office has suggested that local councils can reduce complaints made about developments where a private certifier has been the principal certifying authority by developing clear policies and procedures, training staff and educating property owners and

certifiers (p 84-85). Have these suggestions been passed on to all NSW councils and have they been widely adopted?

Topic notes in our Annual Report are designed to raise awareness of issues that have arisen from specific complaints that have or may have systemic implications. All local councils were written to and advised of the availability of the 2005-2006 Annual Report on our website and hardcopies on request. Anecdotally we understand the local government chapter of our Annual Report is reasonably widely read by General Managers of councils. To that extent, we consider the issue was suitably drawn to the attention of councils. We have not undertaken any survey of councils to see whether these suggestions were taken up.

The issue is most relevant to larger metropolitan and regional councils. Private certifiers do not operate in all council areas and tend to be located in metropolitan and large regional centres where there is extensive development activity such as large coastal areas or the Hunter. In most smaller rural local government areas, the council continues to provide the majority of certification services. As individual complaints arise we continue to make these suggestions to the councils concerned and we are aware that some councils have acted on the suggestions and incorporated them into their enforcement and prosecution policies.

There has been a significant development since the tabling of the 2005-2006 Annual Report that has provided some relief for the problem. The Building Professionals Board commenced operation on 1 March 2007 and is responsible for investigating complaints about and taking disciplinary action against private certifiers for unsatisfactory professional conduct or professional misconduct. Councils are now more likely to tell complainants to make a complaint about a Private Certifier to the Board or to make a complaint themselves about the private certifier. This has reduced the likelihood that people will complain to the Ombudsman about a council failing to act on a complaint about a development over sighted by a private certifier.

We have had discussions with the Board about our overlapping jurisdiction in respect to private certifiers and have provided the Board with informal advice about case management and other complaint handling matters.

4. Corrective Services

On page 95 of the 2005-2006 Annual Report you reported that the Corrective Services Commissioner challenged the Ombudsman's jurisdiction to investigate the systems the department has to prevent the disclosure of confidential information by departmental staff. Has this jurisdictional issue been resolved?

A joint advice was requested from the Solicitor General and the Ombudsman to settle this jurisdictional dispute. The resulting advice was that the subject of an investigation conducted under section 13 of the *Ombudsman Act 1974* must be action or inaction on the part of a public authority.

The Solicitor General took the view that there cannot be an investigation in the abstract into the adequacy of the policies and procedures of a public authority. All conduct must therefore be framed with regards to some action or inaction, or alleged action or inaction, in order for the investigation to have a window into the policies or procedures that govern or should

govern such conduct. If wrong conduct is found, recommendations may then be made about the policies and procedures but they in themselves cannot be the starting point.

In the particular case, there were three original heads of conduct in the investigation notice. The advice made it clear that the Ombudsman did have jurisdiction to proceed with one of them which was "Actions taken since May 2005 to investigate possible breaches of section 257 of the *Crimes (Administration of Sentences) Act 1999* by staff of the Department of Corrective Services". The investigation did in fact proceed albeit with this narrower focus. It was ultimately discontinued on the basis that there was insufficient evidence to make a finding of wrong conduct under section 26 of the Ombudsman Act. However the investigation did identify some opportunities for improvement in the Department's procedures for investigating possible unauthorised disclosures of confidential information. Suggestions were made to the Commissioner pursuant to section 31AC of the Ombudsman Act. At the time we also advised the Commissioner that we would continue to monitor the Department's response to the possible release of unauthorised information through our on-going complaint work. We have subsequently had cause to do this.

The Commissioner subsequently issued a Commissioner's Instruction to all staff in August this year which substantially adopted our suggestions and incorporated them into the Department's procedures.

The Solicitor General's advice highlights an inconsistency in the current jurisdiction of the Ombudsman. The Ombudsman is able to review some policies and practices of some agencies but not all.

Under the child protection provisions of Part 3A of the Ombudsman Act, the Ombudsman has a specific function of keeping under scrutiny the systems for preventing reportable conduct by employees of designated government or non-government agencies or other public authorities, and for handling and responding to reportable allegations, or reportable convictions, involving those employees. Under the Police Act, the Ombudsman has a similar scrutiny function in respect to the systems established within NSW Police for dealing with complaints. Under the Community Services (Complaints, reviews and Monitoring) Act, the Ombudsman has a number of functions including reviewing the systems of service providers for handling complaints relating to the provision of services, assisting service providers improve their complaint procedures and promoting and assisting the development of standards for delivery of community services. All of these functions authorise and necessitate the examination of policies and procedures of agencies.

However, there is no general scrutiny function or specific remit to investigate the adequacy of administrative policies and procedures of public authorities associated with the traditional complaint function of the Ombudsman under Part 3 of the Ombudsman Act. This is despite the fact that the Act specifically authorises the Ombudsman to make recommendations in reports under section 26 that any law or agency practice be changed.

This lack of power to directly examine or investigate administrative policies and procedures is out of step with contemporary statutory developments for Ombudsman in other jurisdictions.

For example, in addition to investigating administrative actions of agencies, the Queensland *Ombudsman Act 2001* provides the Ombudsman with the following specific functions:

- (b) *to consider the administrative practices and procedures of an agency whose actions are being investigated and to make recommendations to the agency:*
- i) *about appropriate ways of addressing the effects of inappropriate administrative actions, or*
 - ii) *for the improvement of the practices and procedures, and*
- (c) *to consider the administrative practices and procedures of agencies generally and to make recommendations or provide information or other help to the agencies for the improvement of the practices and procedures...*

It would be desirable if a similar function was provided for the NSW Ombudsman.

5. Employment – Related Child Protection

The 2005-2006 Annual Report noted your concerns about some of DADHC's investigations and that DADHC's child protection policy was not yet completed (p118- 119). Has the Department finalised their child protection policy and has the Department addressed the concerns that you raised about their investigation practices?

DADHC has provided the Ombudsman with a 'responding to risk of harm' policy, which was approved in June 2007. A copy of this policy (still in draft from September 2006) is also available on its website. We have also received a 'Responding to Allegations Against Employees of a Child Protection Nature' policy in draft form dated August 2006.

In August 2007, DADHC advised us that other parts of its child protection policies, including 'handling allegations against employees' remain in draft form. DADHC's Human Resources department is handling the development and review of its child protection policies. The Child Protection Team of the office is currently drafting a letter to the Director General, DADHC, requesting a copy of all its current draft or finalised child protection policies for comment.

In relation to the concerns raised about investigation practices, to date DADHC has:

- conducted a restructure resulting in its Ethics and Professional Standards Unit (EPSU) becoming responsible for the management of all matters regarding reportable allegations against its employees
- the Director General allocated head of agency responsibilities for reportable allegations/convictions to the Deputy Director General, Resource Management to ensure efficiency and that all employee related matters are handled appropriately regardless of the delegation of the employee
- the EPSU developed a case management system to better record reportable conduct matters, and
- the EPSU also provided investigation training to staff with CPT involvement.

DADHC currently utilises external investigators to investigate reportable allegations against its employees. We have seen some improvement in DADHC's investigative practices to date

as a result of the steps outlined above. However, this continues to be monitored as it is not clear that all concerns have been adequately addressed to date.

6. Protected Disclosures

There has been significant public interest in UNSW's handling of protected disclosures, particularly the treatment of whistleblowers. Given this interest and the resources expended by the Office on the investigation, could some details be provided as to why this investigation was discontinued.

Copies of the final letters to the University of New South Wales and a complainant, setting out the reasons why this investigation was discontinued, are at **Attachment A** (see page 19).

For your information I note that the investigation was discontinued in December 2006, and the legal proceedings referred to in the attached correspondence were withdrawn in March 2007.

7. Community Services

The Department of Community Services acknowledged a number of systemic deficiencies at the time of the Ombudsman's 2004 Special Report to Parliament – Improving outcomes for children at risk of harm – a case study. The complaints about child protection services listed in the Annual Report on page 67 indicate on-going problems with identifying and adequately assessing risk factors, failure to integrate case history and poor file documentation and record keeping.

a) *In answer to questions on notice for the Committee's Thirteenth General Meeting with the Ombudsman, you advised that DoCS had indicated that it would be conducting audits of its risk assessment model and of compliance with requirements for client records management. Has DoCS informed the office of the outcomes of these audits?*

We have not sought advice about the outcomes of the audits. Instead, our focus has been on broad initiatives relating to improved risk assessment practices and the rollout of a comprehensive quality assurance system.

By way of background, our 2005 report included recommendations that DoCS undertake systematic performance audits for each Community Service Centre and advise us about progress in improving initial risk assessments.

In light of advice DoCS subsequently gave us about its initiatives to reform risk assessment practices and undertake ongoing performance reviews, in our 2006 Child Death report we made a series of recommendations relevant to risk assessments and record management.

We have attached a copy of these recommendations (**Attachment B** – see page 29) together with a description and analysis of DoCS' response to each recommendation.

b) Has there been any improvement to the exchange of information between NSW Police, NSW Health and DoCS?

Through our child death review work we have identified ongoing issues in relation to the exchange of information in child protection matters. **Attachment C** (see page 39) contains recommendations we made in our 2006 Child Death report that are relevant to improving the exchange of information across agencies, together with a description and analysis of each agency's response to these recommendations.

What were the outcomes of the Office's review (p69) of the circumstances of children and young people under the parental responsibility of the Minister for Community Services who were living in SAAP services?

Background

Last year we began reviews of the circumstances of 15 young people under the parental responsibility of the Minister for Community Services who were living in services funded under the SAAP. These services are funded to provide transitional accommodation and support for people who are homeless, but there were concerns that they were being required to accommodate children and young people who should be supported within the statutory out-of-home care system.

Findings and Outcomes

We wanted to know why the children were living in SAAP services at the time, and what plans DoCS had to move them to more appropriate accommodation or help them to live independently. The 15 children in the group were aged between 13 and 15 years and from five different DoCS regions. Just over half had been under the parental responsibility of the Minister for 12 months or less, four were subject to interim care orders for two months or less, four had been under the parental responsibility of the Minister for one to two years and three for eight years or more.

The reasons for the children being in SAAP services varied. Six children had — at least initially — been placed in a SAAP service when DoCS initiated care proceedings following sudden or unexpected homelessness and/or breakdown in family relationships. The remaining nine children had been placed in a SAAP service after the breakdown of an existing out-of-home care placement arranged by DoCS. For a few, the SAAP service had been chosen by DoCS because of the programs provided. For others, it was clear that they were in SAAP because there was no other placement available.

The length of time the children had been in SAAP services varied from a few days to several months. One child had been there for two years. Many remained in SAAP for extended periods before moving to appropriate alternative accommodation. We reviewed whether case planning for the children included locating placements with authorised carers and whether there was active casework to achieve this. We also considered whether responsibilities for the day-to-day care and decision-making and supervision of the child while in SAAP were clear.

For most of the children, DoCS' long-term case plans were to move the children to appropriate out-of-home care placements, and we found evidence of casework to achieve this. Five of the group moved to long-term foster placements and three to other alternatives

during or following our reviews. Six of the group remained in SAAP as part of a long-term case plan.

Not all the children had a documented case plan at the time of our review, even though the casework to meet their immediate and short-term needs was generally responsive. We recognised that the unstable circumstances of some children at the time of their entry into care made it difficult to establish a long-term case plan. However, in those circumstances, it was difficult to identify if case planning was adequately promoting their longer-term stability and well-being.

Given the purpose and focus of SAAP, the use of these services for children in out-of-home care raises a number of policy questions. While the day-to-day care needs of the majority of children we reviewed were generally being adequately met, the lack of security of their circumstances was evident for many. For example, some of the children experienced periods of 'time out' from SAAP services. In some cases they had been 'exited' from services and, in most of these cases, it was unclear whether DoCS had been consulted about the placement changes. SAAP services are not required to be accredited by the Children's Guardian or to meet standards for out-of-home care services, so there is a question about their capacity to meet the long-term needs of children in statutory care.

A number of caseworkers told us that they chose the SAAP service because the programs they provided suited the children's needs. Several told us about difficulties finding suitable placement alternatives, especially if children did not have 'high and complex' needs and further foster placements were not considered appropriate.

Conclusions

Against a background of high levels of demand for SAAP services, the use of these services for children in out-of-home care is a significant issue that warrants careful consideration by DoCS, and the SAAP and out-of-home care sectors.

As part of completing our review of this issue, we are meeting with ACWA and the YAA to obtain their views on the role that SAAP should play for young people in out of home care. After considering their views, we will report our findings to DoCS and the Minister.

Did the Office make any recommendations as a result of its study of care proceedings in the NSW Children's Court (p70)?

Recommendations in our Children's Court paper

We attach a copy of our Children's Court paper (**Attachment D** - see page 51). You will note that, at the end of the paper, we have outlined our conclusions from our research into the Children's Court.

On the 24 July 2006 we wrote to ABSEC, ACWA, NCOSS and Dr Judy Cashmore, as members of the Ministerial Advisory Committee, providing them with a copy of the paper. On the same date, we also wrote to the Minister for Community Services; the Director General, Department of Community Services; the Director, Family Law, Legal Aid Commission and the Senior Children's Magistrate, providing them with the paper. On the 16 October 2006 we provided the paper to the Director General, Attorney General's Department NSW.

Furthermore, on 30 March 2007 we made a detailed submission on the current review of the *Children and Young Persons (Care and Protection) Act 1998* (**Attachment E** – see page 103). You will note that in our submission we again canvassed matters relating to the Children’s Court together with a range of other significant issues.

At this stage, we are awaiting the outcome of the review of the Act. Once the legislative changes have been enacted we will then be in a position to assess what further issues we may need to examine.

ATTACHMENT A

Our Ref: ADM/4620

7 December 2006

Professor Fredrick G Hilmer
Vice-Chancellor
University of New South Wales
Level 1 – The Chancellory
Gate 9 – High Street
UNSW
SYDNEY NSW 2052

Dear Vice-Chancellor

Thank you for your correspondence addressed to the Ombudsman and received in this office on 9 November 2006.

As you are aware this office has conducted a number of lengthy investigations into complaints arising from protected disclosures from several individuals associated with the University of New South Wales (UNSW).

A key theme that emerged in the course of these investigations was the problems with the UNSW complaint handling procedures and deficiencies in the manner in which whistleblowers were treated. Our investigations centred on three case studies to focus on the complaint handling issues at UNSW.

In May 2005 we provided UNSW, various staff of the university and the complainants with relevant parts of a document that set out the evidence obtained during the investigation up to that point and outlined some preliminary recommendations as to how and where improvements should be made to the UNSW complaint handling systems. We considered numerous submissions from affected parties and their lawyers in response to this document and then issued a revised document to UNSW and to certain individuals. In the subsequent submissions made by UNSW it was asserted that the legal basis upon which we conducted our investigation was flawed. UNSW foreshadowed initiating legal proceedings and this submission was supported by the advice of senior counsel, although this advice was inconsistent with our legal advice.

After further legal advice was sought we issued a further revised document in May 2006 to UNSW and to other significantly affected parties to provide them with a final opportunity to make submissions before finalising the investigation. At this time Professor Ingleson – who no longer held the position as Deputy Vice Chancellor (International) - commenced legal proceedings in the Supreme Court against the NSW Ombudsman challenging our jurisdiction to investigate. These proceedings are currently before the court and are likely to be listed for hearing in early 2007. Consequently I am, and will continue to be, unable to

finalise any report in this matter until these proceedings are determined. The proceedings are being defended by this office consistent with senior counsel's advice.

Many aspects of our investigation have been lengthy – not only because they were complex but because the requirements of procedural fairness necessitated that the persons of interest and parties involved in the investigation – at one time this numbered 22 – were all afforded an opportunity to obtain legal representation and make submissions in relation to the preliminary documentation arising out of the investigation.

Additionally a large number of internal investigations were conducted and reports prepared by UNSW, including the review of the former Chief Justice of the High Court, Sir Brennan and the St James Ethics Centre report both in relation to the Professor Hall matter. The conduct of these internal investigations and the preparation of these reports on behalf of UNSW were time consuming and resulted in delays to our investigations as the nature and context of the UNSW internal investigations and the recommendations arising impacted significantly on the scope of our ongoing investigations into the University.

As the investigations into UNSW involved the reputation of individuals as well as the university itself, the investigation of these matters have been resource intensive and the impact of these complex and lengthy investigations on the limited resources of the NSW Ombudsman has been significant.

In summary, this investigation has involved three investigations together with a major project to formulate model guidelines for university complaint handling. In terms of the mass of documentation, the number of witnesses, complainants, other parties involved and the volume of submissions attracted, the case has been highly unusual. A further complicating factor has been the number of lawyers involved.

As noted in your correspondence to the Ombudsman, in response to the recommendations of the Ombudsman and the contents of the discussion paper *Complaint Handling in Universities*, UNSW has implemented a number of significant changes in terms of the policies and procedures relating to complaints and importantly who has responsibility within the University for handling them.

Furthermore there have been many changes in senior personnel at UNSW over the past 5 years. The University has had a number of Vice Chancellors over that period and many of the University staff that featured prominently in our investigations – both as complainants and as witnesses and persons of interest – no longer work with the University or hold positions where they would have responsibility for the handling of complaints, in particular protected disclosures.

I am advised that responsibility for the operation of the grievance and complaint process at UNSW now rests with you and the Chief Operating Officer having operational responsibility for the conduct of disciplinary processes in relation to the enterprise agreement and in collaboration with the Deputy Vice Chancellor (Academic) where academic staff are concerned. None of your current executive team were involved in the initial complaints nor are they the subject of our investigation.

I am pleased to acknowledge that the current management at UNSW are strongly supportive of the introduction of our suggested complaint handling guidelines across NSW universities, have facilitated important changes and improvements to the complaint handling

regime at UNSW and have taken significant steps toward implementing my preliminary recommendation in relation to the complaint handling system at UNSW.

I am also pleased to acknowledge your efforts in writing to each of the complainants stating your support for the aims and objectives of the Protected Disclosures Act and acknowledging that the complaint handling processes in place at the time their complaints were received required improvement. I note that UNSW has undertaken those improvements in accordance with the recommendations contained in our Discussion Paper on complaint handling in NSW universities.

Complaints such as those made by the complainants in this matter are essential to the capacity of the NSW Ombudsman to monitor and review the conduct of public sector agencies. The NSW Ombudsman relies on concerned citizens and complainants to bring to its attention incidents of maladministration and poor administrative conduct in the NSW public sector. Arising out of such complaints the NSW Ombudsman can facilitate significant changes in policy and practice and ensure that public sector agencies in NSW perform their duties to the highest standards and staff conduct themselves in accordance with accepted principles of good conduct in public administration.

Whilst universities have not traditionally seen themselves as part of the mainstream NSW public sector, the many complaints received by our office in relation to their conduct and treatment of staff and students, particularly in recent years, has enabled the NSW Ombudsman to play a significant role in opening NSW public universities up to the same scrutiny and management standards as other public sector agencies.

It is our standard practice in circumstances where the objectives of an investigation are met and the agency involved has taken real steps to satisfy the preliminary recommendations of this Office, to consider carefully whether there is any further benefit or purpose in continuing that investigation. Given the change of personnel at the university, the introduction of new improved complaint handling procedures and substantial compliance with my proposed recommendations, I am satisfied that the investigation has led to significant and positive outcomes. In light of the matters outlined in your correspondence and the fact that I would be precluded from finalising any report for an undetermined period of time (possibly up to one year), after careful consideration I have decided to discontinue this investigation.

It has become evident over the course of our investigations into complaints relating to UNSW and other public universities in NSW that there were systemic issues around the way universities in general seemed to be handling complaints from both students and staff. These concerns were raised particularly through our investigation of UNSW. As a consequence we decided to survey relevant procedures in all ten universities and publish a discussion paper on the subject with a view to developing a set of minimum standards for university complaint handling. While prompted by aspects of each of the individual complaints, the investigation into UNSW was driven by our desire to formulate minimum standards for university complaint handling that could be applied to all ten public universities in NSW. The outcome of this extensive consultation - the NSW Ombudsman *Complaint Handling at Universities: Best Practice Guidelines* – we believe will be an important contribution to the standard of complaint handling in NSW Universities.

I am pleased to advise that in spite of the delays that characterised the investigation, the preparation of the complaint handling guidelines has progressed and a pre-publication version of the *Complaint Handling at Universities: Best Practice Guidelines* is enclosed for

Answers to Questions on Notice

your information. We will forward to you a final version of the Guidelines upon their return from printing, at which time a copy will also be placed on our website.

We acknowledge your expressed interest in participating in future discussions around the continuing improvement of the complaint handling procedures at UNSW and look forward to working with you to assist UNSW in achieving best practice in the manner in which it deals with complaints.

Your sincerely

Chris Wheeler
Deputy Ombudsman

Enc

Our Ref: ADM/4620

7 December 2006

Dear

I refer to your complaint to this office dated 17 June 2002.

At the outset please let me express my appreciation to you for your efforts in bringing to the attention of the NSW Ombudsman your complaint regarding the conduct of senior staff of the UNSW and the manner in which you were treated as a result of expressing your concerns to them.

Complaints such as yours are essential to the capacity of the NSW Ombudsman to monitor and review the conduct of public sector agencies. The NSW Ombudsman relies on concerned citizens and complainants such as yourself to bring to its attention incidents of maladministration and poor administrative conduct in the NSW public sector. Arising out of such complaints the NSW Ombudsman can facilitate significant changes in policy and practice and ensure that public sector agencies in NSW perform their duties to the highest standards and staff conduct themselves in accordance with accepted principles of good conduct in public administration.

Whilst universities have not traditionally seen themselves as part of the mainstream NSW public sector the many complaints received by our office in relation to their conduct and treatment of staff and students, particularly in recent years, has enabled the NSW Ombudsman to play a significant role in opening NSW public universities up to the same scrutiny and management standards as other public sector agencies.

Whistleblowers perform an essential service in our society as they bring to light serious problems with the management or operations of an organisation. The position of whistleblowers is of particular interest to our office for a number of reasons. Firstly our interest in complaints – how to manage and resolve them – includes complaints from within an agency. Secondly good administration is not possible without staff being managed and supported effectively. There are few situations in a work environment more challenging than when a member of staff decides to speak up about organisational problems.

As you are aware this office has conducted a number of lengthy investigations into complaints arising from protected disclosures from several individuals associated with the University of New South Wales (UNSW).

A key theme that emerged in the course of these investigations was the problems with the University's complaint handling procedures. We identified substantial deficiencies in the UNSW complaint handling procedures and deficiencies in the manner in which whistleblowers were treated. Our investigations centred on three case studies to focus on the complaint handling issues at UNSW.

In May 2005 we issued portions of a preliminary document to the UNSW, various people named in the document and the complainants, setting out the evidence obtained during the investigation up to that point and outlining some preliminary recommendations as to how

and where improvements should be made to the UNSW complaint handling systems. We considered numerous submissions from affected parties and their lawyers in response to this document and then issued a revised document to UNSW and to certain individuals. In their subsequent submissions UNSW claimed the legal basis upon which we conducted our investigation was flawed. The University foreshadowed initiating legal proceedings and their submission was supported by senior counsel advice that was inconsistent with our legal advice.

After further legal advice was sought we issued a further revised document in May 2006 to UNSW and to other significantly affected parties to provide them with a final opportunity to make submissions before finalising the investigation. At this time Professor Ingleson – who had recently been removed from his position as Deputy Vice Chancellor (International) - commenced legal proceedings in the Supreme Court against the NSW Ombudsman challenging our jurisdiction to investigate. These proceedings are currently before the court and are likely to be listed for hearing in early 2007. I have been, and would continue to be unable to finalise any report in this matter until these proceedings are finalised. The proceedings are being defended by this office consistent with senior counsel advice.

Many aspects of the investigation have been lengthy – not only because they were complex but because the requirements of procedural fairness necessitated that the persons of interest and parties involved in the investigation – at one time this numbered 22 – were all required to be afforded an opportunity to obtain legal representation and make submissions in relation to the investigation, its jurisdiction and its content. Additionally a large number of internal investigations were conducted and reports prepared by the UNSW including the review of the former Chief Justice of the High Court, Sir Brennan and the St James Ethics Centre report both in relation to the Professor Hall matter.

The conduct of these internal investigations and the preparation of these reports on behalf of UNSW were time consuming and contributed to significant delays in our investigations as the nature and context of the UNSW internal investigations and the recommendations arising impacted significantly on the scope of our ongoing investigations into the University.

As the investigations into UNSW involved the reputation of individuals as well as the university itself, the investigation of these matters have been resource intensive and extremely expensive for the university both in terms of internal senior staff time and external legal fees, with legal fees in relation to one complaint alone amounting to in excess of \$1 million dollars. The impact of these complex and lengthy investigations on the much more limited resources of the NSW Ombudsman has also been significant.

In summary, this UNSW case has involved three investigations together with a major project to formulate model guidelines for university complaint handling. In terms of the mass of documentation, the number of witnesses, complainants, other parties involved and the volume of submissions attracted, the case has been highly unusual. A further complicating factor has been the number of lawyers involved. To our knowledge, parties have had acting on their behalf a senior counsel, five junior counsel and three major law firms.

In the course of our investigation into complaint handling at UNSW, the University has implemented a number of significant changes in terms of the policies and procedures relating to complaints and importantly who has responsibility within the University for handling them.

As you would be aware there have been many changes in senior personnel at UNSW over the past 5 years. The University has had a number of Vice Chancellors over that period and many of the University staff that featured prominently in our investigations – both as complainants and as witnesses and persons of interest – no longer work with the University or hold positions where they would have responsibility for the handling of complaints, in particular protected disclosures.

Responsibility for the operation of the grievance and complaint process at UNSW now rests with the new Vice Chancellor Professor Fred Hilmer, with the Chief Operating Officer having operational responsibility for the conduct of disciplinary processes in relation to the enterprise agreement and in collaboration with the Deputy Vice Chancellor (Academic) where academic staff are concerned. None of the current executive team were involved in the initial complaints nor are they the subject of our investigation.

The current management regime at UNSW are strongly supportive of the introduction of our suggested complaint handling guidelines across NSW universities and have facilitated important changes and improvements to the complaint handling regime at UNSW and have taken significant steps toward implementing our recommendations in relation to the complaint handling system at UNSW.

I am advised that the Vice Chancellor, Professor Hilmer has written to you and each of the other complainants stating his support for the aims and objectives of the Protected Disclosures Act. In that letter he acknowledges that the complaint handling processes in place at the time of your complaint required improvement and that the UNSW has undertaken those improvements in accordance with the recommendations contained in our Discussion Paper on complaint handling in NSW Universities..

Outlined below are the preliminary recommendations arising out of our investigation, an edited copy of which was forwarded to you for comment. Under each recommendation I have set out the actions taken by UNSW since the publication of the Discussion Paper and the circulation of the preliminary recommendations to address the issues raised regarding their complaint handling systems:

“5.1 I recommend that UNSW adopt the minimum standards complaint handling regime proposed in the publication accompanying this report entitled: “Minimum Complaint Handling Standards for NSW Universities.”

The UNSW has undertaken a comprehensive review of its complaint handling policies and procedures over the past 4 years and the outcome of this process is a set of policies and procedures that relate to the handling of complaints; grievances and protected disclosures that substantially adopt the minimum standards complaint handling regime as proposed in the publication to be issued by the NSW Ombudsman entitled “Complaint handling Guidelines for NSW Universities”.

A discussion paper outlining the proposed minimum standards for complaint handling was provided to all universities including UNSW. In response UNSW advised the NSW Ombudsman that it supported the establishment of a minimum standards scheme for complaint handling across all NSW Universities and that the discussion paper circulated by the Ombudsman was the key tool that guided

the University in the development of its new policies and procedures for handling complaints and grievances at UNSW.

A perusal of the current policies and procedures of UNSW as they relate to complaint handling confirms that the UNSW has developed policies and procedures that conform with the recommendations of the NSW Ombudsman.

“5.2 In particular, I recommend that UNSW establish a secure centralised complaint records system and nominate a senior member of staff to be responsible for maintaining and analysing records of all complaints and grievances about UNSW staff.”

UNSW has advised the NSW Ombudsman that it has appointed IAB Services to create and maintain a reporting system for the University to record grievances. IAB Services is a NSW government commercial enterprise that specialises in a wide range of assurance and consulting services to State agencies.

“5.3 I recommend that UNSW review its procedures for dealing with academic staff misconduct cases with the objective of simplifying and clarifying the operation of those procedures, such review to be completed before the end of 2005.”

UNSW has completed its review of procedures for dealing with academic staff misconduct cases and has issued a new policy and procedure document .The grievance and complaint handling policies were reviewed in light of the best practice of other universities; the recommendations of the St James Ethics Centre Report into the Professor Hall matter and the NSW Ombudsman Discussion Paper on Complaint handling in NSW Universities. A gap analysis of the existing UNSW policies highlighted some issues that did not meet the minimum standards identified in the Discussion Paper. These issues have been addressed in the revised policies and procedures approved by UNSW Council in December 2005.

These policies include:

- **Grievance Resolution Policy for Staff**
- **Grievance Resolution Procedure for Staff**
- **Grievance Resolution Policy for Students**
- **Grievance Resolution Procedure for Research Students**

Additionally a new Enterprise Agreement was prepared by UNSW in consultation with the Teachers Federation that contains a misconduct investigation framework that conforms substantially with the recommendations made by the NSW Ombudsman.

“5.4 I recommend that UNSW develop and run appropriate training modules for all senior staff whose responsibilities involve inquiring into complaints; tasking others to inquire into complaints; and, determination of complaints. Particular attention should be given to training in the identification and management of conflict of interests and duties in all aspects of complaint handling.”

UNSW has implemented a yearly program of training in relation to the grievance policy and procedures. Training for the Heads of School is mandatory and in relation to other staff training is undertaken at the direction of immediate managers. The training schedule provided by UNSW for 2006 indicates that two sessions of grievance training were held for supervisors of staff and two sessions were held for staff. A specific training session for Heads of School was also conducted.

The Conflict of Interest Policy of UNSW was revised and approved by UNSW Council in mid 2005 and was the subject of staff training.

“5.5 I recommend that for investigating more serious complaints and all protected disclosures, UNSW have (preferably) a core of well trained investigators on staff or alternatively an arrangement with an external organisation to provide professional investigators at short notice to conduct such investigations.”

UNSW advises us that a number of Investigation Officers have been appointed. The criteria relating to their appointment are that they have relevant experience and appropriate independence from the matter in issue. To date investigators appointed have been a barrister; a former academic at University of Sydney and the Director of Operations at the Australian Defence Force Academy.

“5.6 I recommend that UNSW review the operation of its joint appointments with Area Health Services, such review to be completed before the end of 2005.”

UNSW has advised the Ombudsman that they have been in ongoing discussions with representatives from NSW Health, Newcastle University and Sydney University in relation to joint university/health service appointments. The purpose of these discussions is to clarify the appropriate employment arrangements where there are joint appointments.

“5.7 I recommend that UNSW provide a copy of this report and its annexures to the NSW Auditor-General for his consideration in relation to his future audits of UNSW and New South Global Limited.”

UNSW has advised that it has no objection to the NSW Ombudsman drawing relevant issues to the attention of the Auditor General. The Auditor General has an ongoing audit function role in relation to UNSW and conducts an annual audit of the UNSW and New South Global Limited. Additionally AUQA (Australian Universities Quality Agency) audits the functions of UNSW.

It is our standard practice in circumstances where the objectives of an investigation are met and it appears to us the agency involved has taken real steps to satisfy the recommendations of this Office and to remedy the matters that led to the complaints, to consider carefully whether there is any further benefit or purpose in continuing the investigation. In light of the matters outlined above and the fact that I would be precluded from finalising any report for an undetermined period of time (possibly up to one year) I have, after careful consideration, decided to discontinue the investigation into your complaint. Given the change of personnel at the university, the introduction of new improved complaint handling procedures and substantial compliance with my proposed

recommendations I am satisfied that the investigation has led to significant and positive outcomes.

It became evident over the course of our investigations into complaints relating to UNSW and other public universities in NSW that there were systemic issues around the way universities in general seemed to be handling complaints from both students and staff. These concerns were raised particularly through our investigation of UNSW. As a consequence we decided to survey relevant procedures in all ten universities and publish a discussion paper on the subject with a view to developing a set of minimum standards for university complaint handling.

The discussion paper entitled *Discussion Paper on Complaint Handling in NSW Universities* was initially circulated in November 2004 with wide ranging responses being received from universities over the intervening period.

While prompted by aspects of each of the individual complaints the investigation into UNSW was driven by our desire to formulate minimum standards for university complaint handling that could be applied to all ten public universities in NSW. The outcome of this extensive consultation - the NSW Ombudsman *Complaint Handling at Universities: Best Practice Guidelines* – we believe will be an important contribution to the maintenance of a high standard of complaint handling in NSW Universities. I am pleased to advise that in spite of the delays that characterised the investigation, the preparation of the complaint handling guidelines is complete. A pre-publication version of the *Complaint Handling at Universities: Best Practice Guidelines* is enclosed for your information. We will forward you a final version of the Guidelines upon their return from printing, at which time a copy will also be placed on our website.

We are grateful to you for bringing to our attention the poor complaint handling management practices at UNSW and appreciate your contribution to our investigation and the significant and positive outcomes we have achieved in influencing best practice complaint handling at the UNSW.

Your sincerely

Chris Wheeler
Deputy Ombudsman

Enc

ATTACHMENT B

Recommendations in the 2006 report relating to risk assessment practices are outlined below, together with responses by DoCS and our related analysis.

Quality of risk of harm assessment

Context

Our reviews of deaths in 2005 raised questions about the effectiveness of secondary assessment. We found that secondary assessment was at times not holistic and not informed by adequate information gathering and analysis, and that where DoCS assessed risk without full and relevant information, assessments did not always adequately reflect the possible risks to a child. We also reviewed cases where secondary assessment was suspended or ceased before a final determination was made about the child's need for care and protection.

Recommendation 19

DoCS provide advice to this office regarding:

- a) An update of progress in implementing the proposed quality review of each CSC in NSW, including details of the quantitative and qualitative information that will be sought about priority systems, processes and practice.
- b) Progress of the roll out of the neglect policy and revised *Secondary assessment – risk of harm procedure*, and implementation of the *Secondary assessment – risk of harm practice review tool*.

Agency responses

DoCS told us that the Professional Development and Quality Assurance Branch has been established, and other staffing enhancements have been made to support the reviews, including new regional positions. DoCS advised that the reviews are intended to encompass:

- Initial analysis of qualitative and quantitative information on CSC performance (including trends over a three-year period and comparison with like CSCs)
- A '360 degree' review of CSC practice by a regionally based team, including file reviews, observation of practice, focus groups with clients and interviews with local partners. Identification of areas for focused attention and development of a Quality Improvement Plan to address identified issues.
- Linking the Quality Improvement Plan with Regional quarterly review processes to monitor progress on achievements, and CSC reporting on key themes and strategies.

Draft practice standards intended to support the quality review program have been finalised, and development of a Quality Review Toolkit is near completion.

Neglect / Secondary Assessment Implementation Project

DoCS provided advice about the program to roll out revised secondary assessment and neglect policies. Details of topics provided in the training sessions include:

- analysis dimensions within secondary risk of harm assessment
- supervising secondary assessments
- case planning and intervention in neglect

Answers to Questions on Notice

- applying the practice review approach to current neglect cases in early intervention, child protection and out of home care.

DoCS plans to evaluate the effectiveness of the above initiatives.

DoCS also advise that a literature review on neglect matters and the Children's Court has been completed.

A Practice Review Tool Secondary Assessment was piloted in two regions in March 2007.

Our analysis

The proposed quality reviews of CSCs are a significant undertaking in relation to enhancing child protection responses within DoCS. We will continue to monitor the progress of implementation of the reviews.

We acknowledge the scope of the strategies to support the new policies and procedures.

Context

Our reviews identified particular issues about the quality of risk assessment in cases where substance abuse was a concern. We found that risk assessment was at times adversely affected by limited caseworker and supervisor expertise in the area of substance abuse; that information used to inform risk assessment was not always comprehensive and at times there was an over-reliance on parent's own advice about their substance use; and that parental capacity to meet agreements to minimise risks to a child was at times not fully considered.

Recommendation 20

In the ongoing development of alcohol and other drugs training and professional development strategies for caseworkers and managers, including the revision of the Alcohol and Other Drugs module of the Caseworker Development Course, DoCS should consider and incorporate the issues raised in this report, in particular:

1. The challenges for DoCS staff in effectively engaging drug dependent parents, particularly where parents seek to avoid contact with agencies and/or conceal or minimise substance use.
2. The challenges in effectively engaging with, and responding to, women using drugs in pregnancy, in order to minimise the subsequent risk to their child.
3. The need for caseworkers to have a solid understanding of the nature of drug dependence, the range of illicit and legal substances that may be used and the range of their effects, and guidance to apply this information in assessing risk to children.
4. The high vulnerability of infants and very young children in an environment of parental substance abuse.
5. The importance of obtaining critical information from relevant agencies to inform risk assessment.

Agency responses

DoCS told us that the revised Alcohol and Other Drugs (AOD) module of the Caseworker Development Course is now complete and Practice Solutions Sessions have been delivered to all CSCs. According to recent advice from DoCS, the issues raised in our recommendation '*...have been incorporated in the AOD training modules and were also addressed in the AOD Practice Solutions Sessions delivered to all CSCs.*' The Helpline's

Practice Session Module targeted to Team Leaders was introduced in July 2007. DoCS expects that all sessions in the module will have been piloted by the end of August 2007. The department has established a Drug and Alcohol Expertise Unit to provide appropriate advice, resources and tools to DoCS staff.

DoCS notes that the department is collaborating with NSW Health to develop additional training initiatives in relation to drugs and child protection issues that will be *'locally organised and rolled out gradually across CSCs, starting with the drug testing pilot sites.'*

Our analysis

This recommendation went to concerns we had in relation to the quality of some risk assessments for families where parental substance abuse was an identified problem. We were concerned that risk assessment was at times adversely affected by limited caseworker and supervisor expertise in the area of substance abuse. We acknowledge the strategies being implemented.

Recommendation 21

DoCS and NSW Health should provide advice to this office of arrangements between the two agencies to ensure expert drug and alcohol assessments are appropriately sought by DoCS and provided by NSW Health, in cases where parental substance abuse is identified as a child protection concern.

Agency responses

DoCS refers to the response to recommendation 20 above. DoCS also reported that the department is *'encouraging caseworkers to liaise with their counterparts in Area Health Services where there are shared clients to ensure that relevant information about child protection concerns is exchanged. Joint training for 2007 will support this liaison.'*

NSW Health response

This recommendation was supported by NSW Health.

In relation to the joint DoCS / Health training indicated by DoCS, Health noted *'It is planned that as part of this training DoCS staff will receive drug and alcohol information and Health staff will receive additional child protection information, including information on the need for adequate and useful reporting.'* The training will include:

- information and education for drug and alcohol clinicians on how to make an assessment of risk, *'what, when and how to report'*; and
- consideration of the parenting capacities of clients in the context of medical or health conditions.

NSW Health will also:

- look to revise the Prescribers Accreditation Course to include a focus on child protection and child safety issues
- consider opportunities for better training of all clinicians in relation to drug and alcohol history and 'management planning' if a history of excessive use is obtained (child protection issues included)

Our analysis

We acknowledge the training strategies identified above are positive, as are proposed arrangements for supporting the drug testing policy. We will seek a progress report on key initiatives.

Aboriginal children and young people

Context

Our reviews of deaths in 2004 found that some of the children had no, or a limited, response to reports that they were at risk of harm, and that when risk assessments did occur, these often did not comply with standards required by DoCS. In the matters we reviewed in 2005, these issues remained apparent.

Recommendation 23

DoCS should provide a copy of the Aboriginal Strategic Commitment to this office, and advice on the progress of major commitments to improve outcomes for Aboriginal clients.

Agency responses

The DoCS Aboriginal Strategic Commitment 2006 – 2011 was released in November 2006 and a copy was provided to our office. Development of 'various directorate and regional is underway.

The document is described as a 'corporate level' document, but implementation will be at the directorate and regional level, through the development of an annual 'Commitment of Service to Aboriginal & Torres Strait Islander Peoples' Plan', which will include specific actions to meet the projected results identified in the corporate document. Regions and directorates will report six-monthly against the actions contained in the plans.

DoCS confirmed that some of the specific initiatives under consideration include:

- Developing a consultation model for use by CSC staff. The model will '*define cultural consultation, comply with legislation (Aboriginal placement principle) and recognises local differences*'
- Establishing a regional Aboriginal Advisory Group to inform and advise CSCs on projects and programs supporting Aboriginal families and communities.
- Strengthening the capacity of mainstream early intervention services to better meet the needs of Aboriginal children, young people, families and communities
- Increased resources to better support Aboriginal Foster Carer recruitment, training and support.
- Piloting an 'Aboriginal-specific genogram project' to enhance the provision of culturally responsive casework tools and practices, and
- Developing guiding principles and protocols to inform engagement with isolated communities.

Our analysis

We acknowledge the intent of the strategic commitment and will seek a progress report on outcomes of its implementation in areas key to our work.

Adolescents

Context

Our reviews of 22 adolescents who died in 2004 identified a range of challenges for DoCS in responding effectively to young people. Our recommendation to DoCS included a proposal that the department give consideration to the issues raised in the report, including whether existing procedures and models of casework and current practice were effectively meeting the needs of adolescents.

Recommendation 24

DoCS should provide advice to this office regarding:

1. Progress of work with relevant community sector representatives on the issue of youth in Supported Accommodation Assistance Program (SAAP) services.
2. Progress of, and findings arising from, the Child Deaths and Critical Reports Unit research paper on matters arising from the Unit's reviews of deaths of young people by suicide or risk taking behaviour.
3. Progress of DoCS' Centre for Parenting and Research projects to inform policy and practice relating to effective strategies and interventions for adolescents at risk, any findings to date and DoCS' plans to respond to those findings.

Agency responses

DoCS is working on a policy with Youth Accommodation Association (YAA) to develop a policy that clarifies the level of support provided to unaccompanied children under 16 who enter SAAP services. The policy '*...will establish consistent, transparent and equitable arrangements for providing case management and financial assistance for children in YSAAP services.*' DoCS then plan to develop a protocol that will clarify roles and responsibilities of DoCS and YSAAP services. DoCS indicated the policy will be 'settled' in a few months.

CDCRU research re suicide

DoCS' Child Death and Critical Reports Unit has established the *Adolescents at Risk of Suicide and Risk Taking Behaviour Practitioner Advisory Committee*. The committee is comprised of staff that have expertise in working with 'at risk' young people across child protection, out-of-home care and intensive support service programs. The panel will focus on the deaths of young people known to DoCS, as a result of suicide and risk taking behaviour. DoCS told us that '*at the end of a 12-month period the CDCR will prepare advice on the identification of issues and areas for learning and corporate development arising from the review of these cases.*'

Parenting and Research Centre projects

DoCS provided the following information about the current research schedule:

- A literature review on effective strategies and interventions for adolescents in a child protection context has been completed and is now subject to peer review.
- A study of DoCS' staff perceptions of effective casework practice with adolescents has been drafted and is now in revision to incorporate comments.

A review of models of service delivery and interventions for children and young people with high needs was published in November 2006.

Our analysis

We note the progress advised. In relation to young people in SAAP, we note that it appears to be over two years since YAA and DoCS commenced this process, and there are no clear timeframes for implementation

Protective intervention

Context

Our reviews raised concerns about DoCS' decisions to use undertakings where parents had long histories of drug abuse and/or repeated relapses from drug treatment or drug-related mental health issues. In some cases there appeared to be inadequate consideration of the likelihood that parents could – or would – fulfil the terms of agreements.

Recommendation 25

DoCS should provide advice to this office on progress with the review of policies on the use of undertakings, including a copy of relevant revised policies when completed.

Recommendation 26

DoCS should provide details about the department's policy regarding the circumstances where case plans and unregistered care plans alone will be considered to be adequate protective measures.

Agency responses

DoCS told us that recommendations 25 and 26 are being addressed as part of a broader project that commenced with the proclamation of amendments to the *Children and Young Persons (Care and Protection) Act 1998* that deal with Parent Responsibility Contracts (PRC). DoCS have provided us with the draft Business Help topic on PRCs and a trial has commenced in eight CSCs, four of which are also trialling the drug testing policy.

DoCS advised that the next phase of the project will be to revise the policy on the use of undertakings DoCS has started updating the Case Planning Business Help topic, which will *'iterate that undertakings are not a casework option unless they form part of an Order Accepting Undertakings (s 73).'*

In relation to our query about whether the policy will provide direction about circumstances where case plans and unregistered care plans alone will be considered to be adequate protective measures, DoCS advised that *'a case plan must exist for all children and young persons for whom DoCS provides or coordinates a service, so it is more appropriate to provide advice on when other casework options are appropriate in addition to the case plan.'*

DoCS also told us that they have developed a case management policy that is applicable across the Early Intervention, Child Protection and Out-of-Home-Care program streams.

The policy:

- *defines case management, outlines the elements of case management and provides a set of overarching principles to guide practice.*
- *describes criteria for the assignment of case management and notes strategies to manage associated risks.*
- *clarifies the roles and responsibilities of DoCS and the non-government sector in the delivery of case management.*

The policy is publicly accessible on the DoCS website. DoCS are also developing a best practice guide to case planning, monitoring and review. This will be supported by an integrated case-planning template and is due for completion in August 2007.

Our analysis

Our long-term concerns with undertakings have included confusing policies and procedures (which DoCS agreed was the case), lack of explicit requirements for monitoring undertakings, and consequences of breaches.

We made this recommendation in the context of the use of undertakings relating to parental drug and alcohol issues. In this context, the Parent Responsibility Contracts are a positive response. We will monitor the implementation of the contracts and review the *Case Planning* and *Care Plan* policy when finalised.

Timeliness of intervention and monitoring of support services

Context

Our reviews raised some questions about the timeliness of intervention that risk assessment determined to be necessary to protect children, and how DoCS monitors the provision of support services deemed necessary to ensure the safety of children. In some cases, we found that a relatively significant amount of time elapsed between a determination that support was needed, and the provision of that support.

Recommendation 27

The proposed DoCS quality reviews of CSCs should include review of CSC systems and practice in relation to timely implementation of case plans, and the efficacy of systems in place for monitoring the implementation of case plans.

Agency responses

DoCS' refers to the department's response to recommendation 19. DoCS also noted that the *Quality Review Toolkit* that was developed as part of the CSC quality review project, includes *Practice Review Tools designed to 'assess practice in relation to timely implementation of case plans.'*

DoCS also told us that the case planning module of the *Early Intervention Practice Review Tool* has been piloted and reviewed. The result of the review confirmed '*the effectiveness and validity of the tool.*'

Our analysis

This recommendation was made following our finding that in some cases, a relatively significant amount of time elapsed between the decision that a child was in need of protective intervention or support, and the subsequent provision of such support.

The intent of this recommendation was for DoCS to incorporate measures into their CSC Quality Review process to help identify, and subsequently address, any gaps or systems issues in relation to the implementation of case plans.

From the information provided, it appears that this intent will be met by the methodology of the CSC Quality Reviews. As noted above, we will monitor the progress of the quality reviews.

ATTACHMENT C

Recommendations relevant to exchange of information

Agency identification and reporting of risk of harm.

Context

In some of the matters we reviewed, we questioned whether agencies had given adequate consideration to making a risk of harm report to DoCS when responding to incidents affecting the safety and welfare of children. Our reviews indicated that agency staff may not fully appreciate the extent of their obligation as mandatory reporters, and highlighted the need for clarity in guidance provided to staff about identifying possible risks to children.

Recommendation 1

NSW Police should prioritise completion of the Child protection standard operating procedures, and ensure *that the revised SOPS and where relevant, Domestic violence operating procedures:*

- a) give adequate advice to police about circumstances where a risk of harm report to DoCS may be appropriate in cases where the child is not present with the adult and police are aware of a child protection history.
- b) give adequate guidance to *police about circumstances* where it may be appropriate for police to themselves seek further information about the safety of children.
- c) ensure that the procedures encourage full and relevant reporting to DoCS on the type and level of risk posed to children who are present at a domestic violence incident.

Recommendation 2

NSW Police should advise this office of plans for releasing the revised procedures, including associated information and training strategies.

Agency responses

The NSWPF accepted this recommendation and advised that they are currently reviewing the Child Protection and Domestic Violence Standard Operating Procedures (SOPS). Police told us that they '*... will take into consideration the specific comments within this recommendation and the Report when drafting the SOPS.*'

NSWPF provided us with a timetable for completion of the child protection SOPS, through to intended implementation, including the integration of the new procedures into existing NSWPF education programs of the SOPS, in September 2007.

Our analysis

The Child Protection SOPS have been under review for a significant period of time, and as noted in our report, it is critical for good practice that frontline police have clear guidance about identifying children at risk, and their reporting obligations.

We will continue to monitor progress with the Child Protection and Domestic Violence SOPS through our reviewable deaths work and through monitoring the implementation of the recommendations arising from our report *Domestic Violence: improving police practice.*

Recommendation 3

DoCS and NSW Police should provide advice to this office on the progress of their joint work to improve risk assessment procedures for child protection reports from NSW Police, and details of any actions arising from this work.

Agency responses

DoCS told us in October 2006 that the project, with NSW Police, would 'examine the characteristics of incidents reported to DoCS by police and the outcomes of those reports' and 'develop some options for improved reporting mechanisms and risk assessment in police reports.'

The NSWPF advised that it is currently in the process of coordinating data and related analysis to provide to DoCS, and that through this project, 'strategies can be developed to enhance the quality of information communicated between NSWPF and DoCS in relation to children at risk of harm, and consequently, improve decision making and the interagency response to children at risk of harm.'

In addition to the NSWPF/DoCS project, NSW Health has since advised us that it is the lead agency for 'a cross-Agency Domestic Violence Risk Assessment Framework project in partnership with DoCS, NSW Police and the AG's. The project aims to develop a more integrated and consistent service response to domestic/family violence, for earlier, more effective and targeted services to those affected by violence including children.'

DoCS told us that they continue to work with Police on this project. DoCS has analysed child protection reports received from Police, and Police are preparing a similar analysis of their own data. The stated objective of this analyse is to '*help to identify the key pieces of information that the police could routinely supply to DoCS in order to better inform child protection reporting.*' DoCS anticipates that recommendations for improvements to reporting will be made in late 2007.

DoCS' response also says that they are in the process of finalising a Memorandum of Understanding (MOU) with Police. The MOU is aimed at '*ensuring the consistency in practice and procedures for the lawful disclosure of information.*' DoCS anticipate that the MOU will be completed in the second half of 2007.

Our analysis

We will continue to monitor initiatives to improve risk assessment procedures for child protection reports made by police.

Broader initiatives to improve risk assessment in domestic violence will be considered in monitoring the implementation of the recommendation arising from our report *Domestic Violence: Improving police practice*.

Reports indicating criminal offences

Context

In our *Report of reviewable deaths in 2004*, we raised questions about referral of reports indicating possible criminal offences to JIRT or police, and noted some apparent confusion within DoCS' policies and procedures about which matters should be referred to JIRT and/or Police. Our reviews of deaths in 2005 continued to identify issues relating to reports not being referred to JIRT when they appeared to meet JIRT criteria, and inadequate responses to reports unable to be taken up by JIRT. DoCS, NSW Police and NSW Health initiated a review of JIRT.

Recommendation 6

In conducting the review of JIRT, DoCS and NSW Police should consider relevant issues raised in this report and our *Report of reviewable deaths in 2004*, in particular:

- a) That in those cases where JIRT rejects referrals, JIRT should clearly document the reasons for this decision, including details about any information that would be required to enable JIRT to take up the matter.
- b) The need for clarity about the type of reports that DoCS should refer to JIRT and/ or police.
- c) The need to ensure appropriate child protection responses to children who are the subject of reports referred to, but rejected by, JIRT.

Agency responses

The NSWPF told us that the recommendations coming out of the JIRT review address the concerns raised in our recommendation above. NSWPF advised that '*The JIRT review recommendations are consistent with government directions in the Aboriginal Child Sexual Assault Task Force and also take into account Ombudsman's recommendations.*'

Similarly, DoCS told us that the JIRT review has addressed the issues we identified. In particular, DoCS advised us that:

- Referrals to JIRT must be documented, and the rationale for accepting or rejecting a report is to be recorded on both NSWPF and DoCS systems. A hard copy is then to be faxed to the CSC. DoCS told us that the CSCs use this documentation to assist with assessment and subsequent decision-making about the type of protective response that is required.
- JIRT agencies have revised the JIRT physical abuse criteria, and all relevant DoCS, NSW Health and NSW Police staff received training about the new criteria in December 2006. The new referral criteria articulate the circumstances in which a JIRT referral would be appropriate, and provide staff with guidance about the types of physical injuries that would likely meet the required threshold. The referral criteria are accompanied by the *JIRT Injury Guide*, which outlines six broad categories of injury type and then provides specific descriptions of the indicators/markers of injury that fall within each category. The guide also points to potential sources of information that should be canvassed when deciding whether to accept or reject a referral, including for example, the results of any medical assessments, witness statements, inconsistencies in explanations, and results of any police crime scene examinations.

DoCS' revised *Secondary Assessment Risk of Harm* procedures have been rolled out. DoCS states that '*these procedures reiterate the need for CSCs to ensure that any case plans rejected by JIRT and transferred to CSCs are responded to appropriately.*' Further to this, DoCS told us that the policies and procedures for managing case plans rejected by JIRT are currently under review and a new Business Help topic is being developed to operationalise these procedures.

Our analysis

Our recommendation was informed by our reviews of deaths in 2004 and 2005 that raised questions about appropriate referral of reports to JIRT or police. The intent of this recommendation was for DoCS to address the problems we identified regarding the lack of clarity and procedural guidance about this process. We acknowledge that DoCS have made

good progress towards addressing the intent of our recommendation and have indicated that a similar review of the JIRT sexual abuse criteria is planned. We will continue to monitor the progress of the JIRT review, and evaluate the new JIRT sexual abuse criteria and Business Help topic on completion.

Child deaths resulting from methadone toxicity

Context

Among reviewable deaths in 2005, we identified three deaths related to methadone poisoning. In 2003, we reviewed two cases where methadone contributed to, or resulted in, the child's death.

Recommendation 11

NSW Health should provide advice to this office on the progress of the review into the systems related to reporting fatal and non-fatal child methadone overdoses.

Recommendation 12

As part of the review into the systems related to reporting fatal and non-fatal child methadone overdoses, NSW Health should consider the establishment of a consistent state-wide system for the collection and monitoring of data about children presenting to health services as a result of ingestion of methadone. Data collection should include the number and age of children presenting, and the circumstances in which methadone was ingested.

Recommendation 13

NSW Health should implement a policy requiring emergency department staff to identify and inform the relevant methadone prescriber of the admission of a child to an emergency department as a result of ingestion of methadone. This policy should be incorporated into relevant NSW Health policies and procedures relating to child protection and to opioid treatment.

Agency responses

NSW Health has advised of a number of strategies to address these recommendations:

The department is investigating options for reporting of fatal and non-fatal methadone overdoses through the state-wide hospital reporting systems. NSW Health has identified problems in the current data and reporting system in relation to child methadone poisoning and advised us that it is examining opportunities to establish routine monitoring and surveillance of the data contained within three state-wide hospital data collections:

- Public Health Real-time Emergency Department Surveillance System
- Emergency Department Information System, and
- Inpatient Statistics Collection

NSW Health has amended its *Incident Management Policy* to ensure mandatory reporting to NSW Health when a child presents at hospital with methadone poisoning. The policy now states that notification is required '*when methadone or buprenorphine is associated with or potentially associated with a child's presentation or admission to hospital.*' NSW Health will make a risk of harm report to DoCS in these cases. We were also advised that the Drug

Budget 2007-2011 provides funding for NSW Health to establish an investigations unit to specifically investigate fatal and non-fatal methadone poisonings involving children.

NSW Health noted that where '*available information allows the identification of a relevant prescriber*'; NSW Health will notify the prescriber.

In response to our further query regarding the steps that will be taken by hospitals and NSW Health to identify a prescriber, NSW Health advised that information exchange protocols and mechanisms allow for DoCS to request information to identify a prescriber for the purpose of gathering information to inform risk of harm assessment. Currently however, *there is no provision for DoCS to advise prescribers that a child of their patient was presented to hospital with methadone poisoning.*

NSW Health told us that it will negotiate with DoCS '*the specific roles and responsibilities of each Department when a report is made regarding child methadone poisoning*', and that the department would advise us when consultation is finalised and a decision is made regarding who will be responsible for contacting prescribers.

NSW Health will also provide copies to this office of the revised Incident Management Policy and further advice about data collection and reporting of child methadone poisonings.

Our analysis

We acknowledge the range of strategies being implemented by NSW Health to ensure effective responses to children who have ingested methadone. It appears that there is a significant outstanding issue in relation to the provision of critical information about child safety to prescribers.

We will monitor the progress of these strategies.

Recommendation 15

NSW Health and DoCS should provide this office with advice about the outcomes of the joint review of methadone-related child deaths, including a copy of the review report, and details of plans to respond to the review findings.

Agency responses

DoCS told us that the paper focuses on practice and systemic issues, and was soon to be endorsed.

NSW Health noted the paper was close to finalisation, and that further information would be provided as to how the department would respond to the findings.

Our analysis

We will review the report and seek progress on responses to the review findings.

Quality of risk of harm assessment

Context

Our reviews of deaths in 2005 raised questions about the effectiveness of secondary assessment. We found that secondary assessment was at times not holistic and not informed by adequate information gathering and analysis, and that where DoCS assessed risk without full and relevant information, assessments did not always adequately reflect the possible risks to a child. We also reviewed cases where secondary assessment was

suspended or ceased before a final determination was made about the child's need for care and protection.

Recommendation 20

In the ongoing development of alcohol and other drugs training and professional development strategies for caseworkers and managers, including the revision of the Alcohol and Other Drugs module of the Caseworker Development Course, DoCS should consider and incorporate the issues raised in this report, in particular:

- a) The challenges for DoCS staff in effectively engaging drug dependent parents, particularly where parents seek to avoid contact with agencies and/or conceal or minimise substance use.
- b) The challenges in effectively engaging with, and responding to, women using drugs-in-pregnancy, in order to minimise the subsequent risk to their child.
- c) The need for caseworkers to have a solid understanding of the nature of drug dependence, the range of illicit and legal substances that may be used and the range of their effects, and guidance to apply this information in assessing risk to children.
- d) The high vulnerability of infants and very young children in an environment of parental substance abuse.
- e) The importance of obtaining critical information from relevant agencies to inform risk assessment.

Agency response

DoCS told us that the revised Alcohol and Other Drugs (AOD) module of the Caseworker Development Course is now complete and Practice Solutions Sessions have been delivered to all CSCs. According to recent advice from DoCS, the issues raised in our recommendation '*...have been incorporated in the AOD training modules and were also addressed in the AOD Practice Solutions Sessions delivered to all CSCs.*' The Helpline's Practice Session Module targeted to Team Leaders was introduced in July 2007. DoCS expects that all sessions in the module will have been piloted by the end of August 2007. The department has established a Drug and Alcohol Expertise Unit to provide appropriate advice, resources and tools to DoCS staff.

DoCS notes that the department is collaborating with NSW Health to develop additional training initiatives in relation to drugs and child protection issues that will be '*locally organised and rolled out gradually across CSCs, starting with the drug testing pilot sites.*'

Our analysis

This recommendation went to concerns we had in relation to the quality of some risk assessments for families where parental substance abuse was an identified problem. We were concerned that risk assessment was at times adversely affected by limited caseworker and supervisor expertise in the area of substance abuse. We acknowledge the strategies being implemented.

Context

Recommendation 21

DoCS and NSW Health should work together to develop arrangements between the two agencies to ensure expert drug and alcohol assessments are appropriately sought by DoCS

and provided by NSW Health in cases where parental substance abuse is identified as a child protection concern.

Agency Responses

DoCS refers to the response to recommendation 20 above. DoCS also reported that the department is '*encouraging caseworkers to liaise with their counterparts in Area Health Services where there are shared clients to ensure that relevant information about child protection concerns is exchanged. Joint training for 2007 will support this liaison.*'

In relation to the joint DoCS / Health training indicated by DoCS, Health noted '*It is planned that as part of this training DoCS staff will receive drug and alcohol information and Health staff will receive additional child protection information, including information on the need for adequate and useful reporting.*' The training will include:

- information and education for drug and alcohol clinicians on how to make an assessment of risk, 'what, when and how to report'; and
- consideration of the parenting capacities of clients in the context of medical or health conditions.

NSW Health will also:

- look to revise the Prescribers Accreditation Course to include a focus on child protection and child safety issues
- consider opportunities for better training of all clinicians in relation to drug and alcohol history and 'management planning' if a history of excessive use is obtained (child protection issues included)

Our analysis

We acknowledge the training strategies identified above are positive, as are proposed arrangements for supporting the drug testing policy. We will seek a progress report on key initiatives.

Recommendation 22

DoCS should provide advice to this office of:

- a) The outcomes of the trial of the Hearth Safety Assessment Tool and any proposals for broader application of the tool across DoCS². Progress in the roll out of the protocol between NSW Health and DoCS on exchange of information concerning DoCS' clients on opioid treatment, and provision of a copy of the protocol.
- b) Progress in the development and trial of the policy on drug testing in a child protection context, including provision of a copy of the policy and key findings to date.

Agency Responses

Hearth Assessment Tool

A trial of the Hearth Assessment Tool is expected to commence in August 2007. The trial will include an evaluation component.

Protocol on information sharing between NSW Health and the NSW Department of Community Services in relation to persons participating in opioid treatment (methadone or buprenorphine) who have care and responsibility for children under 16 years of age in order

² The Hearth Assessment Tool is an assessment tool specifically designed to assess the safety of children in families where one or both parents present with drug or alcohol issues.

to assess potential risk of harm under the Children and Young Persons (Care and Protection) Act 1998

DoCS provided us with a copy of the protocol in March 2007 and recently confirmed that the protocol is currently being rolled out to CSCs. The protocol formalises how DoCS will seek information under s.248 about client's opioid treatment status if a risk of harm report for a child under 16 relates to misuse of an opioid or opioid treatment, and the report is open and allocated to a caseworker for further assessment.

Parental Drug Testing Policy

A 12-month operational trial of the DoCS *Parental Drug Testing Policy* has commenced in 4 CSCs (Penrith, Campbelltown, Eastern Sydney, and Central Sydney) after CSC staff had completed training in the use of Parent Responsibility Contracts. DoCS have advised that the policy will be evaluated.

The policy is designed to guide the use of parental drug testing and casework actions where positive test results are returned, to assist risk assessment for children and young people where risk is associated with parents' serious and persistent drug use (i.e. drug dependency and /or heavy or binge patters of use). Key elements of the policy include:

- Drug testing is stated to be mandatory where serious and persistent drug abuse was a primary factor in removal of a child, and restoration is being considered. The policy notes that where there is an ongoing risk of drug use that will adversely impact on parenting capacity, there should be a presumption against restoration.
- The policy states that drug testing may also be used to inform decisions about removal in cases where there is a suspicion of serious or persistent drug use that cannot be confirmed by other means.

The policy identifies timeframes and frequency of testing, when testing should commence, and provides some guide to responses where there are positive test results.

Our analysis

The drug testing policy and information sharing protocols are positive initiatives that go towards addressing our concerns. Our recommendation asked for advice only and DoCS have complied with this, however, we will continue to monitor the roll out and evaluation of the *Hearth* assessment pilot, the information sharing protocol, and the drug testing policy.

Interagency response to children at risk of harm

Context

Our reviews and other work in 2005 again showed both the importance of good interagency cooperation and coordination, and that this is not consistently being achieved. Our reviews identified examples of ineffective communication between agencies, inadequate liaison between agencies to ensure full information was available to accurately assess risks to children, and concerns about effective use of section 248 of the *Children and Young Persons (Care and Protection) Act 1998*.

Recommendation 29

DoCS should advise this office of the progress of the review of evaluation frameworks for interagency practice, and timelines and method for the proposed evaluation of the *NSW Interagency Guidelines for Child Protection Intervention*.

Agency Responses

An evaluation framework was developed by DoCS and endorsed by Human Services CEOs in February 2007. The framework involves *'quantitative and qualitative surveys of a sample of CPSOG [Child Protection Senior Officers Group] agencies, key peaks and non government agencies with a child protection role to gauge the take-up and effectiveness of policy and practice from both an agency and field perspective.'*

In March 2007, DoCS provided this office with a draft of the framework for comment. A final version was provided in April 2007. Following this, a consultancy brief, based on the evaluation framework, was finalised in April 2007 and has been issued to an external consultant for further work.

DoCS expects the evaluation to be conducted in two stages, and anticipates completion in 2009.

Our analysis

The evaluation framework is solid and covers key aspects of the guidelines.

Recommendation 30

NSW Health and DoCS should, through an appropriate joint forum, develop a state-wide policy by which hospitals can alert DoCS about the birth of a baby, and through which a coordinated response to any concerns about risk to the baby can be initiated.

Agency Responses

NSW Health refers to the *Children and Young Persons (Care and Protection) Miscellaneous Amendments Bill 2006* and that it will *'strengthen links in reporting of risk of harm and information sharing between NSW Health and DoCS'*.

Further, *'NSW Health and DoCS have discussed systems for implementation of these changes, including mechanisms to facilitate enhanced information sharing and 'alerts' to DoCS upon the birth of babies determined to be at risk of harm following a prenatal report.'*

DoCS advise that they continue to work collaboratively with NSW Health on the development of a system whereby DoCS *'may alert Health about prenatal reports deemed to be at medium to high risk of harm, and Health may, in turn, alert DoCS upon the birth of the baby where risk of harm is still present.'*

The department has recently completed a cost benefit analysis of a number of options and it is anticipated that a policy dealing with 'birth alerts' will be finalised shortly, pending further consultation with NSW Health.

DoCS also refer to their response to recommendation 10. In particular, their drafting of a policy on responding to prenatal reports, for which DoCS is *'working very closely with NSW Health.'* DoCS propose that the *Responding to Prenatal Reports* policy will *'utilise existing DoCS assessment procedures to prioritise reports for assessment within 72 hours and issue a section 248 request to Health and/or other agencies as part of the SAS 1 process'*.

Our analysis

Our recommendation was based on the finding that there are inconsistent systems and arrangements across different CSCs and Area Health Services for alerting DoCS that a baby the subject of a pre-natal report has been born.

We note that legislative amendments to prenatal reporting will strengthen obligations to report risk of harm in relation to children born in hospital. We will continue to monitor progress in relation to policy development and roll out of a relevant process.

Adolescents

Context

Overall, we found that most of the young people who had committed suicide had contact with a number of agencies, but in some of these cases, there was limited communication or coordination between services, including between mental health services and DoCS.

Recommendation 31

DoCS and NSW Health should discuss, at an appropriate joint forum, the issues raised in the *Report of reviewable deaths in 2004* concerning adolescents. In particular, the agencies should consider strategies to promote effective and coordinated child protection and health responses to adolescents who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

Agency Responses

DoCS told us that they have met with the Child and Adolescent Mental Health Services Network to *'develop a draft framework which aims to meet the mental health needs of children and young people in care by seeking to ensure that they receive appropriate services.'*

A Mental Health Outcomes and Assessment Tool – Child and Adolescent Triage Module is currently being considered by DoCS to inform the development of a tool for DoCS caseworkers to use when making referrals to Child and Adolescent Mental Health Services.

The Human Services CEOs have endorsed a Child Protection Senior Officer's Group project to review assessment tools used with young people who are at risk. *'This project will involve identifying the range of assessment tools currently used to assess the needs of this group, across agencies, as well as identifying assessment tools for at risk young people used in other jurisdictions.'*

The stated purpose of the project is to achieve greater integration of assessment tools used with this client group, so as to avoid unnecessary duplication and repeat assessments. DoCS advise that *'the review aims to identify opportunities for greater streamlining and integration.'*

NSW Health told us that they will work with DoCS, through the DoCS-Health Senior Officers Group, to identify strategies to promote effective and coordinated child protection and health responses to adolescents who are reported to be at risk of harm and where concerns include suicide risk and/or mental health.

NSW Health refers to the MOU as above, and the development of the addendum being developed to *'improve linkages between NSW Health and DoCS in the care of adolescents and young people'*, with a focus on adolescents with 'higher levels of need' or who may warrant admission to inpatient units. We confirmed the addendum relates to young people in statutory care.

Health also refers to a regional MOU developed between Northern Sydney/Central Coast Area Health Service and DoCS (Central Coast) in 2002 to *'respond effectively to crisis situations and to provide ongoing support through sound case management practice'*.

Our analysis

The responses do not relate directly to the intent of the recommendation, in regard to the range of issues raised in our report of reviewable deaths in 2004. The recommendation was made in the context of our observation that most of the young people who had committed suicide had had contact with a number of agencies, but in some of these cases, there was limited communication or coordination between services, including between mental health services and DoCS.

As noted in this report, there appears to be no clear cross-agency framework for responding holistically to young people at risk, particularly where child protection concerns are coupled with mental health issues/risk-taking behaviour.

Aboriginal children and young people

Context

Recommendations from our *Report of reviewable deaths in 2004* included a proposal that DoCS consider strategies to improve interagency coordination and collaboration in the care and protection of Aboriginal children and young people. In our view, and given the number of reports of risk that do not result in assessment or confirmation of risk, there is a need for improved joint responses, particularly in regard to information exchange and consultation by DoCS with relevant agencies in assessing risk of harm.

Recommendation 32

Human Service CEOs should provide advice to this office on the progress of:

- a) Human Services CEOs' initiatives in regard to strengthening joint responses to Aboriginal children and young people once a secondary risk of harm assessment has been conducted and risk of harm confirmed.
- b) Child Protection Senior Officer's Group identification and mapping of legal, policy, procedural and practice issues from recent reports on child protection for interagency action.

Recommendation 33

In progressing the above initiatives, Human Services CEOs should consider strategies to strengthen joint responses to Aboriginal children and families more broadly, particularly in relation to:

- a) exchange of information and consultation between DoCS and relevant agencies when assessing risk of harm, and
- b) coordination of support services to families where need is identified prior to confirmation of risk of harm.

Agency Responses

In response to the recommendations, the Chair of the Human Services CEOs Forum advised

- The NSW government has released an *Interagency plan to tackle child sexual assault in Aboriginal communities*. The actions in the plan specifically address improvements to exchange of information when assessing risk of harm.

Answers to Questions on Notice

- The Child Protection Senior Officers Group has undertaken a mapping exercise to identify issues from recent reports on child protection that need an interagency response. This analysis has informed the Group's work plan for 2007–08.
- *NSW Interagency Guidelines for Child Protection Intervention* contain expanded content regarding practice commitments, including an improved interagency response after a secondary assessment has confirmed a child / young person is in need of care and protection.
- A comprehensive communication strategy about the content of the guidelines has been implemented, and evaluation of the guidelines will commence in 2007/08.

Our analysis

We note the strategies advised. We will continue to monitor responses by key agencies to the needs of Aboriginal children at risk and their families.

Recommendation 34

DoCS should provide advice to this office on the progress of evaluation of service delivery models of interagency cooperation, and how the department intends to apply the outcomes of evaluation.

Agency Responses

An Anti Social Behaviour Case Coordination Framework is now being rolled out in a number of locations as part of an Anti Social Behaviour Pilot Strategy. The locations are based in NSW Local Police Area Commands (Canobolas – Orange and Cowra; Orana – Dubbo and some surrounds; Darling River – Bourke and some surrounds). The projects have taken over the structures of the Complex Case Management Response Team (Bourke) and Integrated Case Management (Dubbo).

The pilot is based on the model developed in Redfern-Waterloo, which involves a whole-of government approach with multiple human and justice agencies.

'The Case Coordination Framework provides for a more responsive, holistic and integrated case planning process for high risk children and young people with multiple and complex needs.' The focus is on partnerships for improving and coordinating strategies to *'reduce risks to, and anti social behaviours of, children and young people requiring multi agency intervention.'*

DoCS advised that future extension or expansion of the project will be a matter for the Premier's Department or Cabinet.

Our analysis

We acknowledge the roll out of the framework. Through our broader work on cross agency issues, this office will monitor progress of the pilot project.

ATTACHMENT D

CARE PROCEEDINGS IN THE CHILDREN'S COURT

A DISCUSSION PAPER

INTRODUCTION

Under the *Community Services (Complaints, Reviews and Monitoring Act) 1993*, the Ombudsman has the function of reviewing the deaths of certain children, including children who were reported to the Department of Community Services (DoCS) in the three years prior to their death, and children who died in circumstances of abuse or neglect or in suspicious circumstances.

The focus of reviewing child deaths is to consider the circumstances prior to the death of a child and the role of human service agencies in their life, with a view to identifying issues that may inform strategies for the prevention of future deaths. This focus has required us to look closely at the child protection system in NSW. As care proceedings in the Children's Court represent a significant part of the child protection system, we decided that it was relevant for us to look closely at how care proceedings operate.

The purpose of this paper is to provide a detailed discussion of matters connected with the conduct of care proceedings. In doing so, we believe that this paper will assist people understanding the issues involved, and provide an opportunity for feedback for the purposes of further discussions. At the end of this paper, we point out that there might be value in the organisation of an appropriate forum to focus on a number of matters discussed in this paper.

OUR RESEARCH

DoCS is the lead agency in child care and protection, and brings care applications before the Children's Court. The Court is responsible for making orders on care applications by DoCS. The Legal Aid Commission (LAC) provides and funds legal representation for children and, separately, for parents and other people involved in care proceedings. The work of all these agencies is discussed in this paper.

Some of the issues that we are interested in exploring are:

- What are the relevant factors in decisions taken in the lead up to an application to initiate care proceedings?
- Are care applications being dealt with expeditiously once before the Court?
- Can similar care applications lead to different decisions because they are heard in different locations?
- How often do restoration plans achieve the goal of reuniting children with their natural parents?

Answers to Questions on Notice

- To what extent do restoration plans fail because unrealistic undertakings are being accepted from parents?
- What effect do supervision orders have on the lives of children?

One source of information to assist in answering these questions, or providing a platform for further research, would be accurate and reliable statistical data about the nature and outcome of care proceedings. However, it appears that there is relatively little accurate and reliable statistical information available.

For example, the Court currently has no computerised system to collect accurate and reliable data about its operations. We have been told that the proposed CourtLink computer system is to be installed in the Court by the end of 2007.

In 2005, Court officials established the latest in a series of attempts to collect accurate information manually, previous attempts having produced unreliable data. The new system started on 1 July 2005, and requires court staff to e-mail monthly reports to the Local Courts Statistics Unit. The reports comprise records of seven types of applications and basic case information including children's birth dates and the date of finalisation of applications.

The absence of sufficient data means there is a significant gap in knowledge about a key part of the child protection system in NSW.

For the purpose of our research, we interviewed more than 50 people, including:

- Children's Magistrates, Children's Registrars, and court officials
- senior officers and staff from DoCS
- senior officers and staff of the Legal Aid Commission
- private sector lawyers who specialise in care matters
- staff and clinicians from the Children's Court Clinic
- child welfare academics
- non-government child welfare workers and their peak association representatives.

We have had to rely on anecdotal evidence, supported in some cases by the scant statistics that are available.

DoCS has expressed some concern about our use of anecdotal material in this paper. We acknowledge that there are shortcomings in this approach, but take the view that it is reasonable to draw on the opinions of people with relevant knowledge and experience of the care jurisdiction. We have chosen to include anecdotal material in this paper where it consistently reflects the views of people we have interviewed.

We have also taken into consideration:

- the review of the previous care and protection legislation in 1997
- child protection literature
- the Australian Institute of Health and Welfare Child Welfare Series
- DoCS annual reports and policy documents.

THE CHILDREN'S COURT

The *Children's Court Act 1987* provides for the appointment of magistrates to the Children's Court and the management of the court. It also confers authority on the Senior Children's Magistrate to make practice directions that regulate the Court's practices in care matters.

The dedicated Children's Courts in Sydney are at St James (including an "annex" at Bankstown), Bidura, Lidcombe, Cobham and Campbelltown. There are also Children's Courts at Broadmeadow in the Hunter District, Woy Woy on the Central Coast (with an "annex" at Wyong and Hornsby), and Port Kembla (including an "annex" at Nowra) in the Illawarra region.

There are twelve Children's Magistrates, each appointed for a three-year term. A thirteenth magistrate is on a short-term appointment from the Local Courts.

Specialist Children's Magistrates do not sit in local courts but travel on a needs basis on the country circuit for Children's Court hearings. Non-specialist magistrates at local courts around the State also hear care matters.

The Children's Court has five Children's Registrars who exercise quasi-judicial powers. We have been told that nine Children's Registrars are budgeted for but four of the positions remain unfilled.

THE CARE AND PROTECTION LEGISLATION – LAW AND PRACTICE

The *Children & Young Persons (Care & Protection) Act 1998* ("the care and protection legislation") sets out the regime for responding to reports about children "at risk of harm" and the institution of care proceedings before the Children's Court. It also articulates various principles that must be taken into account in responding to risk of harm reports and instituting care proceedings.

The principles to be applied in the administration of the care and protection legislation – section 9

The legislation requires the Court, DoCS and other agencies to make the safety, welfare and well-being of children the "paramount consideration" in their decisions.

It also requires that the Court and agencies should make decisions that constitute the "least intrusive intervention" in the life of the child and their family consistent with the paramount concern to protect children from harm and promote their development.

When interventions do happen, children and their families must be consulted about problems and solutions. Legal action should be avoided where possible and pursued without delay when needed. If children are to be removed from their families, new care arrangements are to be made as quickly as possible. The legislation emphasises the importance of children retaining family ties through contact arrangements while in out-of-home care. Another important goal is to ensure the permanency and stability of care arrangements for children.

The principle of “least intrusive” intervention – section 9(d)

Section 9(d) of the legislation says that when administrative or legal decisions are made to protect a child, they should be ones that are “least intrusive” in the life of the child and family, consistent with the paramount concern to protect children from harm and promote their development.

There is no research to show how the Court and agencies are interpreting the principle of “least intrusive” action.

Many of those we talked to questioned DoCS’ interpretation of the “least intrusive” principle. It was suggested that some care orders sought by the department are more intrusive than necessary. An example might be an application for an order seeking that parental responsibility of a child be given to the Minister when there is a suitable grandparent able and willing to care for the child. Some people also argued that substandard care plans and restoration planning undermine adherence to the principle. And sometimes, they said, a long-term order can be less intrusive than its short-term counterpart, because short-term orders may be based on an unrealistic assessment of the prospects for a child to return home.

The Legal Aid Commission provided us with examples of cases where its lawyers have challenged DoCS’ applications for care orders on the ground that the care order sought was not the least intrusive option. In one case, a new mother with mental health problems was discharged from hospital with her baby. The pair entered a residential facility where women with a mental health diagnosis may live with their children. While the woman was at the facility, DoCS applied for long term care orders in the Court. The LAC told us it argued successfully that there were no current risk factors for the child and the orders sought by the department were not the least intrusive option. In another case, the LAC represented a woman with drug addiction problems who had agreed with DoCS to the restoration of her baby over a 12-month period. As part of the agreement, the mother was to enter a residential facility and undertake drug rehabilitation. While she was doing this and the baby was in hospital, DoCS filed an application for the long term care of the baby. The LAC says that there were clearly no serious concerns for the child’s safety at the time the application was filed.

The Children’s Court made the following comments on the examples provided by the Legal Aid Commission:

These examples may not be entirely fair to DoCS. In some cases, no matter what the co-operation of the parent, the risk to the child (sometimes the future risk) is so high that DoCS caseworkers will feel compelled to seek an order. They are required by the [legislation] to nominate the order to be sought in the body of the application and, accordingly, they are likely to make an “ambit claim” which, until matters are subsequently clarified and the application is amended, is probably not the least intrusive option. Nevertheless, when the Court comes to making an order, it is the least intrusive option which it seeks to reflect and, by that time, DoCS has very often focused its thinking.

DoCS made the comment that the examples provided by the LAC did not go to the question of whether there was confusion about the concept of “least intrusive” intervention, but were

more concerned with disputes about the appropriate orders that should be made by the Children's Court.

However, DoCS said it was aware of instances where the application of the "least intrusive" principle was capable of clouding the application of other principles. For example, DoCS said it had been alleged that caseworkers had wrongly assumed that adopting a least intrusive approach will mean that court action should be a response of last resort, and that this erroneous assumption had led to unnecessarily detailed contact arrangements. However, DoCS said that to talk about a corporate DoCS "view" was wrong because it seeks to apply the principle appropriately in individual cases.

The department told us that, based on its understanding of concerns expressed by others and its own experience, it expected submissions to the current review of the legislation to comment on the application of the "least intrusive" principle.

In our own submission to the review, we noted our concern about how the principle is being interpreted and applied in practice. Specifically, we noted that our investigations and reviews have identified cases where the level of protective intervention by DoCS following reports of risk of harm was not commensurate with the apparent level of risk to the child or young person.

We also noted DoCS' July 2002 policy statement on taking action in the Children's Court:

The [Act] provides a number of options for meeting the safety, welfare and wellbeing [of] children and young people. Provision for action in the Children's Court is made where all less intrusive casework actions have not met the care and protection needs of the child or young person.

This policy provides some suggestion that court proceedings are not appropriate unless other casework actions have been previously attempted.

In addition, we noted practitioners in this area had advised us that the "least intrusive" principle is often interpreted as a presumption in favour of keeping a child with their family even if this involves ongoing significant risks to the child's safety.

As to the content of the DoCS policy statement quoted above, and the interpretation of the least intrusive principle by DoCS caseworkers, the Senior Children's Magistrate, Mr Mitchell, has made the following observations:

To the extent that the "least intrusive option" principle is often interpreted as a presumption in favour of keeping the children with the family, while this may be the mistaken view of individual DoCS caseworkers, it most certainly is not the view of the Court. In particular, it is not the view of the Court that the proper application of the "least intrusive option" policy should necessarily argue against the commencement of proceedings, and DoCS' July 2002 policy statement ... should be reworked.

In our submission to the review of the Act, we submitted that, where the grounds for a care order have been established under section 71 of the Act, and there are significant risks to the child's safety in keeping them within the family, there should be a presumption that a child should not be returned to the family unless and until the risks have been ameliorated, and that the Act should clearly reflect this position.

Senior Children's Magistrate Mitchell has said that he disagreed with our proposal on the following grounds:

Firstly, it seems to me that the proper principle is clear enough in the legislation as it stands and is well understood by lawyers and by the Court. If it is misunderstood by DoCS, the solution is proper education for departmental workers rather than further [amendment of] the Act.

Secondly, ... it is not clear whether the Ombudsman's proposal regarding a return to "the family" relates to the nuclear family or to one parent to the exclusion of the other or to extended family, and neither is the degree of amelioration clarified.

As to the second comment by the Senior Children's Magistrate, we should observe that, in making our submission to the review of the Act, it was not our intention to seek to provide a draft of the legislative amendment of the type that we contemplated. While we acknowledge the comments by the Senior Children's Magistrate, we believe careful drafting may be able to address his concerns about the need for appropriate clarity in relation to the term "family" in the context of any relevant legislative amendment.

The principle of participation – section 10

Section 10 requires DoCS to provide the child or young person with information about the reason for departmental intervention, an opportunity to express their views, information as to how those views are to be recorded, information about the outcome of any decision, and an opportunity to respond to those decisions. The aim of the section is to ensure that children are able to participate in decisions made pursuant to the Act that have a significant impact on their lives.

The Legal Aid Commission submitted that the Act should be amended to provide that it is the role of the child's lawyer to communicate with the child and explain court processes and decisions of the Court. It said that the responsibility of explaining the legal process should be that of the child's independent lawyer, who needed to carefully take a child's instructions for presentation to the court and formulate a position in the best interests of the child.

In this respect, the LAC pointed out that DoCS staff dealing with children are social workers and not lawyers. The LAC said it accepts that case workers must speak to children in the exercise of their casework responsibilities. However, it said that, once a child's legal representative is appointed, legal issues should be discussed with children only by their independent legal representatives.

In support of its submission, the LAC told us its practitioners frequently see transcripts of conversations between caseworkers and children in affidavits accompanying care applications. It appears that inclusion of these conversations in the affidavit is put forward in support of the case the department is mounting against the parent. The LAC said this illustrates that it is very difficult for caseworkers, who are not legally trained, to turn their minds to the subtle difference between explanation and evidence gathering. According to the LAC, there is a need to protect children in circumstances where discussions with children by caseworkers may become an evidence gathering exercise for the purposes of the court proceedings.

The LAC said that its practitioners understand their obligations as lawyers to their clients and the Court, and these obligations provide protections for children and for the proper administration of justice.

The LAC also argued that there is potential for a conflict of interest where the department seeks orders that are opposed to the views, wishes or instructions of a child or young person. LAC said these situations are not uncommon, and that the child's legal representative is best placed to independently keep the child informed about the court process and legal implications.

DoCS said that the comments by the LAC on the demarcation between the legal issues and casework responsibilities did not accurately reflect the responsibilities imposed on DoCS by the legislation – for example, its responsibility under section 10 to involve children and parents in decision making, and its responsibility under section 78(3) to prepare care plans in consultation. DoCS said that its responsibilities in this respect provided clear examples of where caseworker responsibilities would inevitably cover legal issues. In the view of DoCS, it was unrealistic to expect that all legal matters could be excluded from casework support to a child, because the child's history and current circumstances would involve an intricate web of issues that inevitably included elements of the legal processes involving the child.

We consider that a number of aspects of the LAC's observations are highly contentious. In our view, the crucial question is whether the manner in which information is provided to, and obtained from, a child in the context of care and protection matters is appropriate and in the best interests of the child. Accordingly, we believe that no consideration should be given to the possibility of any amendment to section 10 of the type suggested by the LAC until after there has been a proper and informed debate about the issues involved.

In addition, we note that some of the issues raised in this context are relevant to the question of whether care proceedings before the Children's Court are conducted in an unnecessarily "adversarial" manner. This question is the subject of detailed discussion later in this paper.

Aboriginal and Torres Strait Islander principles – sections 11, 12 and 13

The care and protection legislation makes specific reference to indigenous families, kinship groups and communities. Section 11 says Aboriginal and Torres Strait Islander people are to participate in the care and protection of their children with as much self-determination as possible. Section 12 says indigenous families, kinship groups, representative organisations and communities are to be given the opportunity to participate in decisions concerning the placement of their children and in other significant decisions made under the Act. Section 13 provides that, subject to the general principles in section 9, the placement of a child who needs out-of-home care should be determined in accordance with the principles of placement listed in the section. The first option is for the placement to be with a member of the child's extended family or kinship group.

The practical application of these principles is discussed later in this paper.

Responding to risk of harm reports

Part 2 of Chapter 3 of the legislation establishes a scheme concerning the making of “risk of harm” reports to DoCS. Section 23 defines “risk of harm” concerns as follows:

current concerns exist for the safety, welfare or well-being of the child or young person because of the presence of any one or more of the following circumstances:

- the child or young person’s basic physical or psychological needs are not being met or are at risk of not being met
- the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
- the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated
- the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm
- a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.

Under section 30, when DoCS receives a risk of harm report about a child, it is required to determine whether the child is at risk of harm.

If DoCS forms the opinion that the child is in need of care and protection, DoCS should take whatever action is necessary “to safeguard or promote the safety, welfare and wellbeing” of the child.

The actions that DoCS may take include:

- providing, or arranging for the provision of support services
- developing, in consultation with the parents, a “care plan” to meet the needs of the child and their family (these plans may be registered with the Children’s Court or be the basis for consent orders made by the Court)
- using emergency protection powers under the Act
- seeking appropriate orders from the Children’s Court.

In considering its options, DoCS must have regard to the grounds on which the Children’s Court is entitled to make a care order. These grounds are set out in section 71 of the Act:

- there is no parent available to care for the child as a result of death or incapacity or for any other reason

- the parents acknowledge that they have serious difficulties in caring for the child and, as a consequence, the child is in need of care and protection
- the child has been, or is likely to be, physically or sexually abused or ill-treated
- the child's basic physical, psychological or educational needs are not being met, or are likely not to be met, by his or her parents
- the child is suffering or is likely to suffer serious developmental impairment or serious psychological harm as a consequence of the domestic environment in which he or she is living
- in the case of a child who is under the age of 14 years, the child has exhibited sexually abusive behaviours and an order of the Children's Court is necessary to ensure his or her access to, or attendance at, an appropriate therapeutic service
- the child is subject to a care and protection order from another State or Territory that is not being complied with
- the child resides in out-of-home care that is not authorised by the Act or with an authorised carer who is in breach of the carer's authorisation.

Principles of intervention in responding to risk of harm reports - section 36

DoCS must consider specified principles of intervention when it decides how to respond to risk of harm reports about children.

DoCS must give paramount consideration to the "immediate" safety, welfare and well-being of the child in their usual residential setting. Removal of the child from their usual caregiver should occur only where it is necessary to protect a child from the risk of "serious harm". It should be noted that these principles must be applied in priority to the general principles set out in section 9 of the Act.

The people we interviewed said that most (perhaps 90 per cent) of cases brought to court involve a finding that a child is in need of care. In these cases, everybody – including the parents – agrees that the child needs care for at least one of the reasons set out in section 71.

The question of the need for care is reportedly contested only in a small minority of cases. Many of these cases tend to turn on the disputed facts of a single event. An example would be a contentious medical issue like shaken baby syndrome.

However, consensus among the people we interviewed is that DoCS tends to initiate legal action only in what they described as the most serious cases.

Those interviewed also suggested that, in many cases, there is a history of notifications that suggests intervention could and should have occurred sooner. Lawyers acting as separate representatives for children said they commonly subpoena DoCS files and discover extensive protection issues and previous allegations that appear not to have been

investigated. These lawyers said that they were unable to discern what policy is being used to guide the department's determination of which child protection cases should end up in court.

DoCS said that, before any care application is commenced, it must make a decision as to whether the information it holds would justify the Court making a care order on one of the grounds under section 71 and whether such an order would assist the child in question. In this respect, DoCS told us that, if an adequate level of proof does not exist, or if the department determines that the same results can be obtained through working co-operatively with the family, then it will not institute care proceedings.

DoCS has also told us that it is developing a comprehensive framework for practice improvement, consistent with the recommendation in our "Report of Reviewable Deaths in 2004" that DoCS should undertake a systematic performance audit of each Community Service Centre in NSW. The department has suggested that issues in relation to consistency across all CSCs as to when a matter is taken to court, and how often reports are investigated and assessed, can be appropriately addressed in this context.

Alternative dispute resolution - section 37

Section 37 requires DoCS to consider the appropriateness of using alternative dispute resolution (ADR) services in responding to risk of harm reports about children. The aims set out in section 37 are:

- to ensure intervention so as to resolve problems at an early stage
- to reduce the incidence of breakdown in adolescent-parent relationships
- to reduce the likelihood that a care application will need to be made
- if an application for a care order is made, to work towards the making of consent orders that are in the best interests of the child.

Section 37 itself does not define "alternative dispute resolution services". However, the explanatory note says: "Within this provision, models for counselling and conferencing may be developed to accommodate the unique requirements of a community (whether cultural, geographic or language), the complexities of the case, or the nature and severity of the abuse suffered by the child or young person ". Parliament's intention therefore appears to be to provide for flexibility regarding ADR options and approaches.

The people we spoke to said that ADR is rarely used before and during care proceedings for cases that do reach court. People familiar with the Court at St James and Campbelltown said they saw little evidence of DoCS using ADR at any stage in care proceedings. Other sources said that they had never seen ADR used on the country circuit. Public and private sector lawyers also told us that ADR is very rarely used to seek to avoid care applications, work towards applications for consent orders, or reduce the incidence of breakdown in adolescent/parent relationships.

DoCS caseworkers may be using ADR in cases that do not reach court. However, the affidavits in support of care applications to the court are reportedly short on evidence of the alternatives considered before applications were made.

Our inquiries show that DoCS caseworkers sometimes reach temporary care agreements with parents or carers in attempts to resolve child protection concerns. The existence of such arrangements may be interpreted as a form of ADR. Temporary agreements may be linked to voluntary undertakings by parents or carers. These agreements do not involve formal care orders by the Court and therefore cannot be enforced. Evidence from the Ombudsman's reviewable death function shows that temporary care arrangements may sometimes be used inappropriately and in the absence of proper risk assessments.

DoCS told us that attempts were made early in the life of the current legislation to train DoCS staff in ADR and to bring Community Justice Centres into the process. However, DoCS told us that it is not currently providing ADR training to its caseworkers, although negotiation skills training is available. Nevertheless, DoCS told us that it supports the increased use of ADR, and has been working with Legal Aid to achieve this.

One of the real difficulties in assessing the use of ADR before and during care proceedings relates to how the concept and use of ADR is viewed by the key players.

DoCS said that the Court had consistently indicated opposition to, or failed to be supportive of, ADR approaches and therefore training its staff in ADR seemed irrelevant in relation to the operations of the Children's Court.

Senior Children's Magistrate Mitchell went on to make the following comments on the observations of DoCS:

There is no basis whatsoever for the allegation by DoCS that the Court has consistently indicated opposition to, or failed to be supportive of ADR approaches ... Moreover, even had the Court been opposed to ADR as a matter of principle ... that would have presented no impediment whatsoever to DoCS initiating ADR "designed to address problems at an early stage and to reduce the likelihood that the care application will need to be made".

In this respect, Senior Children's Magistrate Mitchell also noted DoCS' previous failure to provide ADR training to its caseworkers.

Senior Children's Magistrate Mitchell made the following general observations on the use of ADR:

Although care proceedings are often not appropriate for compromise and settlement (like cases involving only the interest of litigants), the Children's Court acknowledges that there is a place for ADR in the child care and protection regime...

The Children's Court employs "in-house" ADR in the shape of preliminary conferences, presided over by Children's Registrars, where each party and the child's interests are represented. No care case goes to a hearing without a preliminary conference and a very high settlement rate is achieved. In many cases, though, resort to external ADR would seem to suffer from the difficulties [that there is a significant power imbalance between the parties in care proceedings, and that the

rights and interests of vulnerable children should not be compromised] ... In the case of early ADR [there would be] the additional shortcoming that there would be somebody to express the interests of DoCS and somebody to represent the interests of the parents [but] nobody to represent the needs and interests of the child.

The use of external ADR in the context of child care and protection is perhaps more evident in Victoria, with its very heavy emphasis on the reunification of families, than in NSW, with its emphasis on care and protection of “at risk” children. Perhaps the usefulness of ADR is not unconnected with the result one is trying to achieve and the particular interests one is seeking to advance.

It is clear from Senior Children’s Magistrate Mitchell’s comments that the Court sees preliminary conferences as a vehicle for ADR in relation to matters before the Court. Before discussing the implications of this further, it will be helpful to examine some of the features of preliminary conferences.

Under section 65, a preliminary conference must be held after DoCS has notified the parents of a child or young person of a care application, and served them with copies of the application. The conference is arranged and conducted by a Children’s Registrar of the Children’s Court. There are options for the Children’s Registrar to defer or dispense with a conference according to circumstances specified in the section.

Section 65 lists the purposes of a preliminary conference:

- identifying areas of agreement and issues in dispute between parties
- determining the best way of resolving any issues in dispute, including by referring the application to independent dispute resolution
- setting a timetable for the hearing of the application by the Court
- formulating any interim orders that may be made by consent.

DoCS said that it has deliberately made a policy decision not to have legal representation at section 65 preliminary conferences. The department said that part of the reason for that decision was to address issues of power imbalance. The department said that the Court has frequently sought to have DoCS legally represented, and that this is inconsistent with its comments about power imbalance.

Senior Children’s Magistrate Mitchell said that the decision by DoCS not to be legally represented at preliminary conferences appeared to be indicative of the lack of the department’s commitment to ADR. In his view, the lack of legal representation was irrelevant to addressing the power imbalance between DoCS and a parent and, if anything, was likely to exacerbate the imbalance because an experienced and properly instructed lawyer was likely to act in a considered way, respecting the interests of others and the nuances appropriate to the ADR process.

The Legal Aid Commission argued that an ADR process to encourage settlement at an early stage can only work where all parties present can make decisions as needed during the conference. LAC told us, that where an agreement is reached, it commonly cannot be

finalised at preliminary conference because the caseworker or manager is unable to make the decision without legal advice. According to LAC, this was not conducive to the settlement process. It said the departmental legal representatives should either be present at preliminary conferences or delegate decision-making powers to a DoCS representative at the preliminary conference.

The Sydney Regional Aboriginal Corporation Legal Service said that they understood that preliminary conferences were intended to provide an opportunity for open and frank discussion and negotiation about the substantive issues involved, to enable parties to be actively involved in decision-making and to avoid the need for litigation. However, it said that, in practice, conferences did not involve meaningful negotiation and were often merely used as a means of making directions for the further conduct of the proceedings. The Service submitted that the effectiveness of preliminary conferences was directly linked to the skills and expertise of Registrars – in particular, their mediation skills and capacity to engage parties in the negotiation process – and the willingness of DoCS and legal representatives to actively participate in discussion and mediation.

In light of the above discussion, why has DoCS argued that the Court has “consistently indicated opposition to, or failed to be supportive of, ADR approaches”? The answer appears to lie in the fact that DoCS is of the view that the legislation does not “give the role of ADR to the preliminary conference”. In this respect, DoCS has made the following observations:

There seems to be some confusion about the respective positions of DoCS and the LAC concerning ADR and preliminary conferences. Section 65(2) says that the preliminary conference can “refer the application to independent dispute resolution”, not that ADR takes place at the preliminary conference. This is consistent with recommendation 6.3 of the Parkinson Review [of the Act]. That recommendation was about holding these conferences away from the court house ... and avoiding the use of “list days” ... The way in which the preliminary conference has been used by the Court, and not whether DoCS is legally represented at them, is what has changed the nature of the preliminary conference. Both LAC and DoCS are very supportive of the appropriate use of ADR. Neither the Review nor the Act gives the role of ADR to the preliminary conference.

We would observe that the legislation supports the use of alternative dispute resolution services that are designed to resolve problems at an early stage and to reduce the likelihood that a care application will need to be made. The legislation also envisages the use of ADR services after a care application is made “to work towards the making of consent orders that are in the best interests of the child”.

While we acknowledge that ADR will not be appropriate in all cases, we would support moves to expand its application in a range of ways before and during care proceedings. We would also support associated research on how such expansion might best be achieved.

In saying this, we recognise the value of the Court’s employment of a form of “in-house ADR” in the shape of preliminary conferences. From the above discussion, there is clearly room for further consideration of how the better resolution of issues can be achieved through this process.

We also acknowledge the concerns of the Senior Children's Magistrate relating to the use of "external" ADR where care proceedings have been commenced. Nevertheless, this need for caution should not exclude the use of external ADR in all cases where proceedings have been commenced. It is clear from the legislation that this is envisaged. It has the support of both DoCS and the LAC. We believe there is scope for the mediator or conciliator involved in ADR of this kind to address power imbalances between parties.

We would therefore be keen to see the major players come together in exploring further options for, and approaches to ADR, and that future use of ADR should be supported by associated research that evaluates the outcomes of the various ADR strategies that are employed.

We also note the recommendation made in the review of the previous Act that "the Minister should have the responsibility for the establishment and funding of alternative dispute resolution services which are independent of the Department." This was to ensure that the mediator or conference facilitator was not a party to the negotiations and was independent of DoCS. Consideration could again be given to this recommendation.

Development and enforcement of care plans – section 38

Section 38 provides that a care plan developed by agreement in the course of ADR may be registered in the Children's Court and used as evidence of an attempt to resolve the matter. A care plan that allocates all or some aspects of parental responsibility to a person other than the parents takes effect only if the Children's Court makes an order by consent to give effect to the proposed changes.

The Children's Court may make orders to give effect to a care plan without the need to be satisfied of the existence of a ground for a care order under section 71 if it is satisfied that the proposed order will not contravene the principles of the Act and the parties understand the plan, have freely entered into it, and have received independent advice about it.

A number of lawyers specialising in care matters report that section 38 is rarely used.

The Sydney Regional Aboriginal Corporation Legal Service said that, while its experience of section 38 care plans was limited, the fact that parties are required to obtain legal advice before signing a section 38 care plan and before a care plan can be registered suggests that either the requirement was not being complied with or that section 38 care plans were infrequent.

We have been told that, at Campbelltown, only a handful of care plans are registered each year, and that, of these, few involve reallocation of parental responsibility and therefore orders by the Court. At St James, section 38 care plans, and supervision orders, are said to make up less than five per cent of all cases.

There is some contention about the use of section 38 care plans at Port Kembla. Some people said that the use of section 38 care plans there is very rare. And the Court provided figures which showed that the total number of applications in the 12 months from 1 April 2004 was 183. Of these, there were 103 applications for parental responsibility orders, 49 applications to vary or rescind a care order, but only four applications under section 38.

However, DoCS has said that section 38 is frequently used at Port Kembla. In support of its contention that section 38 plans were frequently used at Port Kembla, DoCS said that a departmental legal practitioner had advised that section 38 plans had been provided on a regular basis.

It is not easy to resolve these competing accounts of the use of the care plans at Port Kembla. However, one possible explanation is that the legal practitioners and the Court are referring to applications for care plans involving the reallocation of parental responsibility, where the care plan must be approved by the Court, whereas DoCS is referring to the use of care plans generally.

DoCS said that in courts where section 38 is not used extensively, an explanation may be that the Court, in a number of early cases, held that registration of a section 38 care plan required that the matter come before the Court. DoCS also said that, once an order is made under section 38, it is unclear as to whether other provisions such as section 90 apply (section 90 concerns applications for the rescission or variation of care orders). The department said that, when these two considerations were taken into account, its staff might decide that it was simpler and more productive to proceed by way of a care application.

The Children's Court made the following submissions on the use of section 38 care plans:

Whether or not section 38 care plans are often or rarely presented to the Court is a matter for the parties and, in particular, for DoCS. Those plans which involve an allocation of parental responsibility may not be especially attractive to DoCS because, due to section 38(2), such matters have to go to the Court at any event. Furthermore, in the early stages of its involvement with an "at risk" child and his/her family, DoCS may believe that a section 61 care application is appropriate and the possibility of agreement and settlement emerges only later. When that happens, consent orders will probably be as attractive to the parties and convenient to all concerned as will a section 38 care plan.

In our view, the submissions on these points by DoCS and the Children's Court raise questions about the application of section 38, given that its intention appears to be to provide a way to resolve care matters as an alternative to taking action in the Court.

There is a need for reliable data and associated research to provide a solid platform for a more informed debate about the issues. We were advised at one stage that the Court intended to initiate a central register of section 38 care plans. The information in the register would have been collected by requiring each of the State's Children's Courts to supply the Manager of Children's Court Services with relevant data about care plans. However, we have recently been advised that this initiative did not proceed.

The legislative requirement under section 38(3) for parents to have received independent advice about a care plan does not stipulate the source of advice. However, this is likely to be a lawyer.

As to the availability of legal advice, Legal Aid has said that it operates free legal advice services out of each of its twenty regional offices, and that people seeking advice on care matters would be able to avail themselves of these services, although in some cases conflict of interest might limit the nature of the assistance available. Legal Aid also said that appointments to obtain legal advice are not necessary at the Sydney and Parramatta

offices, but are necessary at the small regional and country offices. Legal Aid also pointed out that LawAccess is funded to provide legal advice throughout the state.

DoCS has told us that parents who consent to care plans are receiving independent advice before the matter is heard at court and that this advice is usually self-funded.

However, we have been told that, in some cases where parents have not obtained legal advice about the care plan prior to the court hearing, lawyers have advised parents to reject or renegotiate agreements, thus delaying resolution of the matter.

Emergency applications and care applications – section 46

Under section 43, the department and police are empowered to remove a child from an immediate risk of serious harm, without prior court approval, if the making of an apprehended violence order is not sufficient to protect the child. Under section 44, the department may also act in such circumstances to assume care of a child. In either case, section 45 requires the department to make a prompt application to the Court for an emergency care and protection order, an assessment order, or any other care order.

Emergency care and protection orders involve an order that places the child in the care responsibility of the Director-General or some other person specified in the order. Emergency care and protection orders have effect for a maximum of 14 days. An application for an extension for a further 14 days may be made.

DoCS has told us that it has no data on applications for emergency care and protection orders, including data on which such orders are sought and whether or not they are granted.

The LAC suggested court attendances could be by video link, and that these facilities need to be developed and promoted. The Court has noted that video link and associated facilities are not available at St James or Cobham, but will be available at the Parramatta Court which, from late 2006, will accommodate the majority of care cases. The Court also observed that the use of video link should be encouraged.

An alternative to an application for an emergency care and protection order is an application for the care and protection of a child. The application must specify the particular care order sought and the reasons for it.

We have been told that applications for care orders are the most common way that proceedings begin in the Court.

There is a distinction between the threshold for an emergency care and protection order and that for a care order. To make an emergency order, the Court has to be satisfied that the child is at risk of serious harm. For a care order, the Court must find that a child is in need of care and protection based on any one of the eight grounds listed in section 71.

At St James court, in at least 90 per cent of applications, the finding that a child is in need of care is not contested. At Campbelltown, it is said to be very rare to have hearings to establish grounds. Specialist lawyers with experience representing children and parents also say most cases come to court with lengthy histories and all parties concede the need for care.

There is no empirical evidence available on the frequency of use of any of the eight grounds. However, some people we interviewed suggest that parents are more likely to concede on ground (b) - that they have serious difficulty in caring for the child - or on ground (e) - that the child is suffering or is likely to suffer serious developmental impairment or psychological harm as a consequence of the domestic environment. These grounds are more general than ground (c), that the child has been or is likely to be physically or sexually abused or ill-treated. Parents probably seek to avoid the stigma of conceding responsibility for these specific forms of abuse.

In *Re Irene*, the Supreme Court found that establishment of any one of the grounds sought is sufficient to pass the threshold test. Some people we have talked to hold the view that information about the breakdown of use of various section 71 grounds would serve no useful purpose.

It is interesting to note that the UK legislation has only one ground for the making of a care order - that the child has suffered or is likely to suffer significant harm. The Children's Court has said that it would welcome an amendment to the legislation in NSW, substituting this one ground for the various grounds currently listed in section 71 of the legislation.

Examination and assessment orders - sections 52-59

Section 53 provides that the Children's Court may make an order for the physical, psychological, psychiatric or medical examination of a child.

The section also provides that the Court may order the "assessment" of a child.

Section 55 provides that an assessment order may be made on the application of the Director-General of DoCS or, if a care application has been made, by a party to the application.

If the child is of sufficient understanding to make an informed decision, the child may refuse to submit to an assessment.

Section 54 provides that the Court may, for the purpose of an assessment order, appoint a person to assess the capacity of a person with parental responsibility, or a person who is seeking parental responsibility, to carry out that responsibility. However, such an assessment may only be carried out with the consent of the person whose capacity is to be assessed.

Section 56 provides that the Court must have regard to the following factors in considering whether to make an assessment order:

- (a) whether the proposed assessment is likely to provide relevant information that is unlikely to be obtained elsewhere
- (b) whether any distress the assessment is likely to cause a child will be outweighed by the value of the information that might be obtained
- (c) any distress already caused the child by any previous assessment for the same or another purpose
- (d) any other matter the Court considers relevant.

The Court must also ensure that the child is not subjected to unnecessary assessment.

Section 58 provides that, where the Court makes an assessment order, it must appoint the Children's Court Clinic to prepare and submit the assessment report, unless the Clinic informs the Court that it is unable or unwilling to prepare the assessment report or is of the opinion that it is more appropriate for the report to be prepared by another person. Where the Clinic so informs the Court, the Court is to appoint a person whose appointment is, as far as possible, agreed to by the child, the parents, and DoCS.

The Children's Court Standard Directions provide for six weeks for the preparation of the Children's Court Clinic Report.

The Children's Court Clinic does not undertake any physical or medical examinations of children. There is a memorandum of understanding between DoCS and the Department of Health in relation to medical assessments. Medical assessments are said to be not uncommon and tend to be of an unobtrusive nature. Cases involving allegations of sexual assault tend to come to court with medical assessments already completed.

Clinicians appointed by the Children's Court Clinic usually do "assessments". The most common assessments are for parental capacity. We have been told that there is no specific clinical test available to measure a person's abilities as a parent.

It should be noted that section 54 restricts assessments to the issue of parental capacity for a person "seeking parental responsibility". The Legal Aid Commission told us that there are often relevant parties requiring assessment where parental responsibility is not sought. The LAC said that section 54 should be broadened to provide for the assessment of other family members or proposed short term carers who do not seek parental responsibility. The LAC gave the example of where a grandmother seeks that a child with a disability be placed with her, but does not seek parental responsibility. The only assessment currently available as to her capacity to provide for the child's needs is the department's in-house placement assessment.

In response to the comments of the LAC, DoCS said that the director of the Children's Court Clinic has said that seeking assessments of a range of people on the "off chance" that some may be considered for caring for the child is a waste of the Clinic's resources and one which the Clinic positively discourages.

We acknowledge that the observation by the Director of Children's Court Clinic makes good business sense. However, we are not sure that this point adequately deals with the point made by the LAC that section 54 does not allow for the assessment by the Clinic of short term carers who do not seek parental responsibility, leaving the assessment of such carers to an "in-house" placement assessment by DoCS.

The LAC argued that an independent assessment of parenting capacity should be available to the court in circumstances where the department does not approve a proposed carer. The LAC also said that there is little ability to test the department's in-house assessment.

In response to these comments by the LAC, the Children's Court said that, if there is disagreement between DoCS and a party about the parenting capacity of a person who might otherwise be seen as an appropriate carer for a child, that party is entitled to cross-

examine departmental caseworkers, the author of the assessment, and any other witness upon whom DoCS seeks to rely.

The Clinic has supplied data to us based on a survey of 249 assessments done by clinicians in the six months ending 30 December 2003. Clinicians are required to submit a Clinical Survey Form with each assessment report. The survey covers client types and characteristics including drug and alcohol, domestic violence, mental illness, disability, and culturally/linguistically diverse background. The survey form also records whether the person to be assessed is indigenous.

Drug and alcohol is the most prevalent characteristic, followed by domestic violence. The data does not indicate the prevalence of people with more than one characteristic.

Separate Clinic analysis of survey results for September 2001-June 2002 shows a disproportionate appearance of mothers in the group representing all clients with a diagnosed mental illness. It is noted that mothers are more likely to be subject of an assessment than fathers, grandparents and other carers.

There are many more assessment orders issued at the St James court than at any other court. Data for the 2004-05 financial year shows that St James issued 115 assessment orders, almost twice as many as Campbelltown (65) and almost three times as many as Toronto (45). Cobham, which has two courts, ranks at number four. However, it should be noted that Cobham deals with a significant amount of criminal matters.

One clinician suggested that St James dominates the rankings simply because it has more courts and magistrates than elsewhere.

During the 2004-2005 financial year, of the 56 courts throughout the State, both specialist and non-specialist, 48 made fewer than 20 assessment orders. 30 courts made more than four assessment orders and the remaining 26 made fewer than four assessments.

The data may appear to show a stark divide between the specialist Sydney courts and country courts. The latter are much less likely to order assessments. However, there is no data to directly compare the number of assessment orders against care applications in particular courts. One available comparison relies on a count of new care applications per court in 2003 and, compared to assessment orders made in 2004-2005. This showed that Dubbo had 25 new care matters in 2003 and one assessment order in 2004-05. Equivalent figures for other towns were Cooma (15/1), Cootamundra (4/1), Macksville (22/1), Batemans Bay (21/1) and Kempsey (15/1).

People familiar with the specialist courts said that DoCS uses the Clinic to inform its casework decisions, including the question of whether there is a realistic possibility of restoration. The Court made the observation that all of those involved in a care case, including the Court, will regard the assessment report as part of the material upon which to base a decision regarding the placement of the child, including whether there is a realistic possibility of restoration.

As noted above, the Court must ensure that a child or young person is not subjected to unnecessary assessment. There is no information available on the extent to which magistrates reject applications for assessment orders on the basis that the child should not

be subjected to unnecessary assessment. Variations in the rate of the making of assessment orders by different courts suggest a need to further explore this issue.

DoCS said that the Clinic might be used more frequently than DoCS considers necessary. In DoCS' view, a partial explanation for this is a frequent rejection by magistrates of the professional opinions of DoCS' staff and a resulting search for a decision by an "expert". However, DoCS said it is unaware of any data to support this view.

In the absence of data, we can draw no firm conclusions about this aspect of the use of assessment orders in care proceedings.

Care orders - section 71

As noted above, the Court can make a care order if it finds that there is a need for care and protection on one of the grounds set out in section 71.

Evidence of prior alternative action – section 63

DoCS is required under section 63 to provide evidence of the alternatives to a care order that were considered before lodging a care application, and the reasons why those alternatives were rejected.

We would expect evidence provided under section 63 to be a source of information about the use of ADR. However, we have been told that DoCS meets its obligations under the section in a "cursory" way, usually within one paragraph of an affidavit. Section 63 reports do not appear to be regularly challenged during court proceedings.

DoCS has said that the level of information required is set at the standard required by the Court and that, if the Court were to reject applications because DoCS supplied inadequate information, then DoCS would supply more information. DoCS also noted that the scheme established under the legislation has also been in operation for five years. In addition, the claim that DoCS provided only "cursory" information ignored the fact that the amount of information supplied might be the amount required to serve the interests of the child, rather than some abstract legal purpose.

This raises questions about whether current practice in relation to section 63 accords with the intentions of the legislation, and whether this issue should be considered during the current review of the Act.

Preliminary conferences – section 65

As noted above, a preliminary conference must be held after DoCS has notified the parents of a child or young person of a care application, and served them with copies of the application. The conference is arranged and conducted by a Children's Registrar of the Children's Court.

Section 65 lists the purposes of a preliminary conference:

- identifying areas of agreement and issues in dispute between parties
- determining the best way of resolving any issues in dispute, including by referring the application to independent dispute resolution
- setting a timetable for the hearing of the application by the Court
- formulating any interim orders that may be made by consent.

We note that the use of preliminary conferences has already been extensively canvassed in our previous discussion of alternative dispute resolution. The following discussion contains some additional points about the use of preliminary conferences.

Some of the people we interviewed described preliminary conferences as a way to clarify issues. They claimed that parents frequently leave such conferences saying they now understand the goals of DoCS. Some people reported that section 65 conferences were used to seek clarifications and amendments of draft care plans, draft orders, and associated undertakings and contact arrangements.

Some of our respondents said that the focus by DoCS was on obtaining a finding that a child is in need of care, and that care plans that might be a basis for discussion at a preliminary conference tended to be unformed.

In response to such claims, DoCS noted that the preliminary conference would frequently be held before the receipt of any report by the Children's Court Clinic, which only had to be filed before any final orders were made. Against this background, DoCS commented that to suggest that the care plan should be anything other than "unformed" at the time of the preliminary conference did not adequately recognise the timing of when the production of a care plan was required. DoCS also emphasised that the fact that care proceedings were a dynamic process underlined the difficulty of preparing a care plan too early in the proceedings.

The Senior Children's Magistrate also said that it was not his impression that DoCS focused on obtaining a finding that a child was in need of care to any improper or excessive degree.

Some respondents claimed that many preliminary conferences in country courts proceed without the involvement of any of the five current Children's Registrars. However, Senior Children's Magistrate Mitchell has said that he was not aware of this occurring, and that he had been informed by a very experienced Children's Registrar that he had never heard of any preliminary conference (whether in the country or otherwise) proceeding without the involvement of a Children's Registrar.

Interim orders - sections 62, 70 and 70A

Under section 62, the Court may make a care order as an interim order or as a final order. In making an interim order, section 70A requires the Court to be satisfied that the order is necessary, in the interests of the child, and is preferable to the making of a final order or an order dismissing the proceedings.

Section 70 provides the Court with the power to make “such other care orders” as it considers appropriate for the safety, welfare and well-being of a child, pending the conclusion of the proceedings.

There is no reliable data on the use of interim orders but most appear to involve allocating parental responsibility to the Minister.

Few contested hearings on interim orders are reported at St James. Given that most cases are not contested at the interim phase, parents may believe, or may be advised, that they should focus on the final result and thus not contest interim issues.

Disputes about interim contact arrangements tend to be addressed in section 65 preliminary conferences chaired by a Children’s Registrar. As with many other areas of our research, there is little information available about the frequency of interim orders prohibiting contact. The Court at Campbelltown reports few interim contact orders being made, and more occur at St James.

Once a court awards interim parental responsibility to the Minister, DoCS has the authority to determine contact arrangements. The exception is when the Court makes a contact order under section 86. If the order requires contact to be supervised by DoCS, the department can exercise its discretion on the number of supervised contacts it will provide. There is a dearth of information about the frequency of use of minimum requirements for contact visits on an interim basis. The range and variety of cases appear to lead to a similarly broad range of contact arrangements, including those that are supervised.

One other issue that arose in the context of applications for interim orders was that of the use or otherwise of affidavit evidence.

DoCS said that it was the practice at St James to hear evidence without an affidavit in support of an application for interim orders, rather than merely relying upon the affidavits filed. DoCS suggested that this practice explained why there were more applications for interim orders at St James. DoCS also said that there are cases in the Family Court which do not support the practice at St James, such as In the Marriage of C (1995) 20 Family Law Reports 24. However, in our view, the case cited by DoCS merely supports the proposition that, in the circumstances of the case, it was properly within the discretion of the Family court to refuse to allow cross-examination by one of the parties. It does not suggest that a court is prohibited from allowing cross-examination – indeed, it recognises the discretion to do so.

In response to the observations made by DoCS, Senior Children’s Magistrate Mitchell made the following comments:

If the DoCS allegation is that, at St James, the Court insists on hearing and determining interim applications without an affidavit, that is untrue. If the complaint is that, in addition to affidavits, St James and other registries of the Children’s Court allow oral evidence and even some cross-examination, that is true. Where time permits, even in an interim application where placement and/or contact is involved, an effort is made to allow a parent and a child representative to express his/her case and to test the departmental evidence which quite often proves unreliable. This practice is consistent with natural justice and is the best available method for the Court to discover the truth as to the best interests of the child.

It is submitted that DoCS' reference to the Family Court discouraging evidence in the context of interim applications is unhelpful. Notwithstanding the practice of allowing DoCS' evidence to be challenged and tested, unacceptable delay, in contrast with the situation in the Family Court, has been eradicated from the care jurisdiction of the Children's Court.

It should be noted that these issues are also relevant to the question of whether proceedings are conducted in a "non-adversarial" manner – a question discussed in more detail later in this paper.

Orders accepting undertakings – section 73

If the Children's Court is satisfied that a child is in need of care and protection, the Court may make an order accepting undertakings given by a parent with respect to the care and protection of the child. The Court may also make an order accepting undertakings given by the child, with respect to the conduct of the child, or an order accepting undertakings from both parent and child.

DoCS or a party to the proceedings may notify the Court of an alleged breach of an undertaking.

The Court must respond to a notification of an alleged breach of an undertaking by:

- giving the parties an opportunity to be heard on the allegation
- determining whether the undertaking has been breached
- making such orders as it considers appropriate if it finds that an undertaking has been breached

Orders accepting undertakings are often linked to restoration plans. Undertakings can also be used when children are removed from home on a long-term basis. A parent might promise, for example, not to use drugs during contact visits.

Significantly, the Court cannot require a parent to give an undertaking, and neither the Court nor DoCS can require a parent to, for example, undertake drug testing and disclose the results. This can only occur on a voluntary basis.

Some of the people we talked to raised concerns about the realism of proposed undertakings in certain circumstances and, commonly, a perceived failure by DoCS caseworkers to consider their appropriateness in the context of the care history. For example, restoration planning may involve requirements for urine analysis of parents with long records of drug abuse. It is claimed that DoCS does not always test the undertakings by checking the parents' drug use in the period between the care application and final orders. Similarly, we have heard claims of children being placed with drug-abusing relatives pending final orders, with the department allegedly ignoring evidence of the drug use.

It could be that caseworkers are motivated to take undertakings at face value so that interim arrangements or proposed care plans are kept intact. And it is acknowledged that caseworkers may be under pressure to find scarce interim or longer-term placements for children. But final orders may establish a link between undertakings, a child's placement and care arrangements, and proposed restoration. If there is no realistic prospect that the undertakings can be met, this may undermine prospects for restoration and the legislative goal of a stable placement.

The Legal Aid Commission told us that it sees another problem with section 73. The section states that undertakings may only be provided by a parent or child. Under section 3 of the Act, a parent means a person having parental responsibility for a child or young person. LAC says a natural parent in the Court's care jurisdiction often has no parental responsibility and certainly not during a period of proposed restoration. LAC says the problem is that undertakings cannot be sought from either a parent without parental responsibility, or a person seeking contact such as step-parents, grandparents, and other people of importance to the child. LAC says that it may be entirely appropriate to seek undertakings from such people regarding matters such as behaviour and abstinence from use of drugs or alcohol during contact periods. Without these protections, LAC says, total prohibition of contact is often the result.

The issue of the Court's power to make an order accepting undertakings has been dealt with by the Children's Court in the matter of *Cristian, Tamsin, Jennifer and Karen (No 2)*. This issue arose during proceedings brought in August 2005 by the Director-General of DoCS, alleging a breach of undertakings by the mother. The order accepting the undertakings was made in June 2005, together with orders placing the children under the parental responsibility of the Minister for a period of three years (previously, parental responsibility for the children had been granted to the Minister under interim orders made in September 2004 and in May 2005). The respondent (the natural father) argued that the Court had acted beyond power in making an order accepting undertakings from the mother, because at that time the mother did not have parental responsibility for the children and therefore did not fall within the definition of "parent" under the Act. The Director-General's legal representative argued that section 73 should be read as meaning that the Court was empowered to accept undertakings from natural or adoptive parents even when they do not have parental responsibility. In its judgement in February 2006, the Court found in favour of the respondent, ruling that the meaning of "parent" in section 73 is to be defined in accordance with the definition of the term "parent" in section 3 of the Act.

LAC said that, in order to manage the problem, token parental responsibility is often given to those from whom undertakings are sought. For example, a mother seeking frequent contact retains parental responsibility for religion so appropriate undertakings can be provided. However, the LAC said that this gives rise to unnecessary litigation about allocation of parental responsibility or contact with a child where it cannot otherwise be offered without appropriate undertaking protections.

We have been told that applications to the Court involving alleged breaches of undertakings are not brought often but are not unheard of. The use of realistic undertakings would appear to be one method whereby parents can work towards the restoration of children. For this reason, the appropriateness of the current language in section 73 could be considered in the review of the Act.

Support services - section 74

Section 74 allows the Court to order the provision of support to a child for a maximum period of 12 months. However, section 74 also states that the court cannot make an order unless the individual or organisation consents to it.

DoCS has said that an appeal court judgement has found that the Director-General of DoCS cannot be compelled to provide support services.

The Senior Children's Magistrate is one of a number of people who have told us that the Court's power under section 74 is rarely used. He suggested this was because DoCS cannot be compelled to co-operate in providing services.

DoCS has told us that it cannot comment on this claim because no data is held on the use of section 74 orders. However, DoCS does note that it has increased its spending in supporting placements and arranging for the delivery of services. However, DoCS cannot distinguish from its records between support services arranged as a result of departmental decisions, and those provided as a result of a court order.

Once again, lack of data limits consideration of this issue.

Attendance at a therapeutic or treatment program - section 75

The Court has the power to order treatment for a child who has behaved in a sexually abusive way. This power cannot be used if a child is 14 or older, or if the alleged sexual abuse has led to criminal proceedings.

We have been told that this power is rarely used.

We have also been told of cases where treatment was deemed appropriate but could not be required because the child was 15. The reason for the age limit is not explicit in the legislation but may be tied to the age at which children have the legal capacity to make decisions for themselves and the age at which children are presumed to be capable of crime (*doli capax*).

DoCS agrees that there is rare use of section 75 treatment orders. The department says this is because most treatment programs proceed upon the basis of an admission of guilt by the child. DoCS says the child will rarely make an admission of guilt in the context of care proceedings because such an admission could potentially be used against them in forthcoming criminal proceedings.

The department says a legislative amendment to section 75 is being considered. DoCS has not told us the nature of the amendment under consideration, so we are not in a position to comment further.

Supervision - sections 76 and 77

Under section 76, the Court may make an order placing a child under the supervision of DoCS, if the Court is satisfied that the child is in need of care and protection. The maximum period of a supervision order is 12 months.

Section 77 authorises DoCS to inspect the premises where the child lives for the period of supervision and to meet and talk with the child. The child is required to accept the supervision and to obey “all reasonable directions” of DoCS staff. The Court may make such orders as it considers appropriate if it determines that a supervision order has been breached.

The Court can require reports about the progress of the supervision and whether its purposes have been achieved. There is an option to renew the supervision for up to 12 months and to require reports on the supervision.

Final supervision orders are said to be common in cases where children are allowed to remain at home or where a restoration plan has been approved.

There is no data available on the use or effectiveness of supervision orders, including whether children and young people the subject of supervision orders are allocated a DoCS caseworker during the period of supervision.

Care plans - section 78

If DoCS applies for a care and protection order for the removal of a child from their family, the department must present a care plan to the Court before final orders are made.

The care plan must provide for:

- allocation of parental responsibility for the child
- the kind of placement proposed for the child
- arrangements for contact between the child and their parents and other people
- the agency designated to supervise the placement in out-of-home care
- the services that need to be provided to the child.

The care plan is to be made “as far as possible” with the agreement of the parents and child.

The care plan is only enforceable to the extent that its provisions are embodied in or approved by orders of the Court.

Some of the people we interviewed described care plans as cursory. Some said DoCS staff do not draft care plans until after the need for a child’s care and protection had been established in court. It was argued that this tended to delay the use of section 65 conferences.

Various respondents criticised care plans for failing to address the requirements set out in section 78. Care plans might fail to address sibling contact or a child's special needs. In the latter case, examples were cited of plans that referred to special needs but made no reference to how these would be met. In other cases, care plans for indigenous children were said to omit details about kinship contact arrangements.

Participants in conferences said they would propose changes to care plans. DoCS was seen to be amenable to such proposals. The Court was said to rely on lawyers representing children – the separate representatives – to consider whether care plans were in the best interests of their clients. Some people we talked to said that Children's Magistrates and Local Court Magistrates would themselves subject care plans to varying degrees of scrutiny.

DoCS says that, if a care plan does not comply with the requirements of section 78, then the Court should not be proceeding to make final orders. In DoCS' view, since there are very few adjournments to ensure that care plans do comply with the legislation, the only available evidence is that the Court is satisfied that DoCS is complying with the requirements.

DoCS has further observed that care plans are designed to address both casework decisions and to explain the proposed course of action to the Court, and that these objectives can be inconsistent. DoCS has not elaborated on this point in its submissions to this paper, nor has it indicated its view of the consequences of such inconsistency.

It is our view that the care plans that DoCS presents to the Court must be consistent with the paramount consideration of a child's safety, welfare and wellbeing. Section 78 does not require that care plans include a provision about the way that DoCS explains the plan to the Court.

DoCS has told us that improvements in the way information is given to the Court is the subject of ongoing discussions between the Court, the Legal Aid Commission and DoCS.

Restoration planning and permanency planning – sections 78A, 83 and 84

The legislation provides for the fact that some children may be able to return to their families. The department is thus required to decide whether there is a realistic possibility of restoration, based in part on consideration of the child's circumstances. Also required is consideration of any evidence that the parents are likely to be able to satisfactorily address the issues that led to the removal of their child. A plan will have to include the important notion of permanency planning outlined in section 78A. The goal is to ensure that children get secure, stable and enduring placements for as long as needed, whether or not there are plans to try to restore them to their families. Permanency planning seeks to avoid disrupting children's lives by shifting them from place to place and from one carer to another.

People familiar with the Children's Court at Campbelltown suggest that as many as half of all care applications result in short term orders and a restoration plan. Our sources also estimate that, at St James, the court approves 90 per cent of DoCS applications which involve proposed consent orders linked to restoration. Whether orders with restoration plans are more common than those without is unknown. Nobody knows how many restoration plans are successful and how many fail. There is no data to answer the question.

There has been criticism of permanency planning for indigenous children. However, there is no evidence indicating any pattern in the quality and consistency of application of the relevant principles.

The Legal Aid Commission has said that, in its experience, the majority of care plans are developed without any knowledge of where the child will be placed in the long term. The LAC has said that DoCS' permanency plan is to approach one or more agencies for the purpose of making a referral for long term placement. However, the LAC has said that the agencies contracted to the department to provide out of home care will not accept a referral for long term care of a child until the Court makes a final order.

As to permanency planning, DoCS has made the following comments:

It is accepted that planning may often be undertaken without the knowledge of the desired ultimate permanent carer. This is not just a practice of agencies, as implied by the comments of the LAC, but a recognition that most carers will have decided whether they are prepared to care for children on a short term or long-term basis. If the carer has intellectually and emotionally prepared to care for a child on a long term basis, the emotional anguish that can be involved in starting to care for a child for whom no long term final orders are in fact made can be very traumatic. It is for this reason that section 83(7)(a) places an obligation on the Court to expressly make findings "that permanency planning for the child or young person has been appropriately and adequately addressed", and so concentrates on the planning rather than the actual arrangements.

It is the submission of DoCS that the present role of the Court is to look at what is planned, and not to consider whether individual care arrangements will adequately meet what is planned. To hold otherwise would be to require the Court to assess individual carers and to directly require all carers and their suitability to be interrogated by the Court.

While noting DoCS' submissions, we believe that it is difficult to make a clear distinction between the question of whether permanency planning has been "appropriately and adequately addressed", and the question of whether individual care arrangements will adequately meet what is planned.

This is another area where no agency is collecting or keeping data that might serve as a basis for analysis of the extent to which Parliament's intentions are being given effect in relation to the important principle of permanency planning and the goal of planned restoration of children to their families. However, it is not only data that is needed – this is an area that needs further research to paint an accurate picture of the practical issues that arise, including their implications for carers and children in need of care.

Adoption

The Children's Court has no power to approve adoptions – that is the province of the Supreme Court.

The department's last annual report noted that a total of 11 children under the parental responsibility of the Minister were adopted during 2003-04.

The people we interviewed said they never saw adoption proposals in care plans.

In June 2005, DoCS' Director of Legal Services advised the department's legal representatives that adoption should be considered as one possibility in care applications involving permanent placement. The advice noted that a number of legal representatives had been incorrectly providing advice that the possible adoption of a child should not be mentioned in care applications or care plans lodged in the Children's Court, and that a proposed application for adoption could legitimately be included in the permanency plan provisions of a care plan filed with the Court.

DoCS has told us that it agrees that adoption might be used less frequently than it could be.

Parental responsibility orders - section 79

Section 79 provides for different ways of allocating parental responsibility for a child. The Court may make an order allocating parental responsibility to one parent to the exclusion of the other parent, to one or both parents and the Minister or another person jointly, another suitable person or to the Minister alone. Specific aspects of parental responsibility may also be allocated.

None of the people we interviewed offered a view on estimated numbers and types of parental responsibility arrangements sought or obtained, or the frequency of various types of parental responsibility orders.

The Australian Institute of Health and Welfare Child Welfare Series contains national data on care and protection orders. The most recent data available for NSW is for the 2004-2005 financial year, when 2,537 children and young people were subject to care orders. Of these, 1,718 children and young people were subject to orders for the first time. The largest group by age of children subject to care orders was children aged 10-14, comprising 665 children.

Unlike a number of the other states, NSW did not supply any data on supervisory orders to the AIHW survey.

The AIHW data does not shed any light on the nature and frequency of use of the various options outlined in section 79. However, nearly 90 per cent of all children in care in 2002-03 were subject to final orders reallocating parental responsibility for them. This means that for nine out of 10 children, the Court was satisfied that no other order would be sufficient to meet their needs.

Monitoring of orders concerning parental responsibility – section 82

Section 82 allows the Court the option of requiring written reports about the suitability of care arrangements relating to orders reallocating parental responsibility. DoCS produces the reports for the consideration of the Court. If the Court is not satisfied that proper arrangements have been made for the child, the case can be recalled for a review of "existing orders".

Section 82(1) empowers the Court to require the written report within six months or such other period as it may specify.

Some people we have talked to said that the magistrates do not all agree on the meaning of section 82. Children's Magistrate John Crawford published a paper on the subject in October 2004, in which he observed that section 82:

... does not enlarge upon the nature and scope of such 'review' and this has given rise to some uncertainty of its meaning. Any uncertainty may have contributed to what have been few review hearings.

Our sources say there are two current interpretations of section 82. One is that a review allows for existing orders to be changed. The other is that the Court can express its concerns, but that new orders will require an application by a party to the proceedings.

In the view of DoCS, there are questions about whether the Court is using its power to review appropriately, and whether that power is appropriate in principle.

DoCS has told us that not all magistrates will arrange for matters to be re-listed upon receiving a report. The department observes that if a matter is not re-listed, it is difficult to see the use of the report. (DoCS notes that as well as section 82 reports, the Court can require reports under section 76(4) on the effects of supervision.)

DoCS says that sometimes a series of reviews is ordered over a period of years. The department has said that that this has the consequence of rendering ineffective the notion of the finality of an order and the permanency of a placement. DoCS also argues that this means that emphasis during any subsequent work is placed on a need to respond to a Court timeline, with a potential incapacity to address the needs of a child as they arise.

DoCS also questioned the extent of the Court's ability to judge the changing needs of a child by relying solely on a section 82 report. The department said the Court was not prepared to rely upon a single report from DoCS at the time of making initial or final orders, but was prepared to make new orders based upon a single report. In DoCS' view, this appeared to be an inconsistent approach.

DoCS said there is no data on the use of section 82 reports, but that, anecdotally, it is understood that they are used frequently.

Magistrate Crawford has said that "most section 82 reports point to a favourable outcome for the child". Evidence to corroborate this assertion is not available.

Some lawyers we talked to said some magistrates are assiduous in following up on section 82 reports. However, one source says there is no judicial function available to monitor compliance with section 82 orders.

For its part, the Legal Aid Commission said there is a problem in the lack of consistent court practice of notifying parties that section 82 reports have been provided to the Court. The LAC said there is no provision in the Act as to who should be served. It says some DoCS offices send the report to the Court, and others serve the parties. Each court also has its own procedure for dealing with the reports. There is no obligation to provide copies to the former parties.

LAC also argued that a section 82 report has no proper status and it is unclear whether the report is confidential. LAC says that inconsistent orders and practice are prevalent as there is no guidance in the Act or in the practice directions about how to treat them.

LAC said that it has become good practice for the former child lawyer to follow up on section 82 reports. However, this was a decision for individual lawyers and there was no standard practice in this regard. If a lawyer changed employment or retired, there would be no follow up at all.

As to lawyers following up section 82 reports, DoCS observed:

This appears to be happening without any participation of, or involvement with, any other party to the proceedings, including the child. Irrespective of the child's wishes for the matter to be brought before the Court, the former child's lawyer is having matters relisted. Whatever the merits of enforcing court orders and reviewing care matters, this practice of lawyers acting without instructions needs further consideration.

LAC told us that, in its experience, section 82 reports are often incomplete or even inaccurate. Furthermore, the LAC said that, while the system requires that orders are made for the long term placement of children in out of home care, no actual placement is identified or even guaranteed. The Court and legal representatives must rely on section 82 reports to provide information as to the placement and stability of the child.

LAC said that, at St James, DoCS is arguing in each case where section 82 reports are sought that only one report can be sought under the Act. One case where this argument was not successful is being taken on appeal to the District Court.

Court officials say a section 82 register may be set up in future. This is clearly desirable.

It is clear that this is an area that warrants legislative review to deal with the procedural problems outlined by DoCS and LAC, and to clarify the scope of the Court's powers.

We believe that provisions such as sections 82 and 76 (the latter relating to reports on supervision orders) that enable the court to require reports, provide important safeguards for children who have been removed from the care of their parents or have been placed under the supervision of DoCS. Accordingly, we believe that the Court's power to require reports at whatever periods the court considers appropriate should not be restricted or narrowed. We consider that any issues of procedural fairness could be addressed through legislative amendment or court rules.

The question of whether, and in what circumstances there should be a review of existing orders, and when and how such orders are followed up, raises important issues. Law and policy should reflect the resolution of these questions. One of the more difficult questions is what sort of cases should be followed up in the best interests of the child. This should certainly not be determined upon the basis of individual practice, but grounded in a solid policy position.

Contact orders – section 86

Under section 86, the Court has the power to allow or deny contact between the child and their parents. The Court can stipulate minimum arrangements for contact. It may also require that contact be supervised, subject to the consent of the parent and the proposed supervisor.

There are numerous possibilities relating to the duration and frequency of contact, including increasing contact over time. There is no information about the use of different types of contact orders.

Some of the people we talked to criticised the quality of contact regimes proposed by DoCS as being often short on detail. DoCS has commented that it accepts that the Court appears to make contact orders on the basis of little information. The department says this is particularly so in relation to the impact of these orders on the child and the child's placement. However, DoCS argues that since contact orders are made by the Court, and the Court is not restricted by DoCS' application, then whatever material might initially be supplied by DoCS does not restrict deliberations of the Court in reaching its decision as to the orders to be made.

Some welfare agencies oppose anything other than minimum contact, such as four short meetings per year, for children in long-term foster placements.

The Legal Aid Commission says that some non-government organisations have stated on the record that they will not accept referrals for children where the Court has ordered an amount of contact which they considered inappropriate. In the LAC's view, in some circumstances this may be because the non-government organisation considers that the contact arrangements could adversely impact on potential foster carers and therefore on a placement.

Where the Court orders DoCS to supervise contact arrangements, it appears that, in practice, DoCS can ultimately determine the amount and frequency of contact, because the Court can only order that contact be supervised by DoCS with the consent of DoCS.

DoCS made the following general observations on the question of contact orders:

It should be noted that only the ACT and Northern Territory have similar levels of court involvement in contact to those in NSW. In South Australia and Victoria the court's involvement in contact is limited to interim or short term orders. This is also the practice in Tasmania. In Queensland and Western Australia the court has no involvement in contact. From DoCS' recent enquiries with other jurisdictions, there are no proposals to expand the role in contact for their respective courts.

It should also be noted that in 2002 the Family Law Council (chaired by Patrick Parkinson, the architect of the NSW legislation) recommended that all jurisdictions should extend the role of care courts to encompass contact. Despite reviews of the legislation in Victoria, Queensland, South Australia and Western Australia since that time, no government has adopted this recommendation.

It is DoCS' view that, once a decision has been reached that a child is to be removed from the parents for an extended period (i.e. restoration is not considered viable),

then contact is a social work decision that should only consider the best interests of the child, including the stability of the placement. If any “rights” of the parents are extinguished by this point in time, then the court has no particular expertise to offer in this context.

In any event, a specific order for contact for a young child is unlikely to be consistent with the best interests of that child for the next decade or more and repeated recourse to the legal process to adjust the order makes no sense.

The situation where restoration is potentially viable and an interim order is appropriate will be different. If the parties can agree on the contact regime that will maximise the chances of a successful restoration, then the court should not have a role. However, if the contact regime cannot be agreed, then the court can provide an avenue to resolve the matter. Any court-ordered contact should have a limited duration that reflects the fact that the child’s circumstances will change and that such changes should be dealt with as part of normal case management.

Senior Children’s Magistrate Scott Mitchell has referred to the struggle over contact decisions among the Court, welfare agencies and DoCS. In a speech to a Legal Aid Commission conference last year, he referred to “powerful and influential forces at work, which oppose the concept of contact or, at least, oppose the court’s involvement in it”.

We recognise that the current arrangements present a challenge to all parties to work in the best interests of children and come up with flexible solutions regarding the important issue of children’s contact with family and other significant people in their lives.

We also acknowledge that there are divergent views about the circumstances in which contact is in the child’s best interests and about the extent of contact that is appropriate. We would make several points in relation to this debate.

It is clear that adequate information and further research is needed to inform the debate. In this respect, we note that DoCS has supported the need for further research. It is our view that lack of research in this area makes it difficult to assess the precise nature of and reasons for the perceived flaws in the current system. This in turn makes it difficult to determine whether an overhaul of the current arrangements is required (and, if so, what the changes should be) or whether adjustments to the approaches employed under the current system might be a better way forward.

In these circumstances, we believe that there should be an opportunity for informed public debate between all of the key players on the issues involved, with a view to deciding on a pathway for effectively promoting the maintenance of ties between children and their family – but only where this is clearly consistent with the best interests of the child.

“Non-adversarial” conduct of proceedings – section 93

Section 93 says that proceedings are not to be conducted in an adversarial manner. The section also says that proceedings are to be conducted “with as little formality and legal technicality and form as the circumstances of the case permit”.

Some of the people we talked to were concerned that, despite the aims of the care and protection legislation, Children's Court proceedings seem to be handled on an adversarial basis.

Senior Children's Magistrate Mitchell told us the requirement that hearings should proceed with as little formality and technicality as possible does not permit the Court to dispense with natural justice and standards of procedural fairness. Magistrate Mitchell said that oral cross-examination of witnesses and the receiving of submissions by parties are two ways of giving effect to procedural fairness principles.

Senior Children's Magistrate Mitchell also told us that care proceedings in the Children's Court could be summarised as a hybrid between an adversarial model and a modified inquisitorial model. He said that where there are disputed matters of fact the Court more closely follows a traditional adversarial model of cross-examination. Where there are not factual issues in dispute, the procedure more closely follows an inquisitorial model. It should also be noted that the Court must determine the matter on the evidence the parties choose to place before the Court.

DoCS has told us that it is aware that the Children's Court is considered to be unnecessarily adversarial.

In this respect, DoCS has referred to research in Victoria by Ms Thea Brown and others on the Magellan Project Pilot in Victoria which, the department said, showed that caseworkers considered that they were treated with more respect in the Family Court than in that state's Children's Court. DoCS told us that responses by caseworkers involved in the Magellan Project in the Sydney Registry of the Family Court suggested that this experience is being replicated in NSW.

Senior Children's Magistrate Mitchell said that he had not seen the research to which DoCS referred. However, he said that the question was not whether DoCS officers are respected, but whether their casework and the cases that they present to the Court are adequate. In this respect, he observed that sometimes DoCS work was adequate and sometimes not.

DoCS cited its legal costs and some data relating to appeals to point to differences between the operations of certain Children's Courts in NSW.

DoCS said that to undertake care litigation at St James, it fully engages three legal officers and, between 1 July 2005 and 31 January 2006 paid \$283,520 to external panel legal practitioners. By contrast, for a roughly equivalent number of care matters at Campbelltown, only one legal officer was engaged, and \$12,519 was paid for external panel legal practitioners. DoCS said there is no significant demographic difference between the areas that would explain the difference in outcomes at St James and Campbelltown.

As to DoCS employment of more lawyers at St James than at Campbelltown, and the more detailed treatment of cases at St James, Senior Children's Magistrate Mitchell suggested that this reflected cultural differences between central Sydney and the south western suburbs, particularly among the legal profession, and that a similar effect could be detected in comparing the Family Courts at Sydney and Parramatta.

DoCS told us that it believes that the number of interim hearings and the amount of judicial time per care matter at St James far exceeds any other Children's Court in NSW.

DoCS also told us that little evidence is admitted at St James without contest in that court – even when no other party has led contrary evidence. As to this, the Children’s Court said that this was “simply untrue”, and went on to say:

... if parties, advised and represented by competent lawyers, wish to “contest” evidence led by DoCS, they are entitled to do so. Experience has shown that, not infrequently, DoCS evidence is unreliable and needs to be tested in order to ascertain what are the best interests of the child.

The Court also observed that, notwithstanding the practice of submitting evidence to scrutiny, undue delay in the disposition of care cases was not a feature at St James.

DoCS said it is collecting and analysing data on the number of hearings that last three days or more. It says the initial data seems to indicate that 27% of hearings at St James went for three days or more, whereas only 6% of matters at Campbelltown lasted this long.

In relation to appeals, DoCS said that there were 108 appeals of care matters to the District Court between June 2002 and January 2006, with DoCS being the appellant in only 9% of these cases. Further, while St James heard 23% of all care matters, 42% of all appeals concerned matters before that Court. DoCS said that no other single court accounted for more than 9% of the appeals.

Another view of proceedings at St James came from the Legal Aid Commission. It has been reviewing the operations of its care and protection program since October 2005.

LAC told us that, historically, private practitioners at St James would apply for grants of legal aid to represent children and young people. Applications for grants to represent parents were extremely rare. LAC said that, when it sought to be included on the roster to represent children, this move was met with hostile resistance by private practitioners. However, LAC said that there is now a workable and collegiate relationship between its in-house lawyers and private practitioners whom LAC has appointed to a care and protection panel. There is a roster alternating duty days for parents and duty days for children.

LAC told us that there is a view that the standard of legal representation at St James has been raised significantly since arrangements were put in place for both Commission and private practitioners to represent parents as well as children.

LAC said its people came to St James with the organisational experience of acting as separate representatives for children in the Family Court, bringing a culture of proactive child representation to care proceedings that required casework involving investigation and presentation of material that was in the best interests of the child. Before this, LAC said, the approach of many practitioners in care proceedings was based on the assumption that DoCS would act in the best interests of the child and file material relevant to that issue. Practitioners would rarely issue subpoenas or file affidavits. Instead, they would simply read the material produced by DoCS and provide oral submissions.

LAC said that the culture of challenging DoCS through proactive representation of children in care proceedings set the benchmark for quality legal representation. And it said that practitioners are also now taking a more proactive approach to the representation of parents.

Some respondents suggested another possible reason why proceedings might be conducted in an adversarial matter was the number of parties involved in the case. Cases at St James are said to feature numerous parties – the child, the mother and the father, various grandparents and other relatives – all of whom are represented. Cobham is known colloquially as “grandma’s court” for its apparently high number of grandmothers joined as parties. By way of contrast, there are said to be fewer cases at Campbelltown involving multiple parties.

There may also be variations in the degree to which matters are contested in particular courts. In this respect, some Sydney-based private practitioners told us they had opposed DoCS’ proposals for restoration plans or argued for long-term care orders where the Department sought short-term orders. They suggested that the relative scarcity of specialist care and protection lawyers in country areas could mean that practitioners involved in care proceedings in these areas are less likely to oppose the position adopted by DoCS.

As to the comments of the Legal Aid Commission, DoCS made the following observations:

While not questioning the standard of representation by lawyers in St James, and even accepting the proposition of LAC that this standard has significantly improved in the last few years (while noting that no evidence is supplied in support of this proposition), this does not address the question raised by the evidence supplied by DoCS of a difference in practices between St James and other Children’s Courts.

There are LAC in-house legal practitioners undertaking care matters not only in St James but also at Campbelltown, Cobham, Newcastle, Lismore and Dubbo. It would seem that the LAC submission suggests that its in-house legal practitioners at these other locations do not provide the same level of legal representation, nor the same proactive response, as do practitioners at St James. Comments of departmental legal officers would dispute this suggestion. Departmental legal officers state that (while recognising individual differences) there is the same high level of legal representation by all LAC in-house legal practitioners in care across the State. If the standard of representation is the same, this does not appear to justify data relating to St James being significantly different to other courts.

The discussion above has canvassed the perspectives of the Children’s Court, DoCS, Legal Aid and legal practitioners about whether proceedings before the Court are unnecessarily adversarial in light of the broad stipulation in section 93 that such proceedings “are not to be conducted in an adversarial manner”. That discussion leads us to the following observations about this issue.

One question that arises is what Parliament intended in introducing a requirement that proceedings before the Children’s Court must not be conducted in an “adversarial” manner. In this respect, it could also be observed that there are probably difficulties necessarily inherent in such a broad legislative requirement.

Be that as it may, it seems to us that the fundamental issue in this area is determining the best way to conduct child care proceedings in a way that is both fair to all parties and promotes the best interests of children.

We acknowledge the perspectives of legal practitioners in this area. However, the experience of lawyers has usually been to vigorously represent the interests of their clients in civil or criminal proceedings. Accordingly, they will almost inevitably approach their role in child care proceedings from a similar perspective. It must be said that such an approach does not necessarily assist in facilitating the conduct of care proceedings in a way that promotes the best interests of children.

That said, lawyers do bring other valuable experience to the conduct of court proceedings. For example, they will be attuned to the need to properly test evidence that is presented in the proceedings, so that the court will be in a position to reach informed findings where factual matters are in dispute. And lawyers will also be focussed on attempting to ensure fairness to their client in course of the proceedings.

We also appreciate the perspectives that DoCS and the Children's Court have brought to the consideration of whether proceedings are conducted in an unnecessarily adversarial manner.

What can be said is that the various key players in the conduct of care proceedings are understandably interpreting whether or not proceedings are conducted in an "adversarial" manner from their own background and experience.

In those circumstances, we believe that the appropriate approach to resolve the issues involved would be further discussion, focussed on achieving a much more consensus-based understanding about the expectations surrounding the conduct of child care proceedings before the Children's Court. Any appropriate legislative amendments, practice notes or code of practice to provide guidance to magistrates and legal practitioners in this area should only be developed following the outcome of such a discussion.

Affidavit evidence

We have heard concerns expressed about the quality of evidence that DoCS presents to the Court in its affidavits. Some matters are said to contain voluminous information, but little or no analysis that could assist the court. A common view among the people we interviewed was that the affidavit evidence may be of poor quality despite the fact that many cases arrive in court with lengthy histories of child protection concerns.

As to the issue of affidavit evidence, DoCS made the following general comments:

The NSW Children's Court is the only care court in Australia that only permits evidence by means of affidavit. The Family Court in the Magellan Project, its Children's Cases Program and in the recent (2006) amendments to the Family Law Act permit casework information to be supplied by way of report rather than affidavit. The weight of evidence from each of these other jurisdictions is that requiring all evidence from the child welfare agency to only be supplied by way of affidavit might be what is creating the difficulties – rather than the difficulty being the capacity of caseworkers to produce a quality affidavit.

While not disagreeing with the need to get the best available evidence before the Court, a comment made in relation to the English care jurisdiction might be apposite. In this recent study one of the conclusions was that "the pursuit of an unattainable

level of certainty is a major factor in court delay and therefore a cause of avoidable harm to children.” The question should be asked as to whether it is unrealistic and misguided to have an expectation that affidavits in care proceedings, which are often filed within the same week as the removal of the child, will be of the same quality as documents filed in criminal or commercial proceedings where the documents are filed after very intensive and extensive investigation and relate to simpler factual situations than the complexity of the past and future lives of an individual child.

Given that the court has not been prepared to change its position, DoCS has been forced to employ additional legal officers to assist caseworkers to prepare affidavits. Of the 26 additional legal positions from the funding reform package, it is estimated that 18 EFT are fully engaged in this task. Whilst this has undoubtedly improved the legal quality of affidavits in those locations where the new positions are deployed, DoCS' view is that it will have done little to improve the outcomes for children.

Legal representation – sections 98 and 99

Section 98 deals with the rights of appearance of various parties. Section 98(2) says that the Children's Court may require a party to be legally represented if it is of the opinion that the party is not capable of adequately representing himself or herself.

Section 99 says that the Children's Court may appoint a legal representative for a child if it appears that the child needs to be represented in the proceedings.

The Legal Aid Commission has told us that its statistics, although not completely reliable, indicate significant growth in its care and protection practice since the commencement of the current legislation in December 2000. The LAC said legal representation in care proceedings is invariably funded by the Commission. There is no means test applicable to children or young people. While there is a means test for parents, the LAC told us the demographic of this group is such that it would be a rare case where a parent applicant would be refused legal aid on the basis of means.

Legal services are provided sometimes by in-house practitioners and sometimes by private practitioners. Many of the latter are selected from care and protection panels which began operating in August 2004. At that time 113 practitioners were appointed for a period of two years. The LAC said some lawyers were appointed to represent adults only, because they lacked the necessary expertise to represent children. The remaining appointees were appointed to represent both adults and children. All appointees are required to comply with guidelines and practice standards, and are subject to audit by the LAC.

Some respondents claimed that parents have no access to legal aid and advice before the day of the first court appearance, after DoCS had already removed the child.

We were told repeatedly that parents in care and protection matters tended to be clients with significant problems ranging from drug/alcohol abuse to mental illness and intellectual disability. Sometimes their capacity to keep appointments or assist the Court with evidence was called into question.

Some specialist private practitioners said that they continue to pursue the interests of child clients after their cases are finalised in court. For example, some practitioners reported

maintaining their own records of section 82 monitoring orders in order to ensure compliance by DoCS. There were also examples of separate representatives successfully opposing restoration plans in court.

Questions have been raised about the inconsistent quality of legal representation in country courts, where there are said to be few practitioners well versed in the legislation and sufficiently experienced in care proceedings. Some people we interviewed told us that inconsistency in the quality of legal representation is not confined to country areas but would apply to all areas of legal practice.

The LAC said that, in regional locations where there are no panels, it has no quality controls to ensure that private practitioners have the necessary expertise to deal with care matters.

DoCS has told us that it agrees that there is a scarcity of expert legal practitioners in care litigation, especially in rural areas. However, it also notes that with only about 3,000 care matters in any one year, and most of these being conducted in metropolitan courts, there is not a solid core amount of work to justify large numbers of practitioners. DoCS says most practitioners will be paid either by it or Legal Aid and in both cases the rate of payment is not generous.

DoCS has said that, together with Legal Aid, it is attempting to correct this imbalance by encouraging practitioners to acquire specialist accreditation in child law, encouraging secondment of staff between firms, holding training days in rural locations, and making arrangements for panel practitioners to train junior staff.

Guardians ad litem – sections 100 and 101

The Court can appoint a guardian ad litem (GAL) to represent a child if special circumstances apply, including a child's special needs. The Court can also appoint a GAL for a parent where the parent is incapable of giving proper instructions to their legal representative.

The functions of the GAL are to safeguard and represent the interests of the child or parent, as the case may be, and to instruct their legal representative.

A panel of GALs has been in existence since January 2002. There are no Aboriginal GALs.

There is no data available on the frequency of use of GALs. However, respondents say they are often used.

One lawyer has suggested that GALs do not get invited to care plan meetings, thus limiting their effectiveness. On the other hand, one veteran GAL reports no problems in obtaining sufficient information in order to represent a child or parent.

DoCS has told us that it has had some experience with GALS where they appeared not to understand their role and assumed the position of a lawyer advocating for their client. However, the department says its experience is limited and current practice appears to be improving.

It appears that there is relatively frequent use of GALs. In light of the possibility that some GALs may not fully appreciate the scope and limits of their role, we suggest that guidelines should be developed to clearly explain to GALs how they are expected to perform their functions. The guidelines should also canvass whether and how GALs should be involved in care plan meetings, and their entitlement to information to assist them in performing their role.

Timeliness

The Children's Court time standards applicable from 1 January 2005 require that 90 per cent of care matters should be finalised within nine months of commencement, and that all care matters should be finalised within 12 months of commencement.

Lawyers practising in the Court report that in most cases, matters are finalised within the current time standards. However, some cases are said to take longer. Reasons for delays include orders for assessments, which can add six to eight weeks to a matter. Assessments of parental capacity that involve criminal record checks are said to slow down proceedings. One lawyer reports that 10 to 15 per cent of cases involve an interstate link (for example, a potential family carer), and that interstate inquiries can take six to eight weeks to complete.

DoCS has told us that the average time from filing to the conclusion of a care matter in NSW is approximately seven months, and that only a few matters take longer than 12 months. DoCS has also indicated that the duration of care matters compares favourably with other comparable public law care jurisdictions – in England, the average duration appears to be about 12 months, while matters in the Family Court of Australia's Magellan project took about 8.7 months..

DoCS attributed the improvement in timeliness in the Children's Court to greater rigour being exercised by the Court, and to improvements by DoCS in the standard of its affidavit preparation and presentation of material because it has located legal officers in Community Services Centres.

DoCS said it has started collecting quarterly data on all cases which are taking more than 12 months to conclude, so that these cases can be identified and more intensively case-managed internally. Data for two quarters is now held, but DoCS has said that this data was "not reliable".

It is pleasing to see that DoCS has started to keep data on some aspects of the duration of care matters. This data should assist in establishing benchmarks which should be used to drive improvements to the timeliness of care proceedings, and provide a platform for further research in this area.

We also believe that it is important that the data be available to the public, to enhance the accountability of DoCS and the Court in relation to the timely conduct of care proceedings.

The Aboriginal and Torres Strait Islander principles – sections 11-14

Part 2 of Chapter 2 of the legislation sets out a number of principles that should be applied in care and protection matters involving indigenous people.

Section 11 says that indigenous people are to “participate” in the care and protection of their children with as much self-determination as possible.

Section 12 says that indigenous families, kinship groups, representative organisations and communities must be given the opportunity to “participate” in decisions about significant decisions under the legislation, including the placement of indigenous children.

Section 13 sets out an order of preferred placement for indigenous children, with the first preference being for a member of the child’s extended family or kinship group.

The Sydney Regional Aboriginal Corporation Legal Service told us that compliance with the principles varies significantly between Community Service Centres and between caseworkers. It also said that some private practitioners enthusiastically advocate for compliance with the principles, while others are oblivious to them or, at least, do not engage with them. In addition, it said that magistrates vary in the degree to which they enforce compliance with the principles.

The Service also said that it was important to note that Aboriginal culture was not adequately understood by caseworkers, possibly as a result a lack of training, and possibly as a consequence of a lack of genuine interest in the principles. We note that these points are relevant to later discussion about practical ways of applying the indigenous principles.

Children’s Magistrates, Children’s Registrars, the Children’s Court Clinic and lawyers all say that they would expect to see more applications for care orders in relation to indigenous children given the level of disadvantage in Aboriginal communities.

One explanation as to why they do not see these applications may be that DoCS handles some indigenous matters through informal family or kinship care arrangements. Our reviewable death function has revealed that some indigenous matters are handled in this way. However, we have not obtained information that clearly indicates the number of arrangements that are not seen by the Court.

Significantly, statistics supplied by the Court show very low numbers of care applications in some NSW country areas with indigenous communities.

For example, in Bourke, only six applications for care orders were lodged in the local court in 2002 and 2003. (The information provided by the Court does not indicate whether these applications were for indigenous children.) Furthermore, there were no section 38 consent agreements lodged in the court during the same two-year period.

This situation should be considered in the context of information about the number of indigenous families and children in Bourke, together with information about the social circumstances of the indigenous community.

The 2001 census data for Bourke shows a third of the town's population was indigenous. Half of all children under 14 in Bourke were indigenous, but only 20 per cent of the non-indigenous population was aged under 14.

Of Bourke's single parent families with children under 15, 57 per cent were indigenous. Of all two-parent families, with children under 15, 46 per cent were indigenous.

Rates of school attendance for indigenous children were lower than for non-indigenous children. While 97 per cent of non-indigenous children aged 5-14 were at school, only 80 per cent of indigenous children aged 5-14 were at school.

Bourke's total unemployment rate was 7.7 per cent. Indigenous unemployment was much higher, at 20.8 per cent.

Against this background, some of the people we talked to expressed surprise about what they saw as a very low number of care applications in Bourke. A former local court registrar in Bourke said the number of indigenous juveniles brought before the Children's Court on criminal matters seemed disproportionately high compared to the number of applications for care orders in relation to indigenous children.

As discussed earlier, it is possible that local DoCS caseworkers are handling care matters in a way that does not require or involve these matters coming before the Court. However, there may be other explanations for the low number of applications for care orders involving indigenous children.

DoCS told us it does not have specific data on this issue. However, it said the reasons for the low number of care applications in Bourke would be varied and complex. Unfortunately, the department has not elaborated on this in its response to our questions.

We note that DoCS considered issues relating to care proceedings involving indigenous children during an internal review of the death of an Aboriginal child who died in 2003. The DoCS review report included the following observations:

The reality of the environment in [the community] is such that regular application of Children's Court action would have a significant social impact, not all of it necessarily beneficial. Child protection assessment and intervention in [the community] is open to a high level of misapplication of solutions. In particular a predominantly indigenous community needs to be treated, in child protection terms, with constant sensitivity to the historical impact of Commonwealth and state government policy that led to the "stolen generations". Wide scale removal of children in such communities is not a simple option as a child protection response.

Some of the people we interviewed suggested that there are a number of factors which may contribute to the relatively low number of care applications in relation to indigenous children in particular locations. For example, caseworkers may feel inhibited in bringing care applications because of the legacy of the "Stolen Generations". There is community suspicion of, and even hostility towards, welfare agencies. There are low numbers of indigenous DoCS caseworkers in some locations. And there may be a lack of suitable out-of-home placements for Aboriginal children.

For the purposes of the current discussion, it is also relevant to have regard to data collected by the Australian Institute of Health and Welfare. This shows that indigenous children are put into out of home care at more than eight times the rate for other children. In NSW in 2002-2003, indigenous children were in out of home care at a rate of 36.4 per 1,000. By way of contrast, the rate for non-indigenous children was 4.3 per 1,000. Furthermore, of all children in out-of-home care in NSW during the period, a third were indigenous.

Against the background of the above discussion, we would make the following observations.

Our work in reviewing the deaths of children over a number of years indicates that about 20 per cent of the child deaths that we review involve indigenous children. Our significant investigative work has revealed that the level of protective intervention by DoCS and other agencies in the lives of these indigenous children was not always commensurate with the risks that they faced in their particular situation.

We note that DoCS has introduced Aboriginal Intensive Family Based Services to assist parents and carers to create a safe environment for their children. These services aim to help reduce the number of indigenous children being placed or remaining in out-of-home care through providing intensive support to vulnerable families. Important elements of this initiative are to identify and use culturally appropriate services and service providers and to re-establish family and community ties. There are services of this sort in Redfern, Casino, Bourke and Dapto. In its 2004-2005 annual report, DoCS noted that planning was well underway for the expansion of the Casino service and the establishment of a new service at Campbelltown.

It will be critical to evaluate the success of these services in strengthening the family environment. However, in circumstances where the basic rights of indigenous children cannot be protected within their family situation, there will be a need to apply for care orders, including orders involving the removal of children from their immediate families.

Furthermore, applications for care orders must be considered not only in the context of services to strengthen family environments, but also in the larger context of the need for the greater participation of indigenous families, kinship groups, representative organisations and communities in significant decisions about indigenous children.

Over the past four years, this office has engaged in a program of visiting a large number of Aboriginal communities. During our visits, we have held discussions with thousands of members of these communities, community leaders, elders and indigenous organisations about their concerns. They have increasingly told us of their concerns about the situation of children within their community, and of the need for practical measures to address the problems involved.

It has emerged from the discussions during our visits that one issue that needs more attention is how local people from indigenous communities can participate more effectively with government agencies in the fight against child abuse that occurs in local communities, as envisaged by the legislation. While the principles in the legislation recognise in broad terms the need for such participation, there is no detail about how this participation is actually to be achieved. In light of the growing concerns of Aboriginal communities and the general public about the situation of indigenous children, practical measures are needed to facilitate the "participation" in "significant decisions" contemplated by the Act. Decisions

made in connection with possible care proceedings clearly fall within the scope of the term “significant decisions” under the Act.

The starting point would be determining those people who can properly represent local indigenous communities. In this respect, there is a need for safeguards to ensure that the people involved are appropriate representatives of their community in the promotion of child protection, and are perceived and respected as such by their community.

A further issue that needs to be addressed is ensuring that there can be a full and frank exchange of information between the representatives of local indigenous communities and officers of DoCS and other government agencies involved in child protection, in order to arrive at practical solutions. There may be a need for a legislative mandate to facilitate this, given that there are possible concerns about the scope of the current legislative provisions regulating and restricting the disclosure of information by public sector agencies working in the child protection area.

We acknowledge that this is a very difficult area. For example, we appreciate that there may well be substantial challenges involved in determining who should be regarded as appropriate spokespeople for, and representatives of, particular indigenous communities.

Nevertheless, we believe that it is now essential that indigenous communities, government agencies, and other key players work constructively towards facilitating more meaningful participation by indigenous people in strategies for child protection. In this respect, we suggest that there is room for trialling models which involve genuine participation by indigenous representatives in child care and protection decisions, as envisaged by the Act itself. Indeed, we note that this sort of work is being explored in other Australian jurisdictions. This experience could be used for indigenous participation models in NSW.

General observations about DoCS

Respondents suggest that the shaping of final orders will be influenced by various factors such as the policy and practice of particular DoCS Community Service Centres, as well as the attitudes and skills of caseworkers, and by the approaches of particular solicitors. There is reportedly no uniform approach.

Lawyers said the response by DoCS to “similar fact” situations was unpredictable. One CSC may respond to a case by seeking short term orders and a restoration plan, while another may want long term orders in a very similar case. There may be different local policies in DoCS offices – some are said to see restoration plans as requiring short-term orders, while others will link restoration to a long-term allocation of parental responsibility to the Minister. In the latter case, if restoration does not work out, the caseworkers will not have to return to court for new orders. High DoCS staff turnover is also said to contribute to inconsistent approaches to care matters before the Court - some people we spoke to said changes to case plans before the Court would sometimes be preceded by changes in the caseworkers dealing with the plans.

This is another area that cannot be tested because of the absence of relevant data and review mechanisms.

The reported variations in approach among caseworkers and their managers raise questions about their training and supervision, and access to specialist and legal advice. Whatever the case, the variations also suggest an inconsistent approach to the application of the legislative principles, including that of “least intrusive” action to protect children, consistent with the paramount need to protect them and promote their development.

General observations about Children’s Magistrates

Section 7 of the Children’s Court Act permits the Chief Magistrate to appoint a magistrate as a Children’s Magistrate if the Chief Magistrate is of the opinion that the magistrate has “such knowledge, qualifications, skills and experience in the law and social or behavioural sciences, and in dealing with children and young people and their families as the Chief Magistrate considers necessary to enable the person to exercise the functions of a Children’s Magistrate”.

Section 7 also provides that a Children’s Magistrate must undertake and complete ongoing courses of training required by the Chief Magistrate in consultation with the Senior Children’s Magistrate.

Lawyers who specialise in the jurisdiction have complained that the current legislation was introduced with an initial promise of specialist magistrates, but that this promise has not been kept.

The proportion of care matters handled by non-specialist magistrates is not known. However, we have been told that matters in country courts are often settled by consent.

In some country courts – including Albury, Wagga Wagga, Nowra, Kempsey, Coffs Harbour, Port Macquarie and Lismore – Children’s Registrars conduct monthly callovers. The Children’s Registrars will identify the more complex or contested matters and may request the provision of specialist Children’s Magistrates to hear them. We have been told that magistrates in country centres often request assistance from the specialist Children’s Magistrates for contested hearings.

DoCS has said:

DoCS is unaware of, and therefore cannot comment on, the extent to which appointees as specialist Children’s Magistrate meet the qualification requirements of the Children’s Court Act and whether the training they undertake is either of sufficient duration or depth. It is noted that, unlike other jurisdictions, a Children’s Court does set minimum prescribed standards in these areas. A comparison of steps to meet these standards, as opposed to recruiting and training magistrates in the Local Court generally, may be a useful exercise.

DoCS has also made the following comments on “variations” among Children’s Magistrates:

DoCS accepts that there will always be variations between Magistrates and, indeed, considers that this may be beneficial in creating an environment of debate and learning. However, the variation is not helpful when it occurs without reference to what is done in a care court (as distinct from being a conscious decision to reach a

contrary conclusion) or through a lack of knowledge or experience of matters in the care jurisdiction.

Apart from the issues of qualifications and training, there is the question of consistency in decision-making and practice by the Children's Court.

There are a range of factors that may lead to variations in decisions and practice. We note that research on the situation in Victoria has been conducted by Rosemary Sheehan and published in her 2001 book *Magistrates' Decision Making in Child Protection Cases*. Research of this kind in NSW would be a valuable exercise.

OTHER ISSUES

Parents with a disability

We have taken account of research into care matters in the Children's Court involving parents with a disability. The researchers reviewed the outcomes of 407 care and protection cases that were finalised at Campsie and Cobham Children's Courts from January 1998 to July 1999, a period when the previous Act was in force.

The researchers reported that just under a quarter of all cases featured parents with a disability. The researchers said that parents with a psychiatric or an intellectual disability were significantly over-represented in care proceedings, and that their children were significantly younger than children in matters featuring parents without a disability.

The researchers also said that DoCS intervention to remove children from parents with a disability was often driven by prejudicial beliefs about parenting and disability. During court processes these parents were said to be sidelined and discriminated against because of their disabilities, partly because of a reliance on diagnostic models of assessment, rather than assessment of parenting performance.

The authors of the report directed recommendations for improvement to the Attorney General's department, the Children's Court and DoCS. One of the authors told us that, to their knowledge, none of the recommendations had been implemented. If that is the case, then it should also be said that the reasons for this are not clear. This is a matter that may require further exploration.

Juveniles

Some people we interviewed raised concerns about what they saw as the exclusion of some juveniles from the care jurisdiction of the Children's Court. We heard suggestions that DoCS was concerned with taking action in court for the care and protection of younger children but refrained from doing so for juveniles. Some people we interviewed argued that some young people were being categorised as a "Juvenile Justice problem", even though they might have long histories of child protection concerns.

Senior Children's Magistrate Scott Mitchell has said that what he calls an "unwelcome consequence" of the division between the criminal and care jurisdictions of the Children's Court is that DoCS only comparatively rarely makes an appearance in the criminal

jurisdiction. He said that DoCS is not present in the court in a majority of cases where juvenile offenders are already under the parental responsibility of the Minister.

Section 7 of the Children (Protection and Parental Responsibility) Act provides that a court exercising criminal jurisdiction with respect to a child may require the attendance of one or more parents of the child. However, the section specifies that the term parent does not include the Minister for Community Services or the Director-General of DoCS. Senior Children's Magistrate Mitchell argues that there should be an arrangement, either through a legislative amendment or an administrative agreement, requiring the Minister to ensure that juvenile offenders already in her parental responsibility are properly supported at court.

Magistrate Mitchell said that the absence of DoCS from juvenile justice proceedings is even more troubling when a Children's Magistrate learns of care and protection concerns relating to a young person who is before the Court's criminal jurisdiction.

Procedures were introduced through a Court Bulletin whereby Children's Magistrates would report any of their concerns by facsimile to DoCS, rather than ringing the DoCS Helpline. In addition, Children's Magistrates are able to make after hours reports by telephoning the Department's Director of Legal Services.

Senior Children's Magistrate Mitchell has said that the experience of Children's Magistrates who have made reports to DoCS is that it is often not clear what action, if any, DoCS would be able and prepared to undertake. He acknowledged DoCS is bound by its resources and it is not unreasonable that the department prioritises certain cases. However, he said the present arrangement provided by DoCS is inadequate as an aid to keeping a young person out of trouble and reassuring a judicial officer that a young person will be safe if released on bail or on probation.

Magistrate Mitchell says what is needed is a formal method of invoking the assistance of DoCS where it becomes clear that a child or young person is in need of assistance in the course of proceedings in the Children's Court in its criminal jurisdiction. He said that a Children's Magistrate sitting in the criminal jurisdiction should be entitled to enumerate his or her concerns and call upon DoCS to provide a prompt report as to the care and protection issues surrounding any young person before the Court. The report should indicate what steps DoCS has taken or proposes to take to address those issues and, if no steps are to be taken, the reasons for that decision.

For its part, DoCS noted that the two jurisdictions of the Court had been combined under the *Child Welfare Act 1939* but that legislation separating them was enacted in 1987. DoCS told us that, since July 2004, the Court has put in place its own system to report to DoCS children that Magistrates consider are at risk of harm, with 32 children being reported to DoCS through this system in 2005.

DoCS says that, if its role is to provide a report on the care and protection of the child, then the Department of Juvenile Justice which is already present in all cases in the criminal jurisdiction can obtain this information under section 248 of the Children and Young Persons (Care and Protection) Act. DoCS also argues that the report is likely to contain information that would not normally be available to a court prior to a finding of guilt. The department says this then raises the question of whether this would be appropriate as a matter of procedural fairness. DoCS told us that there are discussions between the Directors-General

of DoCS and Juvenile Justice and the Chief Magistrate on the issue of providing reports and subsequent services.

We would observe that the question is not whether the information would normally be available to the Court, but whether it might be appropriate for proper sentencing. As to procedural fairness, we believe that this is something that could be addressed in consultation with the Court.

Finally, DoCS says if its role is to be a provider of services, then the particular needs of a number of children before the criminal jurisdiction must be identified. DoCS says it must be recognised that it has no powers greater than those of a parent. The department says that the range of services that it can provide is no broader than any parent can provide (assuming that the parent has the financial capacity). However, the Department of Juvenile Justice has access to other services available to children in detention. DoCS has therefore questioned the merit of a proposal that would see it ordered to provide a report to the Court.

We would observe that, while the Court's criminal and care jurisdictions are indeed separate, there is ample evidence that children who are at risk of harm may also be at risk of involvement with the criminal justice system. In 1997, the Bureau of Crime Statistics and Research (BOCSAR) reviewed national and international evidence on family factors and juvenile delinquency, reporting that child neglect was more likely to lead to juvenile delinquency than drug use or poor school performance. In 2005, BOCSAR reported on the results of a study of 5,476 juvenile offenders who appeared in the NSW Children's Court for the first time in 1995. More than 68 per cent of these offenders reappeared in a NSW criminal court within the next eight years, and 13 per cent ended up in an adult prison within that period. BOCSAR said that its study highlighted the critical importance of intervening as early as possible to break the cycle of juvenile crime.

Our own work in reviewing child deaths has also shown that some children – notably adolescents – had lives marked by extensive involvement with DoCS, police and the Department of Juvenile Justice. In our Report of Reviewable Deaths in 2004, we noted the inherent difficulties of protective intervention for young people who may be prone to risk taking behaviour and who may be unwilling to accept the services of human services agencies. DoCS has no powers of coercion under the Children and Young Persons (Care and Protection) Act and cannot force young people to accept or engage with services. Although sections 123 to 133 of the Act provide for 'compulsory assistance', these sections have not been proclaimed.

Given the difficulties referred to above, it is our view that when opportunities for protective intervention do arise, these should be accepted by human services agencies. The appearance of a young person in the criminal jurisdiction of the Children's Court may present such an opportunity. For this reason, we would hope for positive results from the discussions between the Court, DoCS and Juvenile Justice on the issue of providing reports and subsequent services for children and young people who are charged or convicted of criminal offences.

DoCS has expressed concern that the position of the Court on this issue does not adequately take into account the distinction between care and criminal proceedings. Specifically, DoCS has referred to the observations of Brennan J in the High Court decision of *J v Lieschke* (1987) 162 CLR 447:

The two classes of proceedings are distinct. There is some uniformity of treatment of children when they are apprehended and some similarity of incidents attendant on the respective classes (for example, requiring a parent or guardian to attend the Court), but the nature and purpose of 'neglect proceedings' are quite distinct from the nature and purpose of criminal proceedings.

In response, we would observe that there is nothing in our view on this issue that would contravene the principle set out by Brennan J. Instead, we believe that the Children's Court being provided with adequate information to assist them to understand the general lifestyle of young people in appropriate cases will assist the Court in properly exercising its role in its criminal jurisdiction which includes the appropriate sentencing of young people according to law.

Finally, we note that BOCSAR has proposed new research that aims to build on the study of juvenile offenders reported in 2005. BOCSAR put a proposal to DoCS to find out whether there was anything about the pattern of contacts children had with DOCS that would allow predictions about which young people would go on to become recidivist offenders. DoCS proposed a "broader, more robust" analysis that would include the Health and Education departments. DoCS has said to us that it is still keen to pursue the broader research project with BOCSAR.

CONCLUSIONS

Decisions in care proceedings concerning child care and protection may have profound and far-reaching consequences for children, their families, and other people who may become their carers.

The lack of accurate and reliable data in relation to many aspects of care proceedings in the Children's Court is therefore of significant concern. The absence of such data means that there is a considerable gap in information about key aspects of the child care and protection system. One effect of this gap is to make it extremely difficult to draw conclusions about sometimes competing or conflicting positions on issues of process and practice in care proceedings.

However, it is also important to recognise that data collection and associated research are not the only matters that need to be addressed. This paper demonstrates that there are divergent views about a number of important issues such as:

- how the principle of "least intrusive" action should be applied
- how the principle of the participation of children and young people should be applied
- how the principles of indigenous participation should be applied
- the quality and consistency of the application of the indigenous placement principles
- the role of ADR in care proceedings
- how evidence should be put before, and tested by, the Court

Answers to Questions on Notice

- circumstances relevant to the level and frequency of the granting of interim orders
- the interpretation of the requirement that proceedings should not be conducted in an “adversarial” manner
- the adequacy and appropriate use of care plans
- the use of preliminary conferences
- the use of examination and assessment orders
- the use of undertakings
- the extent to which the principle of permanency planning is being given effect
- the use of contact orders
- the quality of the assessments undertaken regarding the possibility of restoration
- the effectiveness of arrangements for the monitoring of orders concerning parental responsibility
- the extent to which there may be greater use of the option of adoption
- the role of Guardians ad Litem
- the handling of care and protection matters involving juveniles appearing in the criminal jurisdiction of the Children’s Court.

Clearly, data collection and analysis alone will not guarantee progress on many of these issues. With some of them, there might be a need for a simple legislative amendment. With others, this will not be sufficient.

The review of the legislation provides a timely opportunity to clarify the legislation. We have referred in this paper to specific provisions possibly requiring legislative amendment, such as sections 54, 73 and 82.

The review also allows for consideration of some of the broad principles in the legislation. From our discussions, there seems to be a general acceptance of these principles, although there is contention as to how some of them should be interpreted. For example, there are clearly differences in interpretation of the “least intrusive” principle. There are also differences about the appropriate manner in which care proceedings should be conducted – in particular, the role of ADR in the process, and how “adversarial” proceedings should be. Again, different interpretations of the principles have led to debate about the appropriateness of contact orders. What would constitute good progress on some of these issues is a complex matter.

For many issues, it is important to recognise that legislative change at this stage might not be desirable or might only be part of the solution. For example, while there would be benefit

in the legislation “fleshing out” issues such as ADR, how proceedings before the Court should be conducted, and the nature of indigenous participation in care and protection decisions, legislative change alone will not ensure best practice.

Progress on these issues will also need to involve appropriate research and/or ongoing debate. In this regard, it is important to recognise that many issues involve principles that are heavily value-laden. As this paper reflects, there is considerable scope for different parties seeking to apply the principles in different ways.

The fact that there is already discussion on a number of these issues is healthy. However, to ensure that there are good outcomes, the discussion needs to be open and transparent, involve a broader range of stakeholders, and lead to concrete outcomes within reasonable timeframes.

In this paper, we have sought to outline some of the important issues arising in connection with care proceedings. We intend to circulate the paper broadly to assist people understanding the issues involved and to promote further discussion. We look forward to receiving constructive feedback that would assist in further consideration of the issues.

In a draft version of this discussion paper, we suggested that there might be value in considering the organisation of a forum to focus on a number of the matters discussed in this paper. We also suggested the possible creation of a standing committee or working party comprising a broad range of experts, which could advise the government and Parliament of proposals for improvements in practice and, where necessary, the need for legislative reform.

In response to these suggestions, DoCS observed that our suggestions appeared to have given inadequate consideration to the existence of two forums in which relevant issues were already discussed. One of these was a working party consisting of the Children’s Court, DoCS and the LAC, with other parties such as the Attorney General’s Department, the Department of Juvenile Justice, and the Department of Ageing, Disability and Home Care being involved for specific issues. This working party is “endorsed” by the Attorney General and the Minister for Community Services. The working party deals with “technical” matters involving legal processes and procedures.

There is also a Ministerial Advisory Council, which comprises:

- the Chief Executive Officer of the NSW Council of Social Service
- the Chief Executive Officer of the Association of Children’s Welfare Agencies
- the Chief Executive Officer of the Aboriginal, Child, Family and Community Care State Secretariat
- the Children’s Commissioner
- Dr Judy Cashmore
- a representative of DoCS.

This Ministerial Advisory Council considers broad issues, and has been working intensively on advice to the Minister for Community Services about the review of the legislation.

We acknowledge the valuable contribution of the Ministerial Advisory Committee. However, the question is whether the current arrangements of the Committee would be adequate to

ensure that the many complex and critical issues canvassed in this discussion paper are fully addressed. The creation of a standing committee or one or more working parties to research and debate many of these issues may serve to complement the work of the Committee. We recognise that research of the kind that we have proposed needs to be supported by appropriate funding.

It would also seem that the current working party involving the Children's Court, DoCS and the LAC appears not to have been able to resolve many of the issues raised in this discussion paper. Furthermore, there is a need for an open and transparent process with clear timeframes that entails the involvement of other stakeholders beyond those represented. In these circumstances, we maintain our recommendation that consideration be given to the creation of an additional forum to research and consider the issues involved.

ATTACHMENT E

Our reference: ADM/542
Contact: Mr Steve Kinmond

The Secretariat
Review of the Children and Young Persons (Care and Protection) Act 1998
Department of Community Services
Locked Bag 28
ASHFIELD NSW 1800

Dear Sir/Madam

Discussion Paper – Statutory child protection in NSW: Issues and options for reform

I refer to the letter from the Director-General of the Department of January 2007 (received here on 25 January) enclosing the Report on the review of the Children and Young Persons (Care and Protection) Act 1998 and the “Discussion Paper for Review – Statutory child protection in NSW: Issues and options for reform”.

This office appreciates the opportunity to provide its submissions in response to the matters raised in the Discussion Paper. We have structured our submissions by reference to the headings used in the Discussion Paper.

4.1 Mandatory reporting

We note that the Discussion Paper puts forward a number of options for facilitating improved reporting practices.

(1) Require reporters to provide clearer evidence of a real risk

The Discussion Paper canvasses the possibility of higher thresholds for the mandatory reporting of the risk of harm to children and young people, such as a requirement for “reasonable evidence” of a risk of harm and/or the “real likelihood” of harm.

We do not support either of these approaches.

While it is true that the current threshold “reasonable grounds to suspect” is not necessarily precise and may be open to different interpretations by mandatory reporters, this criticism can also be levelled at thresholds such as “reasonable evidence” and “real likelihood”. Indeed, we consider that, in practice, the threshold of “reasonable grounds to suspect” is more readily understandable – and more appropriate – than thresholds such as “reasonable evidence” and “real likelihood”.

“Reasonable evidence”

A threshold such as “reasonable evidence” would impose on the reporter the need to consider what actually constitutes “evidence” of a risk of harm. While the concept of “evidence” may be well understood by people such as lawyers and those involved in investigative work, it may not be entirely clear to, and therefore confusing for, other people. Accordingly, the introduction of the word “evidence” might well create more difficulties for reporters than assessing whether there are “reasonable grounds to suspect” a risk of harm.

Furthermore, the requirement that there should be actual evidence of a risk of harm, and that this evidence should also be “reasonable”, appears to be too high as a threshold for mandatory reporting. It is preferable for the question of the availability of evidence as to the risk of harm, and the strength of that evidence, to be explored and assessed by DoCS following a mandatory report.

Finally, as the Discussion Paper emphasises, mandatory reporting should be “both a siren that calls us to action where there is a crisis for a child and an early warning system that should work to avoid such crises”. A threshold which requires “reasonable evidence” of a risk of harm may well militate against fulfilment of the second stated rationale for mandatory reporting.

“Reasonable likelihood”

Similar criticisms can be made of a higher threshold of “reasonable likelihood” of harm.

Mandatory reporters may take differing views as to both the meaning of “likelihood” and whether that likelihood is “reasonable”. Again, the need to assess the meaning and application of these terms is more difficult and confusing than assessing whether there are “reasonable grounds to suspect” risk of harm.

It would also become the responsibility of the reporter to assess whether there would be a “real likelihood” of harm. Such an assessment is inherently difficult to make. We believe that it is preferable for the actual likelihood of harm to be determined as a matter of risk assessment by DoCS.

Again, a threshold which requires a “reasonable likelihood” of harm might well eliminate reports that could and should properly form part of “an early warning system”.

(2) Identify serious and persistent parental drug use as a behaviour with the potential to cause harm

It could be argued that the inclusion of this ground is not strictly necessary, since it is already covered in substance by the broad definitions of “at risk of harm” under paragraphs (a), (b), (c) and (e) of section 23. Nevertheless, there would appear to be merit in focussing particular attention on the issue of drug abuse giving rise to a risk of harm to children and young people.

However, we have concerns about a number of aspects of the wording of the amendment to section 23 suggested in the Discussion Paper, namely:

The child or young person is living in a household where there is evidence of serious and persistent parental use of illicit drugs and, as a consequence, the child or young person is at risk of serious physical or psychological harm.

One concern is that the reference to “evidence” of drug use may create unnecessary confusion or difficulty. A reporter may consider that they should have actual evidence of drug abuse before being required to report the matter. As discussed above, the concept of “evidence” may be understood by people such as lawyers and those involved in investigative work, but may not be entirely clear to, and therefore confusing for, other people. Furthermore, there may well be inherent difficulty for a reporter in obtaining evidence of drug abuse. In those circumstances, we suggest that the term “evidence” should not be used. In this respect, we note that section 23(d), which concerns situations of domestic violence giving rise to a risk of harm, does not specifically refer to the need for “evidence” of domestic violence.

Furthermore, the use of words such as “persistent” and/or “serious” may well lead to difficulties for reporters in assessing the level of drug abuse that is required to warrant a mandatory report of risk of harm. In addition, a requirement that the drug abuse be persistent and/or serious appears to be unnecessarily high, in circumstances where the principal focus should be on whether the drug abuse gives rise to a risk of harm.

In addition, while the abuse of illicit drugs may pose a risk of harm, it is also possible that the abuse of prescribed drugs may give rise to such a risk. In those circumstances, we suggest that the use of the word “illicit” is unnecessarily restrictive of the circumstances in which concerns about drug abuse should be the subject of a mandatory report.

Finally, it would also appear to be unnecessarily restrictive to confine the drug abuse in question to that of one or both parents. There may be others residing in or visiting the household whose drug abuse also poses a risk of harm.

In light of the above discussion, we suggest that any amendment to section 23 should be along the following lines:

The child or young person is living in a household where there is abuse of drugs and, as a consequence, the child or young person is at risk of serious physical or psychological harm.

The advantage of this formulation is that it is easy to understand and, importantly, does not simply refer to the existence of drug abuse, but clearly links any drug abuse to the risk of serious physical or psychological harm – just as the current section 23(d) appropriately links a situation of domestic violence to the risk of harm to a child or young person.

(3) Strengthen focus on neglect or “cumulative risk” cases

We agree with the suggestion that the word “current” should be removed from the term “current concerns” in the definition of “risk of harm” under section 23.

We also agree with the suggestion that neglect of a child or young person should be specifically added to section 23 as a ground on which a report of risk of harm should be made.

4.2 Exchanging child protection information

Our submission to the review of the Act

In our submission to the review of the *Children and Young Persons (Care and Protection) Act 1998*, we recommended that the legislation should clearly permit the exchange of information between prescribed bodies in relation to the safety, welfare and well-being of children and young people.

In support of this position, we said:

Effective information exchange is fundamental to good care and protection practice. However, our work has identified that there are significant problems with information exchange between agencies. Some of these problems appear to exist because of perceived legal impediments to information exchange, and poor understanding of what information can be exchanged, when it can be exchanged, and who can exchange it.

DoCS and prescribed bodies should not be constrained in exchanging information relating to the safety, welfare and well-being of a child or young person.

Our comments were made against the background of our work in reviewing the deaths of children and young people, where we have found that a significant failure in the current system for the care and protection of children and young people relates to the need for the improved and timelier exchange of information.

Our current submission

We strongly adhere to the position put forward in our previous submission. In the alternative, we would recommend that, at the very least, key agencies whose work may often involve dealing with critical issues relating to the protection of children and young people – that is, DoCS, the NSW Police Force, the Department of Health, health organisations and hospitals, and the Department of Education and schools – should be clearly entitled to exchange information relating to concerns about the safety, welfare and well-being of a child or young person.

Our arguments in support of this position are as follows.

The legislative scheme for the exchange of the information

Under section 248 of the Act, DoCS is specifically entitled to furnish “prescribed bodies” with information relating to the safety, welfare and well-being of children and young people, and to direct such bodies to furnish DoCS with such information.

The “prescribed bodies” under section 248 are:

- the NSW Police Force
- government departments and public authorities
- government schools and registered non-government schools
- TAFE establishments

- public health organisations within the meaning of the *Health Act 1990*
- private hospitals
- any other body or class of bodies prescribed by the regulations.

Clause 7 of the regulations currently provides that the following are prescribed bodies for the purpose of section 248:

- private fostering agencies
- residential child care centres and child care services
- designated agencies
- private adoption agencies
- the Family Court of Australia
- Centrelink
- the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs
- any other organisations the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children.

Significantly, section 248 does not permit prescribed bodies to exchange information relating to safety, welfare or well-being of children and young people between or among themselves.

Section 248 therefore seems to be proceed on an assumption that DoCS is at the centre or "hub" of all matters in relation to the care and protection of children and young people. As we discuss further below, this assumption is misconceived.

It is section 254 of the Act which governs the circumstances in which prescribed bodies may exchange information. Significantly, that section has as its starting point a general prohibition on the disclosure of information "obtained in connection with the administration or execution of this Act". The section then goes on to provide for the exceptional circumstances in which information may be disclosed. One such circumstance is the provision to the prescribed body of the consent of the person from whom the information was obtained. In the absence of consent, the prescribed body will only be able to disclose the information "in connection with the administration or execution of" the Act or the regulations under the Act, or with "other lawful excuse".

Difficulties with the legislative scheme

In practice, the legislative scheme under section 254 means that a prescribed body will have to carefully examine whether, and to what extent, the other provisions of the Act and the regulations, as well as other legislation, permit it to disclose – or restrict it from disclosing – relevant information to other agencies. This is not necessarily an easy exercise. The meaning of some provisions of the Act or other legislation may not be clear or open to debate. There may be difficulties in the application of the provisions to the circumstances of the particular matter. One particular difficulty may be interpreting and applying the provisions of the *Privacy and Personal Information Protection Act 1998* and/or directions made under that legislation.

Furthermore, in circumstances where the improper disclosure of information under section 254 of the Act is a criminal offence, agencies will understandably be cautious – perhaps

unduly so – in disclosing information where there are or may be problems in interpreting and applying the relevant legislative provisions.

As we have emphasised above, our work in reviewing the deaths of children and young people has revealed that a significant current failure in the system for the care and protection of children and young people relates to the need for the improved and timelier exchange of information relating to the protection of children and young people.

Against that background, it would clearly be desirable for there to be much greater clarity about whether, and to what extent, prescribed bodies can exchange information relating to the safety, welfare and well-being of children.

The significance of the principle in section 9

Given that the fundamental principle of the Act, as articulated in section 9 of the Act, is that the safety, welfare and well-being of children and young people must be “the paramount consideration”, it is, on its face, difficult to understand why the Act should not specifically and clearly permit the exchange of information between and among DoCS and prescribed bodies where such exchange is necessary or desirable to ensure or promote the safety, welfare and well-being of children and young people. It is particularly difficult to understand why the legislation does not encourage information exchange between key agencies in those circumstances where critical child protection issues are at stake.

The significance of section 29A and the Interagency Guidelines

In this context, it is also important to emphasise the recent introduction of section 29A of the Act, which provides:

Person who makes a report is not prevented from helping a child or young person

For avoidance of doubt, it is declared that a person who is permitted or required ... to make a report is not prevented, by reason only of having made that report, from responding to the needs of, or discharging any obligations in respect of, the child or young person the subject of the report in the course of that person’s employment or otherwise.

Furthermore, the recently revised Interagency Guidelines include the following (our emphasis):

3.1 After reporting – an agency’s initial responsibilities

*Reporting is just the beginning of the child protection process and is not necessarily the end of a reporter’s role or responsibility in a matter. **Where reporters were providing services to the child and family prior to reporting, it is important that these continue to be provided.** Key considerations at this time include:*

- ***what role can the reporter or the agency play to support the child or family?***

- ***what will be the consequences for the child or young person of withdrawing support?***
- ***what further or new information about the child, young person or family is available to the reporter, and how is this best communicated to the Department of Community Services?***
- *what expertise can the reporter contribute to assist the Department of Community Services in accurately assessing risk of harm, or that may assist in the development of a case plan?*
- ***can the reporter continue to monitor the child's situation for additional indicators of abuse or neglect?***

It is often unwise for the reporter to withdraw or delay contact with the child or family on the basis of lodgement of a report of risk of harm. Where a practitioner is unsure about their continuing role with the child, young person or family, guidance could be sought from the local Community Services Centre or Joint Investigative Response Team to whom the report was transferred.

Another consideration is whether it is possible and appropriate to link the child, young person or family to other appropriate services within your agency or with another agency. These might target more peripheral difficulties facing the child and family (such as housing, financial management), or provide additional services aimed at supporting and strengthening the family.

Taking these recent developments into account, it appears to us that it is a necessary corollary of the obligations on, and expectations of, agencies responsible for the safety, welfare and well-being of children and young people that they should be able to provide appropriate information to – and receive appropriate information from – other agencies to assist them in the performance of their functions, and that the Act should clearly articulate their rights in this respect.

As mentioned above, section 248 of the Act appears to proceed on the assumption that DoCS is at the hub of all care and protection matters involving children and young people. However, the reality is that, for many matters, other key agencies will be playing the central role, and will therefore need to be able exchange information with other players. Once again, it is important to emphasise that our perspective is informed by our reviewable deaths work, which highlights the need for the greater and more timely flow exchange of information about the safety, welfare and well-being of children and young people.

The involvement of non-government organisations in the care and protection of children and young people

It is also important to emphasise the increasing involvement of non-government organisations (“NGOs”) in the system for the care and protection of children and young people. For example, the role of NGOs is critical to the early intervention program currently being rolled out by DoCS. Similarly, the responsibility for case management of children and young people in out-of-home care is increasingly being transferred from DoCS to NGOs.

In these circumstances, it is our submission that there should be a clear capacity for DoCS and certain prescribed bodies to exchange information about the safety, welfare and well-being of children and young people.

The use of information for other purposes

A major concern raised in the Discussion Paper is that information provided to agencies for the purpose of ensuring or promoting the safety, welfare or well-being of children and young people might be used for some other purpose or purposes by the prescribed body or agency. Another concern is that even the development of clear business rules will not prevent the possibility of the inappropriate use or disclosure of the information.

We acknowledge these concerns. However, we submit that the careful development and application of suitable business rules should serve to prevent or minimise the inappropriate use or disclosure of information.

Furthermore, even if there may be some legitimate concerns about the potential risks involved, these are not sufficient to outweigh the very significant public interest in ensuring the promotion of the appropriate exchange of information among prescribed agencies about the safety, welfare and well-being of children and young people, particularly that needed for their effective and timely protection.

The proposal by the Ministerial Advisory Committee

We note that the Ministerial Advisory Council recommended that there could and should be a power to pass on information without consent where it concerns the “health” of a child or young person.

It will be clear from the above discussion that we do not agree with this approach because we consider that it is unduly narrow. We would also submit that the meaning and scope of the term “health” is not sufficiently clear – particularly in the context of legislation which is concerned with the “safety, welfare and well-being” of children – and would therefore be difficult for agencies to apply in practice.

The protection of the identity of reporters

Another concern raised in the Discussion Paper is the protection of the identity of reporters.

We stress that the proposal that we have made in this and in our previous submission to the Review of the Act does nothing to undermine the protection afforded to reporters by section 29(1)(f) of the Act, which specifically provides:

the identity of the person who made the report, or information from which the identity of that person could be deduced, must not be disclosed by any person, except with:

(i) the consent of the person who made the report, or

(ii) the leave of a court or other body before which proceedings relating to the report are conducted,

and unless that consent or leave is granted, a party or witness in any such proceedings must not be asked, and, if asked, cannot be required to answer, any question that cannot be answered without disclosing the identity or leading to the identification of that person.

The proposal in the Discussion Paper

The Discussion Paper ultimately suggests that the legislation could be amended to allow the Director-General of DoCS to release information to police and/or another law enforcement agency where the information was required to assist in the investigation of a serious crime – but only with the approval of the Court (presumably the Children’s Court), which would have to be satisfied that it was in the public interest to do so, and could also specify conditions as to the release and/or use of the information.

As to this suggestion, we would point out that the time which would be involved in preparing an application to the Court, making submissions, and obtaining the Court’s decision, might well militate against the timely provision of information, and prejudice the effectiveness of the criminal investigation.

Conclusion

For all the reasons discussed above, we strongly submit that the Act should clearly permit the exchange of information between and among DoCS and all prescribed bodies in relation to the safety, welfare and well-being of children and young people.

However, if it is thought that there are still real risks posed by the breadth of this scheme in relation to the possibly inappropriate use and/or disclosure of information, we would recommend an alternative and more limited scheme. At the very least, the key agencies whose work may involve them in dealing with issues concerning the care and protection of children and young people – that is, DoCS, the NSW Police Force, the Department of Health, health organisations and hospitals, and the Department of Education and schools – should be clearly entitled to exchange information relating to concerns about the safety, welfare and well-being of a child or young person.

4.3 The best interests of the child

We generally support the formulation of the “best interests” principles suggested in the Discussion Paper, as set out at pages 32-33, and the suggested amendment to section 8(a), as set out at page 33.

Removal of the “least intrusive intervention” principle

In particular, we support the removal of the “least intrusive intervention” principle in section 9(d) of the Act, for the reasons set out on page 28 of the Discussion Paper. In this respect, we note that we canvassed in detail a variety of problems in relation to the application of the “least intrusive intervention” principle in our recent Discussion Paper on “Care proceedings in the Children’s Court” (at pages 4-6). A full copy of our Discussion Paper on care proceedings is attached to this submission, for the purposes of considering both this issue and other matters raised in DoCS’ current Discussion Paper which are the subject of further submissions below.

Concerns about the suggested principles

Although we generally support the formulation of the “best interests” principles suggested in the Discussion Paper, we do have concerns about two particular aspects of that formulation.

Principles (c)(i) and (d)(ii)

Our first concern is about the inclusion of specific time frames in principles (c)(i) and (d)(ii).

As currently formulated, principle (c)(i) includes the following:

A decision on the viability of restoration should, other than in exceptional circumstances, be taken within 6 months of the child or young person entering out-of-home care where the child is under 2 years of age and, for any other child or young person, within 12 months of entry into out-of-home care

and principle (d)(ii) requires that consideration of the issue of restoration should include:

... in any event, whether restoration can and should (other than in exceptional circumstances) occur within 2 years of the child entering out-of home care.

It does not appear to be appropriate to include specific time frames in a proposed provision concerning the broad general principles that articulate the “best interests” of children and young people. If expected time frames are to be included in the Act, they should be contained in the separate provisions which set out the operation of the system following the commencement of care applications.

Furthermore, there is the question of whether the timeliness of the consideration of, and decision-making with respect to, the issue of restoration has indeed been a problem in practice.

In our Discussion Paper on “Care proceedings in the Children’s Court”, we have specifically considered the question of the timeliness of decisions in relation to the placement of a child or young person – see the discussion at page 39 of our Discussion Paper. We note in particular that the current data does not necessarily permit a reliable estimate of the time frames within which care proceedings are or should be finalised. However, we also note that some of the data being collected by DoCS “should assist in establishing benchmarks which should be used to drive improvements to the timeliness of care proceedings, and provide a platform for further research in this area”.

Leaving aside the issues surrounding the actual timeliness of decision-making, and the adequacy of the data relevant to the consideration of this issue, it is worth considering whether it is desirable to include specific timelines in the legislation itself.

A possible difficulty with the current formulation of the suggested time frames is that there is the risk that what are intended as maximum time limits could be treated in practice as appropriate time frames for decision-making about the issue of restoration. This difficulty could be further compounded by the use of the phrase “other than in exceptional circumstances”. At the same time, it must be recognised that the suggested general principle does emphasise that the “earliest possible consideration” should be given to the question of restoration.

On balance, we support the view that there should be some reference to timelines in the Act. However, as discussed above, we submit that this should not be contained in the “general principles” provisions of the Act, but rather in the provisions which set out the operation of the system following the commencement of care applications. We also suggest that, at the same time, there should be a commitment by relevant agencies to capture and monitor reliable data on the question of the timeliness of relevant decision-making.

Principle (c)(ii)

Our second concern is about suggested principle (c)(ii), which is that “the child’s or young person’s placement should not be disrupted unless required for the safety, welfare and well-being of the child or young person” (our emphasis).

We consider that the word “required” is too strong, and carries with it a real risk of raising the same sort of problems that have been raised by the “least intrusive intervention” principle. We suggest that it would be preferable to replace the word “required” with the words “it promotes”.

4.4 Preventing harm to children: body piercing

We do not wish to make any specific submissions on this issue.

4.5 The role of the courts in the child protection matters

We have given very detailed consideration to the role of the Children’s Court, and many of the crucial issues that arise in this respect under the legislation, in our recent Discussion Paper “Care proceedings in the Children’s Court”. As noted above, a full copy of our Discussion Paper is attached to this submission.

Against that background, we now turn to the specific issues for consideration canvassed in the Community Services Discussion Paper.

(1) The scope of the role of Children’s Court

The requirement for proceedings to be conducted in a “non-adversarial” manner

The Community Services Discussion Paper says that:

One substantial area of criticism is that the requirement for a non-adversarial approach to proceedings is honoured in the breach, and that adherence to legal technique remains a dominant feature of child protection proceedings.

Our Discussion Paper (at pages 33-36) contains an extensive discussion of the application in practice of the requirement under section 93 of the Act that proceedings are not to be conducted in an “adversarial” manner, and canvasses in detail the various perspectives of DoCS, legal practitioners and the Children’s Court on this issue.

Importantly, our discussion of this matter reached the following conclusion (at pages 37-38):

... it seems to us that the fundamental issue in this area is determining the best way to conduct child care proceedings in a way that is both fair to all parties and promotes the best interests of children.

...

... the various key players in the conduct of care proceedings are understandably interpreting whether or not proceedings are conducted in an "adversarial" manner from their own background and experience.

In those circumstances, we believe that the appropriate approach to resolve the issues involved would be further discussion, focussed on achieving a much more consensus-based understanding about the expectations surrounding the conduct of child care proceedings before the Children's Court. Any appropriate legislative amendments, practice notes or code of practice to provide guidance to magistrates and legal practitioners in this area should only be developed following the outcome of such a discussion.

While we note that there is a Working Party consisting of the Children's Court, DoCS and the Legal Aid Commission which deals with technical matters involving legal processes and procedures, it does not appear that either this Working Party, or some other forum involving those involved in the Working Party and other key players, has engaged in the type of broad discussion about the problem of "adversarial" proceedings of the type recommended in our Discussion Paper.

Accordingly, our submission is, again, that an appropriate forum among the key players should be arranged to focus on achieving a more consensus-based understanding about the expectations surrounding the conduct of child care proceedings.

We would emphasise that such a forum should take place whether or not the Children's Court is replaced by some form of tribunal, or the scope of the Court's role is limited in some way. We would anticipate that, in the absence of such a forum, most of the current difficulties in relation to the issue of whether, and to what extent, care proceedings are or should be conducted in a "non-adversarial" manner are likely to persist, irrespective of whether the Children's Court or a tribunal is involved in the proceedings.

The proposal for the creation of a tribunal

It is unclear from the Discussion Paper what the precise benefits of a change from the use of the Children's Court to the use of some form of tribunal would be. This would be the case whether or not the Children's Court is replaced by a tribunal, or the role of the Court is confined in the way canvassed in the Discussion Paper.

If it is contemplated that the use of a tribunal would, of itself, resolve the problem of "adversarial" proceedings, we do not believe that would be the case. As discussed above, the fundamental issue would remain – how to determine the best way to conduct child care proceedings in a manner that is both fair to all parties and promotes the best interests of children.

Furthermore, it is our experience of tribunals at both the State and Commonwealth levels that, in practice, proceedings before such tribunals operate legalistically and in an adversarial manner.

Alternative dispute resolution

An important issue related to the appropriate resolution of care matters both before and during care proceedings is the role of alternative dispute resolution (“ADR”). For this reason, we canvassed in detail the nature and extent of ADR in our Discussion Paper on care proceedings (at pages 10-14). Our conclusions on this matter included the following (at page 13):

... the legislation supports the use of alternative dispute resolution services that are designed to resolve problems at an early stage and to reduce the likelihood that a care application will need to be made. The legislation also envisages the use of ADR services after a care application is made “to work towards the making of consent orders that are in the best interests of the child”.

While we acknowledge that ADR will not be appropriate in all cases, we would support moves to expand its application in a range of ways before and during care proceedings. We would also support associated research on how such expansion might best be achieved.

...

We would therefore be keen to see the major players come together in exploring further options for and approaches to ADR, and that future use of ADR should be supported by associated research that evaluates the outcomes of the various ADR strategies that employed.

In this regard, the potential for expanded use of ADR options such as family counselling and, for care matters involving indigenous children and young people, circle sentencing, warrant close examination.

Ultimately, once firm decisions are made about the merits of specific ADR strategies, there would appear to be value in entrenching appropriate ADR strategies within the legislation. In this respect, it should be noted that, while the legislation is strong in promoting the principles of ADR, it is not particularly clear on how these principles can be given effect in practice.

(2) The role of the Court in ordering contact

The question of contact orders by the Children’s Court was considered in detail in our recent Discussion on care proceedings in the Children’s Court (at pages 31-32). Significantly, our conclusion on this issue was as follows:

We recognise that the current arrangements present a challenge to all parties to work in the best interests of children and come up with flexible solutions regarding the important issue of children’s contact with family and other significant people in their lives.

We also acknowledge that there are divergent views about the circumstances in which contact is in the child's best interests and about the extent of contact that is appropriate. We would make several points in relation to this debate.

It is clear that adequate information and further research is needed to inform the debate. In this respect, we note that DoCS has supported the need for further research. It is our view that lack of research in this area makes it difficult to assess the precise nature of and reasons for the perceived flaws in the current system. This in turn makes it difficult to determine whether an overhaul of the current arrangements is required (and, if so, what the changes should be) or whether the approaches employed under the current system might be a better way forward.

In these circumstances, we believe there should be an informed public debate between all of the key players involved, with a view to deciding on a pathway for effectively promoting the maintenance of ties between children and their family – but only where this is clearly consistent with the best interests of the child.

We maintain this position, and consider that the Community Services Discussion Paper would provide a useful platform for “an informed public debate between all of the key players involved”. Whether the collection and consideration of separate submissions from the players in response to the Community Services Discussion Paper is an adequate substitute for a debate of the nature contemplated in our own Discussion Paper is seriously open to question.

Whether or not a decision is made to remove or limit the current role of the Children's Court in relation to the question of the determination of contact, we submit that it is essential to establish what constitutes “good practice” on the issue of contact in the light of evidence-based research, and to introduce appropriate “benchmarks” for the application of such practice.

(3) Managing appeals to final orders for parental responsibility

One practical difficulty in assessing the merits of the options for change canvassed in this section of the Discussion Paper is that, while it is noted that there has been a dramatic case in the number of appeals to the District Court, there is no information provided as to the actual outcome of the appeals and the reasons for those outcomes. In the absence of this information, it is impossible to assess the extent to which these appeals were successful or unsuccessful, whether the decisions of the Children's Court were overturned – particularly its decisions in relation to final orders – and the actual grounds leading to the success or otherwise of particular appeals.

Leaving this problem aside for the moment, it must be said that there will almost invariably be some ground for argument as to the merits or “correctness” of the Children's Court's decision. We can therefore understand the apparent attractiveness of limiting the scope for appeals from decisions of the Children's Court.

However, we would submit that the first option canvassed in the Discussion Paper – that of limiting appeals to those against alleged “errors of law” – is, as a matter of principle, unduly restrictive, given the importance of the issues at stake for children and young people and their families.

The second, more generous, option is that the District Court would only review cases where the appellant could satisfy the Court that a review of the decision would be in the best interests of the child or young person, and that there is the prospect of a significantly different outcome on the basis of the available evidence. The difficulty with this proposal is that the making of submissions on these “threshold” issues level would, in practice, probably take the same or almost as much time as arguing the substantive merits of the case. In those circumstances, there is a real question as to the efficiency and effectiveness of the proposal.

Ultimately, we consider that, while it may be important to eliminate unnecessary appeals, there is not enough information in the Discussion Paper to adequately assess whether – and, if so, how – the basis for appeals from decisions of the Children’s Court should be more limited in scope.

Other matters not raised in the Discussion Paper

Our Discussion Paper on care proceedings canvasses a number of matters that are not specifically raised by the Community Services Discussion Paper, but which we believe warrant further careful consideration. These matters are listed below.

- ***Monitoring and review by the Children’s Court of the suitability of care arrangements (section 82 of the Act)***

See the discussion at pages 29-31 of our Discussion Paper.

We note in particular that the issues canvassed in this section of our Discussion Paper need to be considered in the context of the question raised in the Community Services Discussion Paper about the role and functions of the Children’s Court, and whether and to what extent the functions of the Court should be taken over by a tribunal.

- ***The Aboriginal and Torres Strait Islander principles (sections 11-14 of the Act)***

See the discussion at pages 39-43 of our Discussion Paper – in particular, our discussion at pages 42-43 about the need for the greater participation of indigenous families, kinship groups, representative organisations and communities in significant decisions about indigenous children.

Our conclusions on this issue included the following (at page 43):

... we believe that it is now essential that indigenous communities, government agencies, and other key players work constructively towards facilitating more meaningful participation by indigenous people in strategies for child protection. In this respect, we suggest that there is room for trialling models which involve genuine participation by indigenous representatives in child care and protection decisions, as envisaged by the Act itself. Indeed, we note that this sort of work is being explored in other Australian jurisdictions. This experience could be used for indigenous participation models in NSW.

In this context, we refer to our earlier discussion about ADR, including family conferencing and circle sentencing.

We note that the use of these types of models would also assist in “fleshing out” at a practical level the application of the general principle under section 12 of the Act that indigenous people are to participate in the care and protection of their children with as much self-determination as possible.

- ***Orders for assessment (section 54 of the Act)***

See the discussion at pages 17-19 of our Discussion Paper – in particular, our discussion of the point (at page 18) that section 54 of the Act does not allow for the Children’s Court Clinic to assess short term carers who do not seek parental responsibility.

- ***Orders involving the acceptance of undertakings (section 73 of the Act)***

See the discussion at pages 22-24 of our Discussion Paper – in particular, our discussion (at pages 23-24) about the problems in relation to undertakings given by a person who does not legally have “parental responsibility” for the child or young person, as defined by the Act.

Unproclaimed provisions of the Act

We note that some provisions of the Act have not yet been proclaimed – in particular, those relating to out-of-home care, including voluntary out-of-home care, and compulsory assistance. These matters are not canvassed in the Discussion Paper. It appears to us that there is scope for further discussion of whether and, if so, when the unproclaimed provisions should come into operation and/or when further amendments to the legislation are required or desirable, and the timing of decision-making on these matters.

We trust that the above submissions are of assistance.

If the Secretariat and/or officers responsible for considering the submissions wish to discuss any aspect of our submissions, they are welcome to ring the Deputy Ombudsman and Commissioner for Community Services, Mr Steve Kinmond, on 9286-0989 or myself on 9286-1001.

Yours sincerely

Bruce Barbour
Ombudsman

NSW OMBUDSMAN ANNUAL REPORT 2006-2007

Question

Proactive projects

Can you provide the Committee with more detail on the mystery shopper audits that were conducted into DADHC customer service provision? Please include an overview of the results of the audit in your response (page 17 AR 06-07).

Answer

The DADHC audit was one of a series of audits of customer service standards in the NSW public sector conducted by the NSW Ombudsman. We have previously audited aspects of the work of the Roads and Traffic Authority, RailCorp, Sutherland Shire Council, Baulkham Hills Shire Council and the Government Information Service amongst others.

The aims of these audits are:

- To assess the standard of frontline customer service at selected public authorities whose core business involves a high level of customer/client contact.
- To highlight any deficiencies in the level of customer service provided by these authorities.
- To report and make recommendations for improvement in any case where the level of customer service is considered to be seriously deficient, unreasonable or discriminatory.
- To provide general feedback to the agencies sampled.
- To motivate public sector staff to provide high levels of customer service and a long-term maintenance of customer service standards.

Methodology

In conducting the audits the NSW Ombudsman uses a standard methodology based on 'mystery shopper' principles.

The quality of customer service offered by an organisation can be measured by a set of five general dimensions or criteria that people use to make judgements about the quality of service provided. These are:

- Reliability: the ability of the organisation to perform its promised services dependably and accurately.
- Responsiveness or promptness of service: the willingness of the organisation to help its customers/clients and provide prompt service.
- Assurance: the knowledge and courtesy of the organisation staff and their ability to convey trust and competence.
- Empathy or customer focus: the caring, individualised attention the organisation provides its customers/clients (expressed through its accessibility, style of communication and understanding of the customer/client).
- Tangibles: appearance of the organisation's physical facilities, equipment, personnel and communication material.³

³ Zeithaml, the: Parasuraman, A & Berry, L (1990) Delivering Quality Service, Free Press, New York.

As far as possible, our audit methodology samples a number of objective measures of these constructs to provide an overall insight into the quality of customer service provided by the Department agency. Mystery challenges were designed for the four main avenues through which customers communicate with DADHC, ie, face-to-face, by telephone, by letter and by email.

We determined to spread the tasks between three DADHC offices:

- the Northern Region office in Lismore
- the Western Region office in Dubbo
- the Metro North Region office in Parramatta

These offices were chosen to allow for an evaluation of DADHC's work across the state, in particular the delivery of services from the regional offices.

Staff in the General Team of the Ombudsman's Office coordinated the audit. Given many staff in the Community Services Division (CSD) are known to DADHC staff, and have ongoing relationships with staff in relation to our work, the CSD's staff did not participate in the actual implementation of this audit. The mystery customers were drawn from other staff of the Ombudsman who represented a mix of gender, ages and ethnic origin in order to mirror the variety of customers with whom DADHC would deal.

CSD staff, however, wrote the mystery shopper scenarios because of their intimate knowledge of DADHC's functions and services. . The scenarios used for making information requests or other service transactions were based on genuine complaints made to the Ombudsman about DADHC, and on material provided by DADHC about its services including DADHC's webpage. The service requests were limited to the provision of relatively straightforward information that should have been readily at hand and did not involve any unreasonable expenditure of time or physical resources on the part of DADHC.

The primary aim of the mystery shopping exercise is to motivate agency staff to provide high levels of customer service and the long-term maintenance of customer service standards. The report to DADHC therefore provided feedback for the staff of DADHC on how its customer service performance is likely to be perceived by typical customers.

The audit was not an in depth evaluation of DADHC's organisational performance but used a randomly timed 'critical incidents' data collection methodology to provide a snapshot of its general standard of customer service. The audit was conducted between 15 March and 31 May 2007 and involved 88 separate customer/agency interactions consisting of 51 telephone calls, 16 letters, 18 email challenges and three visits to local offices.

How the audit was conducted

Telephone

A total of 51 phone calls were made to the three DADHC offices between 21 March and 31 May. There were 18 calls to Western Region, 16 calls to Northern Region and 17 calls to Metro-North Region (Parramatta). Ten scenarios were put to each regional office by ten different staff members to test consistency of advice given. An additional 21 individual

scenarios were put to only one office— eight of these calls went to Western Region, six to Northern Region and seven to Metro-North Region.

Correspondence

We tested DADHC's service provision in response to written correspondence by sending 16 mystery customer letters over the period 4 March 2007 to 20 April 2007. The letters covered a variety of issues handled by DADHC, including some matters related to DADHC's work but that were outside DADHC's jurisdiction. The letters were sent to the three regional offices. All letters are sent from the one post office box to ensure the most consistent delivery times to the agency.

Emails

We sent 18 emails to the DADHC email address 'info@dadhc.nsw.gov.au'. This email address was obtained from the 'Contact DADHC' link from the DADHC website homepage.

Regional office visits

Because two of the three regions used for this audit were outside the Sydney metropolitan area, we determined to visit each office on only one occasion. We conducted a simple assessment of each office using a standard audit tool. Staff visited the DADHC office when attending the area for other duties.

Summary observations

Telephone contact

Performance in regard to telephone contact was mixed. DADHC staff performed well in regard to the manner in which they provided information, and the accuracy and completeness of their responses. DADHC staff dealt with the majority of telephone scenarios well and deserved praise for their handling of the matters. A number of mystery shoppers noted their particular appreciation of the service of a range of officers and DADHC staff should be commended for this. The difficulties experienced by our mystery customers were not related to the overall quality of advice given.

We believe best practice inquiry handling involves the first contact person being able to answer the majority of enquiries, and referring a caller to another person only if he or she presents a problem that cannot be answered by the initial officer. In this regard DADHC performed poorly. Even accounting for the problems in accessing the Information Referral and Intake (IRI) service at Western Region and Metro North (due to an incorrect phone number and a phone number inaccessible from mobile phones) this objective was poorly met. On numerous occasions messages were taken for calls to be returned. There were sometimes delays in this occurring and on other occasions our callers had to play phone tag before they could speak to the appropriate staff member.

We reported to DADHC that they urgently needed to address their telephone contact and information provision processes. It is worth nothing that if DADHC is able to improve the reception and allocation of telephone inquiries, the good work already done by staff providing advice will be improved by the ease of experience of customers.

Service provided by correspondence

In responding to written correspondence DADHC's timeliness was commendable. Responses were received on average in less than two weeks, save two letters that were not responded to. However, it was a concern that 42 per cent of the letters provided information that was incomplete or where one or more aspects of the inquiry were not addressed. Our report to DADHC suggested staff should be reminded to provide full responses and ensure they respond to all aspects of the letter.

While the format of letters was relatively standardised, a few responses were in the form of hand written notes. We further suggested that DADHC should consider whether a standard format for responses should be required.

Service provided by email

While DADHC's response to the emailed inquiries was prompt – and the response time was never longer than 8 days – some concerns about the processes used to respond to emails have been identified. DADHC does not usually answer emailed inquiries directly, responding by asking the client to call their IRI service. We observed:

- People may be emailing DADHC because it is easier for them to do this rather than contact DADHC by phone.
- Some people may be unable to phone DADHC, or be uncomfortable doing so, and potentially this may be related to a disability.
- It seems appropriate that initial general advice is provided via email, even if the person is asked to contact DADHC for further information about the matter they have raised. This is the process followed at the Ombudsman's Office, even if the only information that can be provided is whether the matter is one the office can assist with and to request further specific details via email.
- That while it appears to a visitor of the website that DADHC will respond to inquiries via the 'info' email address, this appears not to be the case and emailers are asked to make their inquiries by phone.
- There may be email addresses available for regional office IRI units, but these are not provided on the website.

We suggested DADHC review the results of this audit and consider:

- Whether management of email inquiries requires a change to procedures to ensure customers who contact DADHC by email can receive information about services in the same manner.
- Whether regional office IRI direct email addresses should be provided on the website and how local offices will manage responses.

Local Office visits

We visited each office involved in the audit. The layout and cleanliness of the offices was thought to be appropriate by all mystery customers. The availability of information in the Western and Northern Region offices was appropriate, however there did not appear to be any written material available at the Metro North Region office in Parramatta. It was also

concerning that the staff member at this office was unable to provide a Seniors Card application form.

We asked our mystery customers to assess disabled access and the visitor to the Dubbo office observed that the button to call staff to the front counter if it was unattended was at a height that may make it difficult for a person in a wheelchair to reach. We suggested DADHC immediately assess the location of the buzzer office to ensure it can be observed and used by all customers.

Signage at the office varied, partly because DADHC is not the sole tenant in the building. We asked DADHC to assess whether external signage is possible at all regional office locations. We believe this would ensure potential visitors are not confused as to where the office is located when, as is the case in Lismore, the building external signage indicates another organisations presence.

Response from DADHC

On the whole the feedback from DADHC regarding the audit was positive. The agency agreed to a number of the suggestions made by our office and advised the following outcomes/changes as a result of the audit report:

General

- Our comments about incorrect phone numbers and providing regional office emails addresses have been forwarded to the web development team for consideration as part of a redevelopment taking place over the next 12 months.
- Corporate communications are checking regional office details and obtaining local office email contacts.

Metro North Region

- Metro North corrected their phone number on the website.
- Metro North agreed to provide further staff training to ensure information provided is helpful and appropriate. There is ongoing training in relation to providing accurate and complete advice.
- Metro North has advised all staff returning calls to apologise for any delay in responding.
- Metro North has prepared a template letter to be used for all written responses.
- There will be a leaflet rack installed outside the DADHC office in Parramatta.

Northern Region

- Northern Region commented that the audit feedback was very useful in assisting them to review customer service standards.
- Northern Region advised they will train all new reception staff in the basic information callers might ask.
- Northern Region has recently appointed an additional IRI staff member and installed three additional outgoing phone lines. A review of messages given will be undertaken.
- An internal review of correspondence was undertaken in May 2007 and as a result Northern Region has instituted a system of registering, tracking and checking correspondence to ensure quality.

Western Region

- Western Region updated its phone number on the website, and included a number that can be called from mobiles as well as an email address.
- Western Region is reviewing their signage.
- Western Office will address the location of the front desk buzzer when a major refit is conducted in the 2007/2008 financial year.

However, DADHC did not agree with our suggestion that they provide advice to inquiries via email and not require the person to contact them by phone. DADHC do not believe emails queries should be responded to by email as general practice, and they appear to want to continue their reliance on the telephone service.

IRI staff do not have voicemail and are advised not to leave their name when returning a call, this is so anyone can answer an inquiry if the call is returned. We made comments about the reception and allocation of calls. DADHC advised they believe that the reception and allocation of calls is appropriate to ensure people get spoken to as quickly as possible.

Western Region believed it is appropriate when responding to letters to ask the person to telephone the IRI service, rather than responding to the inquiry in writing.

DADHC did raise a concern with the Ombudsman about one particular scenario we used. It appears this scenario created some work for a DADHC staff member, who attempted to locate the caller in DADHC databases in order to take action on their query. This was unintended as the scenario was purposely written with incomplete information in an effort to prevent such action. The Ombudsman advised DADHC that every effort is made to ensure minimal disruption to an agency and apologised this was not achieved on this occasion.

Question

Chapter 1: Corporate Governance

What were the main outcomes of the consultant's review of community service complainants and other stakeholders (page 23 AR 06-07)?

Answer

In May/June 2007, we engaged independent consultants, ARTD, to develop a client satisfaction framework for the Community Services Division (CSD). The framework involved surveying formal and informal complainants, child and family and disability peak agencies, community service providers and Official Community Visitors (OCVs) to ascertain their level of satisfaction with their involvement with us.

The sample group for the pilot involved 46 formal complainants, 23 informal complainants⁴, 22 peak agencies, 3 community service providers and 9 community visitors⁵.

⁴ Formal complaints are usually in the form of a written complaint or notification and generally lead to follow up or intervention with a service provider. Informal matters generally do not lead to such follow up and in some cases the issues are not within our jurisdiction.

Stakeholder views were sought about:

- accessibility and helpfulness
- timeliness – whether we promptly consider matters brought to our attention
- referral to appropriate organisations – when we are unable to handle matters, whether we explain why and identify other appropriate organisations that may be able to provide assistance
- fairness and impartiality
- transparency of our actions, and
- service system solutions and improvements – whether we seek solutions and improvements that will benefit the broader community.

Overall, a high proportion of complainants were positive about their interactions with us.

However, while generally positive about how we handled their complaints, only 40% of complainants ultimately reported that they were satisfied with the outcome of their complaint. Therefore, not surprisingly complainant satisfaction relates directly to the percentage of formal complaints that are resolved.⁶

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

With regard to helpfulness, 98% of complainants said that the person that they mainly dealt with within our office was courteous; 75% said the person understood their concerns; 78% said the person was competent to deal with their concerns and 87% said they listened to their concerns.

74% of complainants said that we dealt with their complaint within a reasonable timeframe.

⁵ With regard to the sample, the consultants noted: "In our view, the collected data provides a reliable snapshot of satisfaction among clients of the (CSD). However, due to the relatively small sample sizes the complainant responses should be treated cautiously." This was explained to be due to the following: "Assuming 600 formal complaints per year, the confidence intervals are about + 13%. Also because not all complainants could be contacted or agreed to participate, there may be some selection bias."

⁶ Complaint outcomes: In 2006-07 the CSD resolved or made recommendations for service improvements to services in 54% of the 569 formal complaints finalised during the year. Between 1 July and 31 December 2007 the CSD finalised 308 formal complaints. We resolved 144 (47%) of these complaints. In 2006-07 we resolved 243 (43%) of 569 finalised formal complaints. The CSD defines 'resolution' as an improvement in the service provided to the complainant and/or person subject of complaint. In our annual report, we report also on a performance indicator – we aim to resolve and/or suggest and recommend improvements to services in 50% of finalised formal complaints. This performance indicator is comprised of the number and proportion of total complaints resolved (47% year to date, as noted above) and the number of suggestions and recommendations for service improvement we make following complaints and direct investigations. We are unable to provide details about the latter at this time, as we are still developing reports in our new data base. However we will report about both complaint resolutions and service improvement suggestions and recommendations in the forthcoming annual report.

Answers to Questions on Notice

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

78% of complainants indicated their belief that we were fair and impartial in dealing with their complaint. The consultants said this figure was strongly associated with complainants' satisfaction with the outcome of their complaint - all those satisfied with the outcome of their complaint believed we were fair and impartial, while just over half of those who were dissatisfied with the outcome of their complaint held this view.

70% of complainants agreed that actions and decisions about their complaint were adequately explained to them and 65% felt they were kept informed about the progress of their complaint.

In relation to service system solutions and improvements, the consultants noted that most of our work in this area falls outside our complaint handling function. However, 21% of complainants reported that our work in connection with their complaint had led to system-wide improvements for service receivers.

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

Peak agency stakeholders in particular, had an improved perception of the CSD's engagement with the sector in recent years. In particular:

- 89% of peak agencies either found the Ombudsman's Office very accessible (74%) or somewhat accessible (16%);
- 100% of the peak agencies believed the Ombudsman's Office was accessible to complainants;
- All peak agencies believed the Ombudsman's Office is impartial in dealings with complainants, and almost all (94%) believed the office's dealings with complainants was consistent;
- Peak agencies were very positive about the CSD's engagement with the sector and felt it was contributing to solutions (to issues and problems in the sector). In particular, peak agencies commented positively about their access to, and the responsiveness of, senior CSD staff, and the awareness of CSD staff about key issues affecting the sector;
- Some peak agencies commented that, since the merger of the Community Services Commission with the Ombudsman, the CSD has improved its engagement with the sector, including better engagement about Indigenous matters.

All but one of the OCVs surveyed agreed that the CSD contributes to systemic service delivery improvements for service residents. OCVs were also very positive about the services they receive from the Ombudsman's Office, including our visiting allocations, support for travel and accommodation, and induction and training.

Question

How will the work undertaken by the independent contractor on the development of data classification systems impact on the reporting of issues identified by official community visitors (page 25 AR 06-07)?

Answer

The OCV data classification system will:

- increase the consistency of OCV reports about service issues
- introduce a risk prioritisation framework, enabling OCVs to better identify and report service issues that:
 - directly or potentially impact on the safety, care or welfare of residents of visitable services and require prompt or urgent action by services
 - affect the quality of life of residents and/or relate to a service's systems, policies or procedures
- enable OCVs to better report service issues against relevant disability and out-of-home care service standards
- enable better analysis and reporting on service issues and trends.

Question

Can you provide the Committee with details on how the budget for the four program areas of Police, General, Child Protection and Community Services are calculated (Figure 7 on page 28)?

Answer

We receive funding by way of a parliamentary appropriation. All funds are allocated to the Office and the Ombudsman has the flexibility to allocate his funding internally, subject to public sector financial and budgeting legislation, policies and guidelines.

For State Budget reporting purposes, the Ombudsman has four programs – Police, General, Child Protection and Community Services. Internally we allocate funding between our four business units and our corporate team.

Because of our increasing workload, the internal allocation of funding is based around maintaining, if possible, our staffing levels. This is becoming increasingly difficult particularly as we have had to absorb a number of unfunded pay increases awarded to public servants. We have also had to absorb budget cuts or 'savings initiatives' that have been applied to all public sector agencies. Since 2002-2003, the cumulative impact of the 'saving initiatives' for 2007-2008 alone is over \$1.2 million.

Approximately 78% of our expenses are employee related, which includes salaries, superannuation entitlements, long service leave and payroll tax. The remaining 22% relate to the day-to-day expenses of running of our office, which include rent, fees, travel, maintenance, depreciation and training.

Answers to Questions on Notice

Internal budgeting and the allocation of resources commence in March/April when the Ombudsman receives details of his allocation for the next financial year. The amount provided is allocated as follows:

1. Official Community Visitor (OCV) scheme, which we administer on behalf of the Minister for Community Services and the Minister for Ageing and Disability Services. We have maintained the level of funding for this program since the Ombudsman took over responsibility for its administration in 2002. The OCV program is included in the community services program.
2. Our legislative review function. Funding has been specifically provided for this purpose. The legislative review program is included in the police program.
3. Our fixed operating expenses such as rent, electricity, maintenance, insurance, as well as some whole of office items such as stores and printing. The internal allocation in these areas is based on expenditure in previous financial year as well as making provision for any known increases/decreases in costs or in our use.
4. Some of our discretionary operating expenses such as travel and training. The allocation for most of these items is relatively small.
5. Salary costs of the Ombudsman, Deputy Ombudsman and Assistant Ombudsman
6. Salary costs of designated whole of office positions – which have been agreed require full funding eg Youth Liaison Officer and Aboriginal unit positions
7. Salary costs for the remainder of our positions. The allocation of salary and other employee related expenses to the business areas and to corporate is based on our approved establishment levels. If there is insufficient funds to cover our established positions, each business area and corporate will commence the financial year projecting a deficit.

Question

Chapter 4: Police

The Annual Report notes that the deficiencies identified by the Ombudsman in police investigations were remedied in 84% of cases (page 53 AR 06-07). What happened in the remaining 16% of cases?

Answer

As the Annual Report indicates, the substantial majority of complaint investigations conducted by NSW Police Force (NSWPF) are satisfactory.

In circumstances where the Ombudsman is not satisfied with the investigation undertaken or management action proposed, the Ombudsman may make a request for further action pursuant to sections 153 and 154 of the Police Act 1990. The Commissioner of Police or his delegate is not required to comply with the Ombudsman's request. However, as reported, most of the time deficiencies were identified in investigations reviewed during 2006/2007, action was taken to remedy the matter in response to the Ombudsman's request (84% of matters).

In those matters where no action is taken in response to a request from the Ombudsman, the following processes are implemented:

- The matters are referred for review by the Assistant Ombudsman (Police) to determine whether the reasons provided by NSWPF for not acting upon the Ombudsman request are reasonable. Considerations at this point include the nature of the complaint, the investigation or management action already undertaken, the time since the alleged conduct occurred and whether any further action is likely to result in a different outcome. This review may result in a further request to a more senior officer within NSWPF, either in writing, verbally or through a meeting.
- In some circumstances, the Ombudsman may determine to prepare a report about the matter pursuant to section 155 of the Police Act, including the failure of NSWPF to comply with a request. These reports are provided to the Minister and any complainant, in addition to the Commissioner.
- A third option in appropriate circumstances, is for the Ombudsman to undertake an investigation under the Ombudsman Act 1974 to explore both the police investigation of the complaint matter, and the reasons for any failure to comply with a request made by the Ombudsman. At the conclusion of any investigation a report is prepared and provided to any complainant, the Minister and Commissioner.

Examples of matters the subject of investigation and/or report by the Ombudsman in 2006/2007 include:

- An unsatisfactory investigation of a complaint about the conduct of police officers when executing a search warrant at licensed premises.
- A substantial delay by NSWPF in responding to concerns raised by the Ombudsman about the investigation of adverse judicial comments about police officers made during court proceedings against the complainant.
- A failure of police to properly investigate a complaint of improper strip searching following a drug detection dog indication.
- A failure by police to properly investigate allegations of alleged detrimental action taken against an internal police complainant.
- A failure by police to properly investigate allegations that certain officers had received stolen goods.
- A failure by police to properly deal with matters arising from a police pursuit which ended when the pursued vehicle collided with an oncoming heavy vehicle.

Question

The auditing of 24 deficient investigations led to a change in outcome in nine matters as a result of further investigation by police (page 61 AR 06-07). What happened in the remaining 15 cases? Were any potentially systemic issues uncovered?

Answer

Since the completion of the Ombudsman's annual report, we have improved our arrangements for monitoring the outcome of matters where concerns have been raised by the Ombudsman about the quality of the police investigation or management decisions resulting from the investigation. Our most recent audit for a period from July to October 2007, reviewed 41 matters which were determined by the Ombudsman to be unsatisfactory.

Similar to the matters identified in the Annual Report, the common issues arising included the failure to identify key issues or to pursue a relevant line of inquiry. Other common areas where police investigations were not satisfactory included delays affecting the quality or availability of evidence, the failure to plan or use appropriate investigative strategies, the failure to obtain further information from or interview the complainant and the failure to identify and address policy and procedural issues.

Of the 41 matters audited, there were 16 complaints where outcomes changed as a result of Ombudsman oversight. Systemic issues addressed included a review of CCTV standard operating procedures, the provision of proper instruction regarding strip searches in operational briefings involving the use of drug detection dogs and the reminding of police officers within a command of NSWPF policies concerning the acceptance of gratuities. In other matters, findings were revised, management action altered and proper procedures applied to ensure fairness to police officers.

The fact that an investigation is unsatisfactory and steps are taken to remedy the investigation, will not of itself mean that a different outcome is achieved. However, it is only through proper investigation of issues that the correct outcome can be attained with any certainty. For serious matters the pursuit of every reasonable line of inquiry is necessary. Where these inquiries are not undertaken by NSWPF, the Ombudsman will raise them, not with the view to achieve a changed outcome, but to ensure that the right conclusions are reached with the requisite degree of certainty. Sometimes these further investigations will result in additional evidence either in favour of or against the allegation made.

The Ombudsman proposes to continue with our auditing of deficient investigations, both to identify in an ongoing manner trends around deficiencies with the view to improving police practice in the long term, and to record systematically those matters where deficiencies raised have resulted in altered outcomes.

Question

Following from the Ombudsman's investigation into misconduct at the Police College in August 2006, NSW Police Force established an inquiry lead by Ms Chris Ronalds SC (page 61 AR 06-07). One of Ms Ronald's recommendations was to establish a specialist unit for dealing with sexual harassment and discrimination. The Commissioner for Police announced the establishment of a specialist workplace equity unit in June 2007. Have NSWPF implemented the rest of Ms Ronald's recommendations?

Answer

Ms Ronalds' inquiry into sexual harassment and discrimination in the NSWPF made 79 recommendations, and resulted in the creation of a Steering Committee charged with developing an action plan to address the recommendations. Four working parties, including one focusing on the complaints system and investigations, were convened to make recommendations to the Committee. As noted in the Annual Report, the Ombudsman participated in the complaints working party, convened in March 2007. Since that time, in August and September 2007 Ombudsman staff have received briefings on possible processes to improve the management of harassment and discrimination complaints. Most recently we have met with the manager of the new Workplace Equity Unit to provide comments on draft guidelines.

Throughout these discussions, we have indicated a willingness to consider amended arrangements to deal with police complaints involving harassment and discrimination to facilitate proposed new police processes to deal with these matters. In January 2008, following our contact with the Workplace Equity Unit, we were advised that amended guidelines would be provided to our office in the very near future.

We have not been fully briefed on the progress of other recommendations arising out of Ms Ronalds' review. We understand that a number of positions in the Workplace Equity Unit remain unfilled as at January 2008, and that new complaint procedures are yet to be finalised. We are presently writing to NSWPF seeking a further update as to the progress of these procedures, and full advice as to the implementation of other recommendations arising from Ms Ronalds' review.

Question

The Annual Report notes on page 62 that NSWPF have been using the Complaint Allocation Risk Appraisal (CARA) system to determine if a complaint should be managed locally or allocated to another command since 1 March 2007. A joint evaluation of CARA by the Police Integrity Commission, the Ombudsman and NSWPF has been planned. When will this assessment take place?

Answer

A schedule for the joint audit of CARA was proposed in November 2007. The Ombudsman provided, and PIC and NSWPF agreed to, an audit tool in December 2007. The PIC also selected relevant matters to be the subject of audit in December 2007. A meeting between agencies is proposed for late January 2008, and the audit proposed to be undertaken in February 2008. Matters being examined in the audit include:

- whether risks associated with allocating a complaint to a particular command for investigation were identified
- if so, were appropriate steps taken to deal with those risks?
- whether CARA asks the right questions to deal with any conflict issues in complaint allocations.

Question

How is the implementation of electronic notification of new complaints from police progressing (page 63 AR 06-07)?

Answer

From 12 September 2007 all new complaints from NSWPF have been provided to the Ombudsman electronically, and hardcopy notification of new complaints has been dispensed with. Appropriate business arrangements to ensure safeguards should the electronic notification system fail, and to provide appropriate security for the transfer of information have been settled.

Answers to Questions on Notice

We are presently finalising a trial of electronic notification of police complaint investigation reports, which is in its final stages of review and approval. We envisage that in the near future hardcopy provision of police investigation reports will also be dispensed with.

We note that while these arrangements have some resource impacts upon our office, they are further evidence of our commitment to ensure an appropriate and efficient working relationship with NSWPF in undertaking our oversight of police complaints and investigations.

Question

Following the release of the Ombudsman's special report on domestic violence in December 2006, the Ombudsman made 44 recommendations to NSWPF. The Annual Report notes that NSWPF accepted the majority of the recommendations (page 64). Which recommendations were not accepted, and why? What progress is NSWPF making in implementing those recommendations that were accepted?

Answer

Two recommendations were not accepted:

23a. NSW Police and DoCS develop a shared risk assessment model that will assist in alerting either agency about children and young people at risk of harm, particularly in situations of domestic violence

NSWPF response:

"There is a jointly funded initiative between NSW Police Force, Dept of Health and Dept of Community Services to develop an interagency risk assessment tool. Dept of Health is responsible for driving this project. There are no plans to develop any other risk assessment models for NSW Police.

Also relevant to this recommendation is that from 29 January 2007, mandatory reporters will be required to complete the DoCS Helpline standardised fax form if they are unable to access the Helpline by phone when reporting a child at risk of harm. This fax form has a section titled 'Safety Concerns', which required the person making the report to provide details regarding any concern for safety or welfare of a child if there are issues of domestic violence.

This form – designed in consultation between DoCS, NSW Police and external stakeholders – provides a standard format for fax reporting of children at risk of harm. The fax form will be placed on the NSW Police Intranet after DoCS have been advised of the Commissioner's formal endorsement of the form."

34. NSW Police develop a risk assessment model to guide the decision-making of police in responding to individual domestic violence incidents, and require LACs to utilise it.

NSWPF response:

“There is a jointly funded initiative between NSW Police Force, Dept of Health and Dept of Community Services to develop an interagency risk assessment tool. Dept of Health is responsible for driving this project. There are no plans to develop any other risk assessment models for NSW Police.

There have been modifications on COPS to ensure certain details are obtained at the incident. The work from Education Services – Domestic Violence Project would inform any future changes in police practice.”

Ombudsman comment

The Attorney General’s Department, NSW Health, DoCS and the NSWPF are financial partners in a project to develop a domestic violence Cross Agency Risk Assessment Tool (CARA). The CARA is intended to provide an integrated and consistent service response to domestic violence and facilitate cross-agency communication on individual cases of domestic violence. The CARA will be developed over the next 12 months and will then be trialled for a 12 month period.

The Deputy Ombudsman (Community Services) and the Cross Agency Team Manager have been invited to attend a meeting of the CARA Reference Group on 4 February 2008 to brief them on the background to our recommendations, as well as the relevance of this tool to previous recommendations made in our annual reviewable child death reports.

Additionally, NSWPF is cooperating with DoCS on a DoCS-led project that is examining strategies to enhance the quality of information communicated between NSWPF and DoCS in relation to children at risk of harm.

In August 2007 NSWPF advised that it had established an internal working party to consider strategies to:

- improve compliance with risk of harm reporting requirements
- improve the quality of the police response to children at risk of harm
- provide police with better information and support in relation to managing children and young people at risk of harm and working with other agencies
- implement a more systematic, focused approach in LACs relating to children at risk of harm.

Police are now required to use the standardised fax form referred to by NSWPF in their response to recommendation 23a.

NSWPF progress – implementation of supported recommendations

NSWPF established a Domestic and Family Violence Working Party in May 2007 to progress the implementation of the recommendations of our report, as well as relevant State Plan commitments. The Working Party is divided into four working groups: Legal; Human Resources; Education; and Standard Operating Procedures and is overseen by a Steering Committee which meets monthly. Ombudsman officers attend Steering Committee meetings and provide feedback where appropriate. The anticipated date of completion for the implementation project is June 2008.

Answers to Questions on Notice

The solid progress made by the steering committee and its working parties in implementing the recommendations of our report is commendable. In particular, the significant work undertaken to revise the *Domestic and Family Violence Standard Operating Procedures* and reform the program of domestic violence training provided to police officers. Also noteworthy, is the progressive rollout of domestic violence evidence kits which commenced as a result of the Premier's announcement earlier this year to fund this initiative, which we recommended in our report.

Our Cross Agency Team Manager met with police representatives recently to progress two of our key recommendations, namely the development in 2008 of a domestic and family violence good practice monitoring framework and code of practice. So far, the remaining recommendations are being progressed in accordance with agreed timeframes in the implementation plan.

The provision of additional funding by the Department of Community Services for an additional five positions within the Commissioner's Inspectorate to focus on domestic and family violence, including a prosecutions coordinator position, will strengthen the capacity of the NSWPF to respond in a strategic way to domestic and family violence. At this stage, we are confident that with increased resources, the NSWPF is also well placed to continue implementing the recommendations of our report.

Question

In relation to the Ombudsman's review of police pursuits, the Annual Report states that NSWPF accepted 23 of the 29 recommendations (page 64). What reasons were given for not accepting six recommendations? The Annual Report also notes an apparent lack of progress in implementing the recommendations. Have NSWPF given any reasons for the lack of progress? Have they moved to implement any of the recommendations?

Answer

The recommendations made in our investigation into compliance by NSWPF with the Safe Driving Policy, and not accepted when first made, primarily related to the following three areas:

- We recommended enhanced procedures to enable VKG staff to report concerns about a pursuit. Police advice was that the current procedures were sufficient for concerns to be raised. Our own view was, and remains, that these arrangements could be made clearer.
- We recommended NSWPF review data capture for pursuits, to enable data about charges laid at the time of arrest to be collected. This data is critical to any cost benefit analysis to the community, and to NSWPF, of the decision by police officers to engage in pursuits in circumstances other than where serious crime has been identified. More recently, NSWPF have agreed to examine the option of conducting an analysis of a sample of pursuits to assess the value of capturing this data on an ongoing basis.
- We recommended amendments to both the Safe Driving Policy and In Car Video (ICV) standard operating procedures to encourage increased use by commanders and supervisors of ICV footage to review pursuits, especially in circumstances where they

suspected pursuits may not have complied with the Safe Driving Policy. The police advice was that the current procedures, where ICV was obtained through the Highway Patrol Supervisor and access to the footage was detailed through the standard operating procedures, should remain. Most recently, during our meeting with NSWPF in December 2007, it was agreed that this issue would be reconsidered, especially regarding the provision of ICV where a breach of the Safe Driving Policy is suspected.

A number of our recommendations are to be addressed in the current review of the Safe Driving Policy, due for completion by December 2007. We have recently sought advice as to the progress of this review.

Our recommendations as they relate to training will be affected by the current benchmarking exercise being conducted by NSWPF in relation to driver training which has followed our investigation.

We are receiving quarterly reports on the implementation of our recommendations. We are closely monitoring these, and examining in detail information provided and supporting material relevant to our recommendations. While we remain concerned at the progress of implementing our recommendations, there are a number of reviews on foot as a result of our report which, dependant upon their outcome, may facilitate the implementation of our recommendations and other improvements to the conduct of pursuits by NSWPF. In due course, if we remain concerned about the general progress of NSWPF, we will consider what further action is required to ensure appropriate responses to the issues raised in our investigation.

Question

Chapter 5: Covert Operations

The Annual Report notes at page 70 that amendments made in 2006 to the Commonwealth Telecommunications (Interception and Access) Act 1979 included provision for the interception of communications of an innocent third party known to communicate with a person of interest. They also provided for stored communications warrants which allow law enforcement agencies to lawfully access through covert means emails, SMS and voicemail messages. The Annual Report further notes that the failure over recent years to amend the Telecommunications (Interception) (NSW) Act to keep it up to date with the Commonwealth legislation means that the Ombudsman does not have the power to monitor how agencies use these new interception powers.

Are these new interception powers widely used by law enforcement agencies? Is any other monitoring of how these powers are used done by any other agency? Does the Ombudsman consider this outdated legislation to be a problem?

Answer

It is still too early to tell exactly how often interception agencies will use "B" party warrants and stored communication warrants as these extensions of interception powers are relatively recent, only taking effect from 1 July 2006 and 13 June 2006 respectively. As such, the 2006-2007 period is the first full reporting period in which agencies have obtained "B" party warrants and stored communications warrants. However, there is no currently available public information on the use of these types of warrants for the 2006/07 period.

The Commonwealth Attorney General publishes an annual report on the operation of the *Telecommunication (Interception and Access) Act 1979* ("the Commonwealth Act"). The latest available report is for the period ending 30 June 2006.

During our most recent inspections we have noted that NSW agencies have obtained "B" party warrants and stored communication warrants but they represent a very small percentage of total warrants. The inspection function under the legislation does not require the inspection agencies to distinguish between the types of warrants issued except in relation to named person warrants. The Commonwealth Ombudsman is the responsible inspection authority in relation to stored communications warrants so statistical information about those types of warrants should also become available. Stored communications warrants are unusual. Although they are called warrants, they are essentially one off access documents which only last for 5 days and there is a period of 3 days following in which a new warrant can't be issued. They are designed to access information leading up to the possible issue of a telecommunications interception (TI) warrant. This information was previously available to agencies under the Telecommunications Act

The incidence of the use of telecommunication interception powers can be gleaned from the following information. The data comes from the Commonwealth Attorney General's Annual Report under the *Telecommunications (Interception and Access) Act 1979* for the period ending 30 June 2006 and contains historical data for two previous years.

Table 1 Applications for telecommunications interception warrants

AGENCY	RELEVANT STATISTICS	APPLICATIONS FOR WARRANTS		
		03/04	04/05	05/06
AUSTRALIAN FEDERAL POLICE	Made	671	647	514
	Refused/withdrawn	11	0	2
	Issued	660	647	512
AUSTRALIAN CRIME COMMISSION	Made	390	261	202
	Refused/withdrawn	0	0	0
	Issued	390	261	202
NEW SOUTH WALES CRIME COMMISSION	Made	827	798	835
	Refused/withdrawn	3	3	2
	Issued	824	795	833
INDEPENDENT COMMISSION AGAINST CORRUPTION	Made	31	58	17
	Refused/withdrawn	0	2	0
	Issued	31	56	17
NEW SOUTH WALES POLICE	Made	470	422	543
	Refused/withdrawn	7	1	0
	Issued	463	421	543
POLICE INTEGRITY COMMISSION	Made	62	59	52
	Refused/withdrawn	0	0	1
	Issued	62	59	51
SOUTH AUSTRALIA POLICE	Made	126	86	140
	Refused/withdrawn	0	0	0
	Issued	126	86	140
VICTORIA POLICE	Made	269	358	352
	Refused/withdrawn	0	0	0
	Issued	269	358	352
WESTERN AUSTRALIA POLICE	Made	182	180	199
	Refused/withdrawn	4	0	0
	Issued	178	180	199

AGENCY	RELEVANT STATISTICS	APPLICATIONS FOR WARRANTS		
		03/04	04/05	05/06
WESTERN AUSTRALIAN ANTI-CORRUPTION COMMISSION	Made	22		
	Refused/withdrawn	4		
	Issued	18		
CORRUPTION AND CRIME COMMISSION OF WESTERNAUSTRALIA	Made	9	20	79
	Refused/withdrawn	2	0	0
	Issued	7	20	79
TASMANIA POLICE	Made	---	0	1
	Refused/withdrawn		0	0
	Issued		0	1
TOTAL	Made	3059	2889	2934
	Refused/withdrawn	31	62	5
	Issued	3028	883	2929

The Commonwealth Attorney General's report contains data about named person warrants, which are a subset of the warrants detailed in Table 1. The following table details the number of named person warrants and services intercepted by the four eligible NSW authorities for the same periods.

Table 2 Named person telecommunication interception warrants

Agency	Relevant statistic	Numbers		
		03/04	04/05	05/06
NSW Police	Warrant applications made	16	13	12
	Refused/withdrawn	0	0	0
	Issued	16	13	12
	Renewal applications issued	2	2	2
	Total number of services intercepted#	47	32	40
NSW Crime Commission	Warrant applications made	25	36	41
	Refused/withdrawn	0	0	0
	Issued	25	36	41
	Renewal applications issued	9	9	9
	Total number of services intercepted#	104	184	88
Police Integrity Commission	Warrant applications made	3	5	0
	Refused/withdrawn	0	0	0
	Issued	3	5	0
	Renewal applications issued	0	0	0
	Total number of services intercepted#	14	8	0
Independent Commission Against Corruption	Warrant applications made	3	6	0
	Refused/withdrawn	0	0	0
	Issued	3	6	0
	Renewal applications issued	0	0	0
	Total number of services intercepted#	6	15	0

The figures for the 03/04 and 05/06 years do not include the services intercepted under renewal warrants so comparison with figures for the 05/06 year must be made with caution.

In 2005/06, the NSW authorities incurred approximately \$9 million of expenditure in connection with the execution of telecommunication interception warrants. In that year there were 1097 arrests made on the basis of lawfully intercepted information obtained by the

NSW agencies, and there were 618 prosecutions and convictions in which lawfully intercepted information by those agencies was given in evidence.

Question

Is any other monitoring of how these powers are used done by any other agency?

Answer

Apart from the Commonwealth Ombudsman's inspection function in relation to stored communication warrants, the NSW Ombudsman is the only monitoring agency in relation to all other telecommunication interception powers exercised by NSW law enforcement agencies. The Commonwealth Attorney General is provided with agency reports and reports from the Commonwealth and state inspecting authorities and tables an annual report that provides a general overview of the use of these powers at a national level.

Question

Does the Ombudsman consider this outdated legislation to be a problem?

Answer

The NSW Ombudsman has long considered the discrepancies between the Commonwealth and the NSW legislation in this field to be a problem and we have commented in several annual reports on this issue. The provision in relation to "named person warrants" is of particular concern because after the original warrant has been issued by a judge or eligible member the decision on which services and how many are to be intercepted is made by the chief officer of the agency. So in some instances a "named person warrant" is issued and over the course of that warrant, often for 90 days, the chief executive officer can authorise as many services as he or she reasonably believes the target is likely to use to be intercepted. Yet the NSW legislation does not require the inspection agency to examine the records relating to these connections.

There are a number of instances where the Commonwealth legislation and the NSW legislation should be complimentary, as envisioned by Section 35 of the Commonwealth Act.

1. The references to warrants in the NSW legislation refer to Part VI warrants, which was the designation prior to the 2006 amendments. The Commonwealth Act now refers to these warrants as Part 2.5 warrants in keeping with the changes to the Commonwealth Act. As a result there is an argument that the NSW legislation is now obsolete as there are no Part VI warrants in the Commonwealth Act. This appears to be a fundamental problem which should be addressed.
2. In relation to records to be kept Section 81 of the Commonwealth requires the following:

81 Other records to be kept by Commonwealth agencies in Connection with interceptions

(1) The chief officer of a Commonwealth agency must cause:

- (a) *particulars of each telephone application for a Part 2-5 warrant made by the agency; and*
- (b) *in relation to each application by the agency for a Part 2-5 warrant, a statement as to whether:*
 - (i) *the application was withdrawn or refused; or*
 - (ii) *a warrant was issued on the application; and*
- (c) *in relation to each Part 2-5 warrant whose authority is exercised by the agency, particulars of:*
 - (i) the warrant; and**
 - (ii) the day on which, and the time at which, each interception under the warrant began; and**
 - (iii) the duration of each such interception; and**
 - (iv) the name of the person who carried out each such interception; and**
 - (v) in relation to a named person warrant—each service to or from which communications have been intercepted under the warrant; and**

The NSW and South Australian legislation do not provide for the requirements outlined in bold, whereas Victoria, Western Australia, Tasmania and the Northern Territory all require these records to be kept.

The records in (c) (i) to (iv) are required for all warrants and (v) only for “named person warrants”. The details relating to the day and time which interceptions begin and the duration of the interception are important safeguards and should be the subject of independent inspection by the NSW Ombudsman as is the case at the Commonwealth level and in other States and Territories.

3. The definition of restricted record is different in the NSW and Commonwealth legislation. The Commonwealth definition describes a restricted record as:

restricted record means a record other than a copy, that was obtained by means of an interception, whether or not in contravention of subsection 7(1), of a communication passing over a telecommunications system.

The NSW legislation does not contain the words “other than a copy”. As a result the definition includes virtually all records. The NSW agencies have commented that this means they operate under a more onerous record keeping regime than their Commonwealth counterparts. There should be consistency between the Commonwealth and the State definition of what constitutes a restricted record.

4. The Commonwealth Act also allows for the inspecting agency to more thoroughly examine whether breaches of the Commonwealth Act have occurred. Section 5C provides:

5C Information or question relevant to inspection by Ombudsman

- (1) *For the purposes of this Act, information or a question is relevant to an inspection under Part 2-7 or 3-5 of an agency’s records if the information or question is about:*
- (a) *in any case:*
 - (i) *the location*
 - (ii) *the making, compilation or keeping; or*

- (iii) *the accuracy or completeness; of any of those records;*
 - (b) *in any case—any matter to which any of those records relates; or*
 - (c) *if the Ombudsman suspects on reasonable grounds that an officer of the agency has contravened this Act—any matter relating to the suspected contravention.*
- (2) *Nothing in subsection (1) limits the generality of a reference in this Act to information, or to a question, that is relevant to an inspection of an agency's records.*

While Section 12 of the NSW Act provides that the NSW Ombudsman may report on breaches of a provision of the Commonwealth Act, we have in the past encountered some jurisdictional challenges in investigating possible breaches. This provision, particularly subsection 1(c), would enable the NSW Ombudsman to adequately investigate any breaches of the Commonwealth Act.

5. Finally the Commonwealth Act provides for the exchange of information between the Commonwealth and state inspecting authorities through Section 92A:

92A Exchange of information between Ombudsman and State inspecting authorities

- (1) In this section:

State agency means an eligible authority of a State that is an agency.

State inspecting authority, in relation to a State agency, means the authority that, under the law of the State concerned, has the function of making inspections of the kind referred to in paragraph 35(1) (h).

- (2) The Ombudsman may give information that:
- (a) relates to a State agency; and
 - (b) was obtained by the Ombudsman under this Act; to the authority that is the State inspecting authority in relation to the agency.
- (3) The Ombudsman may only give information to an authority under subsection (2) if the Ombudsman is satisfied that the giving of the information is necessary to enable the authority to perform its functions in relation to the State agency.
- (4) The Ombudsman may receive from a State inspecting authority information relevant to the performance of the Ombudsman's functions under this Act.

There is no reciprocal provision in the NSW Act which is problematic. A clear statement allowing for exchange of information between all inspection agencies would be beneficial.

The Commonwealth Attorney General recently wrote to the Ombudsman noting that I had raised for the second year in a row the failure of State legislation to keep pace with changes to the *Commonwealth Telecommunications (Interception and Access) Act 1979*. The Attorney said he shared my concerns and informed me his department was currently developing proposals with a view to eliminating inconsistencies between Commonwealth and State legislation. He said he intended to discuss these proposals with the NSW Attorney General with a view to rectifying the situation in the near future.

Question

Chapter 7: Departments and Authorities

Many of the issues which the office has dealt with concern core business of departments and agencies eg the operation of the new structure for the Office of the Protective Commissioner; delays in dealing with applications to the Crown Lands Division of the Department of Lands; compliance with standards required to qualify for a licence (Ministry of Transport); providing comprehensive, plain English reasons for decisions (Department of Housing); delays in processing development applications (Department of Planning).

Do departments and agencies react positively to suggestions by the office for improvement to policies and procedures? Where suggested changes are made, how does the office check that improved policies and procedures are working for customers or clients?

Answer

Generally departments and authorities are responsive to our recommendations and suggestions. During the 2006 – 2007 financial year for instance, agencies implemented 89 per cent of the recommendations made by our General Team and Police Team following formal investigations. We recently upgraded Resolve, our complaints database, to enable us to capture that information for our informal suggestions made after preliminary investigations.

Our compliance rate is high. This is due to a number of factors, the chief being the persuasiveness of our investigations reports and appropriateness of the recommendations made.

Before finalising formal investigations, we consult with agencies and take into account their views on whether our draft recommendations are feasible and the most appropriate way to meet the intended objectives. We also endeavour to always make our recommendations and suggestions specific, measurable, achievable, reasonable and time specific.

We do not have the resources to do extensive follow up in relation to the impact of changed policies and procedures flowing from recommendations that are accepted. We principally see that as a responsibility of the agencies concerned and would expect to be provided with feedback about any problems encountered.

On occasion our recommendations include a requirement that the agency puts in place measures to check that the changes led to the expected improvements for customers and clients. More generally, we would expect agencies to assess at appropriate intervals whether identified problems have been remedied.

After any investigation or lengthy preliminary inquiries we monitor more closely the issues raised in similar complaints and inquiries. This is to ensure that, if the same issues continue to be raised, we are in a position to take further action with the agency.

Question

Chapter 8: Community Services

You report that 63% of community services complaints were assessed and determined within 10 weeks (page 81). In the 2005-2006 reporting period, 75% were finalised within 10 weeks. Can you explain the main reasons for this variation in results?

Answer

The decline in the number of complaints assessed and determined within 10 weeks was due to a substantial turnover in complaints staff. During 2006-07 seven of the 11 staff in the Complaints & Investigations Team (C&I Team) changed due to a retirement, the accidental death of one staff member, and staff pursuing promotional and career development opportunities both within the Office and externally. The staff changes included the two Team Leaders, three of our four Investigation Officers, and other staff.

The CSD has managed and addressed the staffing issue by:

- recruiting and filling vacant positions;
- creating 1.6 additional Senior Investigation Officer (SIO) positions to manage complex complaints and provide added guidance and mentoring to junior staff.

We have also improved our monitoring of complaint handling time frames, and action on delayed matters, by moving the CSD on 1 July 2007 to an enhanced Ombudsman Resolve complaints database. This system, associated with enhanced case management reporting strategies, has resulted in an improvement in these turnaround figures this financial year⁷. However, with the recent loss of three managers from the CSD complaints area, we will need to continue to closely monitor our performance in this area.

Question

In the recommendations made to community service providers following a review of their complaint-handling systems (page 83), were agreed outcomes/actions identified? And was a timeline for implementation put in place? If not would such developments be beneficial?

Answer

At the commencement of the project, each service that we proposed to review was advised that a report on the outcome of our review would be provided to them. These individual service reports identified areas that required further development and included specific recommendations and suggestions on how the service should improve their complaint handling systems. In addition, in October 2007 we finalised a report on the major issues

⁷ The CSD's performance indicator in relation to timeliness is to assess and determine 70% of complaints within 10 weeks of receipt (refer below, question on notice in relation to this performance indicator). In 2005-06 63% of formal complaints were assessed and determined within 10 weeks of receipt of the complaint. Between 1/7 – 31/12/07 the CSD has assessed and determined 89% of formal complaints within 10 weeks of receipt of the complaints. The improvement in timeliness may not be as high as 25%, and needs to be considered with caution at this stage. On 1/7/07 the CSD began to use the whole of Ombudsman Resolve complaints database. Business rules and reporting from this database are still being 'bedded in', and will be reviewed in May 2008, to ensure their accuracy. However, our case management of individual complaints confirms an improvement in the timeliness of our handling of complaints.

relating to complaint handling in the family support area. Family support services across NSW have been provided with this report.

Services were also informed that, if necessary, we would organise a follow up visit to review their progress in addressing the issues raised.

All services have responded to the recommendations made in our reports. We have also maintained ongoing contact with these services and provided feedback on their proposed changes to practice.

Senior managers and management committees have also reported increased promotion of their complaint handling systems and reviews of their complaint handling practices.

Some of the services operate under the auspice of larger organisations. A number of these larger organisations have applied the lessons learnt from our review of their individual services to the whole of their organisation and developed new policies, brochures and other documentation pertaining to improved complaint handling in response.

Positive outcomes from the review have also included the development and delivery of a complaints management training program for DoCS senior staff across the state in the Partnerships and Planning team. The purpose of this training is to allow these staff to provide consistent quality advice and support to DoCS funded services in their area on effective complaint systems and practices. A strategy for offering complaint handling training and resource support to Family Support Service staff is also being implemented by the peak agency, NSW Family Services Inc. This additional work by DoCS and NSW Family Services Inc is in response to the issues identified in our October 2007 consolidated report.

Question

What was the response to the suggestion, reported at pages 84-5 in relation to the review of child protection legislation, for a forum focussing on expectations in child care proceedings?

Answer

Our view on the benefit of ongoing discussions between key agencies on critical issues around children's court matters was initially contained in our Children's Court paper finalised in the middle of 2006. The Minister for Community Services, members of the Ministerial Advisory Committee, the Children's Court, the Department of Community Services and the Legal Aid Commission received a copy of that document. In our subsequent submission for the review of the Children and Young Persons (Care & Protection) Act dated 30 March 2007, we again provided our Children's Court paper. With the establishment of the Special Commission of Inquiry into Child Protection, we sent Commissioner Wood a copy of that paper. Commissioner Wood will be focusing solely on the Children's Court at a roundtable discussion on 22 February 2008. We have been asked to be on the panel for these discussions.

Question

The annual report outlines the first stage in a project to better understand the needs of Aboriginal foster carers and non-Indigenous carers of Aboriginal children in NSW. What has been the response to the project to date and what future stages of the project have been planned?

Answer

We have completed the first stage of the project which involved interviews with over 100 carers from around the state and analysis of our survey data.

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

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

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

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

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

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

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

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

Question

Details are provided in the Annual Report of DoCS releasing a draft policy in March 2006 for consultation with relevant peak agencies: Assisting unaccompanied children under 16 years in SAAP youth accommodation services (page 86). Are you satisfied with the progress of DoCS to date in relation to the development of this policy?

Answer

We have concerns about progress with the development of this policy. DoCS undertook to develop policy in this area in 2004 and released a draft policy in March 2006, which is yet to be finalised. However, while we are concerned about the failure to finalise the policy, we were advised that DoCS had meetings with the relevant sector peak agency in October 2007 to progress the policy development.

On 5 November 2007, we provided DoCS with a draft report of our group review of young people in care who are placed in SAAP services. In that draft report we recommended that DoCS provide advice about the progress of the policy. DoCS provided a response on 1 February 2008, which included advice about ongoing policy development in this area. On 5 February 2008, we issued our final report on this matter. It includes a recommendation for DoCS to provide a report to the Ombudsman by 29 February 2008 with detailed evidence of progress in finalizing the policy and a timeframe for its completion.

Question

You report that you have asked DADHC for detailed information about their plans for accommodation services, and that in the coming year you will be obtaining legal advice to inform your continued monitoring of these issues (page 88). What were the issues about which legal advice was sought?

Answer

Concerns have been raised with the Ombudsman about the development of some accommodation support models in response to the government's 10 year plan for disability services, *Stronger Together*. Those concerns relate to the 're-development' of some currently operating institutions (also known as large residential centres) and development of new accommodation models and the extent to which these services can meet the needs of

Answers to Questions on Notice

people living in NSW who require accommodation support, in particular, promote their participation in the community.

Based on the information provided to the Ombudsman by DADHC, we sought advice from Senior Counsel about the compliance of various accommodation models - either currently operating or proposed for development - with the provisions of the *Disability Services Act 1993* (DSA). This included advice about:

- whether the maintenance of institutions, or their redevelopment, can comply with the DSA
- any particular challenges that would need to be met in order for compliance with the DSA to occur, and
- the provisions of the DSA that concern 'transition plans' for services which did not comply with the DSA at the time of its introduction.

We were provided this advice in December 2007. We met with DADHC for initial discussions about that advice on 31 January 2008.

Question

When do you anticipate a response from DACHC in relation to your queries regarding the implementation of their strategy designed to improve services for people from CALD communities (page 89)?

Answer

DADHC provided a response to our written enquiries on 25 June 2007. The department's advice indicated that it had undertaken a significant amount of work towards implementing the CALD Action Plan. As part of our analysis of the department's advice, we consulted with peak organisations including the Multicultural Disability Advocacy Association (MDAA) on 14 August and 27 November 2007. We have informed DADHC that we will seek a briefing later this financial year on its progress in implementing the strategy.

Question

What assessment has been done of the effectiveness of the child and family services education project (page 94)?

Answer

The June 2007 Client Satisfaction Survey sought advice from those surveyed about Ombudsman/CSD information and awareness activities, and their familiarity with Ombudsman functions and activities. The survey identified that the vast majority of stakeholders surveyed, including complainants, peak bodies, OCVs and others, reported strong satisfaction with the Ombudsman/CSD information and awareness activities, which includes the child and family services education project.

The following feedback was provided by participants at child and family information sessions:

- *Very supportive of (CSD) presentation. Knew a lot about CPT function but work of the CSD not as well known –so very useful. Several people reported they had very positive experiences with the office.* (Representative from the NCOSS Children's Forum Audience, which was made up largely of child care services staff)
- *Very informative and very useful – we will circulate the information to everyone in the network.* (Representative of the NCOSS Health Policy Group)
- *The feedback from your presentation was very positive! We will certainly be interested in other training your office offers.* (Representative from Kindergarten Union)

We have also received feedback from three training sessions for DoCS Childcare Directors training. Many participants said they would now review their policies and practices and felt motivated to do so. They said the training changed their perspective on how to view complaints and particularly changed their knowledge about and attitudes to complaints and their critical importance in informing service improvement.

There was also positive feedback about the Deputy Ombudsman's presentations to PANOC services and staff. The information he provided was received very well, and has led to further involvement of the CSD in the health sector.

We have also recorded positive comments from participant evaluations of CSD education and training workshops.

Question

You report that in 2006-07 Official Community Visitors provided 9507 hours of services to residents, a significant increase on the 7581 hours in 2005-06, and that three new Official Community Visitors started during the year. How many hours of service to residents were provided in 2005/06 and in 2006/07 per Visitor (page 95)?

Answer

2005/06: 270.75 hours per Visitor. Although there were 47 Visitors during the financial year period, only 28 worked for the entire financial year. A number of Visitors' appointments ended in the first month of the period, and several other Visitors began their appointments in the last month of the period.

2006/07: 316.9 hours per Visitor. There were 33 Visitors during the financial year period. Three completed their appointment in the last month of the period, three began their appointments three months before the end of the period, and two resigned during the period.

Question

The number of visits by Official Community Visitors to services for children, young people and adults with a disability went from 109 in 2005-06 to 54 in 2006-07 (page 96, Fig 42). Can you provide some background as to the reasons for this decrease?

Answer

In the past three years there has been a decrease in the number of services for children, young people and adults with a disability, and the number of residents in these services.

Number of visits made by Visitors – three year comparison

	2004/05	2005/06	2006/07
No. of services	26	22	18
No. of residents	236	125	71
Hours of Activity	340	316	180
No. of Visits	76	109	54

The decline in the number of services and residents, and visits to these services, primarily relates to these services being devolved in accordance with the Government and DADHC's disability service devolution strategy.

The large number of visits in 2005-06 was the result of Visitors conducting more regular, but shorter visits.

Historically, these services were mostly congregate care facilities, often providing accommodation for children, young people and adults with high and complex needs, including medical support needs, eg, Grosvenor, Mannix/Whitehall, the Hall for Children. The former residents of these services have been moved to more appropriate group home, host family and other accommodation models.

Question

Chapter 10: Corrections

Our relationship with DCS is generally positive and cooperative. We try to resolve the majority of concerns brought to us quickly and at the local level, so this professional relationship is important. Staff working in centres and throughout the department generally provide us with information and respond to our questions in a timely manner. They will continue to do so as long as the most senior staff in their department encourage them to respond to us in this way and lead by example. (page 104)

Does the office receive appropriate cooperation from senior DCS staff?

Answer

In most cases the simple answer to this question is yes. As was noted elsewhere in chapter 10 of our annual report, the existence of a corrections unit in our office has enabled strong working relationships to be developed throughout the department, including with those in the senior executive. The Assistant Commissioner, Office of the Commissioner is responsive to our requests for information and ensures prompt action is taken if unreasonable delays are experienced by us in dealing with other parts of their department. Within the Office of the Commissioner's ministerial liaison unit, an officer has been nominated to co-ordinate all Ombudsman matters which assists us in following up replies to correspondence. However, on occasion, and in relation to some specific areas of the department's operations, we can

sometimes experience delays or reluctance by staff to deal with us directly so as to avoid making a comment or decision which may be at odds with the Commissioner's view.

Over the past 12 months we have also seen the department withdraw from the formal quarterly liaison meetings that were attended by the Commissioner and/or members of the Board of Management, and by the Ombudsman and/or Assistant Ombudsman (General) and senior staff from our Corrections Unit. These formal senior level liaison meetings have largely been replaced by regular liaison meetings between senior operational staff from both organizations. These still provide an extremely useful information exchange mechanism, but unfortunately do not demonstrate the same commitment to a sound working relationship to the staff of both organisations that the previous meetings provided. The change to the liaison meetings appeared to coincide with the jurisdictional challenge to an investigation by our office, which is noted on page 112 of the Annual Report for 2006/07.

Question

Chapter 11: Juvenile Justice

You have noted the increase in the number of young people in custody in juvenile justice centres over the past two years and the difficulties in accommodating them (pages 115-6). Is there evidence that this trend will continue and what will be the implications for the operations of juvenile justice centres and for detainees?

Answer

Nearly all juvenile justice centres have been operating consistently over capacity during the last year. They have been coping with the additional numbers by putting mattresses on the floors of other detainee's rooms and using holding rooms as bedrooms. These measures are tolerable in an emergency for short periods but this practice has been going on for a considerable time now. We identified this emerging problem in our Annual Report for 2005-06.

In addition to the obvious practical problems of mattresses, bedding, possessions and clothing having to go somewhere, there is the risk detainees will be put in together who shouldn't be, that tempers will flare and fights start in small spaces accommodating more people than they are designed for. Dining and other communal areas in units are overcrowded. Routine maintenance and showers/ toilets breaking down now pose a disproportionate problem as there are no spare rooms. Holding rooms are not available for detainees needing to be confined or segregated.

There is every indication the high numbers will continue. Changes to the Bail Act and the current law and order focus are both causing the high numbers. We have noted that bail refusals by the court are more common. Our understanding is that the most recent changes to the Bail Act mean if you have breached bail in the past it will now be almost impossible to get bail again. Police are increasingly rigorous in enforcing bail conditions, especially in areas with high numbers of Aboriginal young people. This has been identified in audits conducted by our office of the implementation of the NSW Police Aboriginal Strategic Plan. This has further resulted in many young people being detained in custody for bail breaches which means they are unlikely to get bail again for future offences.

The Department of Juvenile Justice has plans to build a larger centre to replace Keelong but that requires a site to be purchased and is clearly some years away. An extra unit is also to be built at Orana (Dubbo) but again that work has yet to start.

There seems to be no clear solution to the current shortage of beds. While there is an unused unit at Cobham, as well as spare unit capacity at Juniperina, there are difficulties associated with both of these possible solutions. The Juniperina Juvenile Justice Centre is a girls centre. While it has been built in such a way that detainees would not need to mix if it were necessary to put boys there, it would be a significant decision to have a mixed sex site, as it may have many other implications. Our information is that the Department does not have the funds to open the extra unit at Cobham permanently without having rolling lockdowns in the other units, which it is reluctant to do. Opening the unused unit at Cobham would accommodate an additional 15 detainees, and while it would provide some relief, it is not enough to solve the larger problem.

In addition to the beds shortage, there are a number of other issues in need of review:

- the adequacy of school (DET) and clinic (Justice Health) sizes and staffing in each centre
- the adequacy of provision of support services, such as psychologists, psychiatric services, and dentists.

Although these issues are important, the most immediate problem is the shortage of beds.

Question

Chapter 12: Freedom of Information

What proportion of access to information complaints had not been determined by the agency with which the application was lodged (page 122)? When were some of these applications lodged and is it anticipated that they will be determined soon?

Answer

In 35 (16.8%) of the 208 complaints received in 2006-2007, the agency had failed to respond at all to the applicant's FOI application. In figure 53 of our 2006-07 annual report we characterised some of these complaints as 'access refused – deemed' and others as 'wrong procedure – delay'. Please also note that some other complaints had not been 'determined' by the agency because negotiations to change the scope or pay an advanced deposit had broken down, or the agency had claimed an unreasonable and substantial diversion of resources, and then the applicant complained to us. These have not been counted in the 35 because we understand the question to be 'in how many complaints have agencies failed (deliberately) to make a determination at all'.

The longest delay was approximately 8 months; that is, the applicant had not received any determination for 8 months before they complained to our office. All these matters were resolved following our office's involvement, with determinations made in most cases. In other cases, the applicant withdrew the application or the information was provided to the applicant outside of the FOI regime.

Question

You report that in May 2007 you wrote to DET enclosing advice from the Solicitor General and asking DET to consider redrafting their policy on the disclosure of school accident reports (page 125). Has a response been received from DET in relation to this matter?

Answer

In response to our suggestion we received a letter from DET on 4 July 2007 advising that they were considering this matter but were waiting until the conclusion of *State of NSW v Jackson* [2007] NSWCA 279 to make a final decision. We have not yet received any further formal response. However, at a meeting with Departmental officers on 6 November 2007, they advised that the Department was thinking about changing the wording of the policy to state that school accident reports *may* be subject to legal professional privilege. They were also considering implementing a practice requiring a lawyer to assess each FOI application to decide whether or not the report was privileged.

We intend to write to the Director-General in the very near future seeking an update on this matter and an update on the progress the Department has made in implementing recommendations made by Ms Robin Gray in her review of the Department's handling of FOI applications.

Question

Chapter 13: Protected Disclosures

While being mindful of the prohibition on the Committee from reconsidering decisions made by the Ombudsman at s.31B(2) of the Ombudsman Act 1974, given the inherent public interest in the disclosures made about certain University of New South Wales staff, and the amount of time spent by the Ombudsman investigating this matter, could you please explain why you decided not to report the results of your investigation.

Answer

Unlike the ICAC, and certain other Australian Ombudsman, the NSW Ombudsman has no general discretion to make reports in the public interest (other than a special report to Parliament under s.31 of the Ombudsman Act).

In this particular case, the Ombudsman was precluded from finalising the investigation and making a report under s.26 of the Ombudsman Act due to the proceedings that had been instituted in the Supreme Court by the former Deputy Vice Chancellor (International) of the University of New South Wales.

As set out in attachment A to our Answers to Questions on Notice for the 14th General Meeting, this was one of the reasons why the decision was made to discontinue the investigation. It appeared to us that we would have been unable to finalise a report under s.26 for probably a further 12 months, in circumstances where the matters we were likely to recommend in any such report had largely already been addressed by the University.

Question

Chapter 14: Employment-related child protection

Case Study 67 relates to an allegation made against a parent who was volunteering at an independent school (page 136). Do independent schools respond well to the work of the Ombudsman in this area?

Answer

There are over 400 independent schools in NSW that provide educational services based on a broad and disparate range of religious and ideological persuasions. Whilst many schools are members of peak organisations such as the Association of Independent Schools, Association of Christian Schools etc, the responsibility for complying with the requirements of Part 3A of the *Ombudsman Act 1974* rests with the Principal of the school.

Given the large number of stand alone agencies, our strategies with this sector have largely involved:

- establishing forums to discuss emerging issues,
- being available for telephone inquiries and case discussions,
- engaging the peak organisations to disseminate information, provide training and facilitate a class or kind arrangement for independent schools.

We find that most independent schools are committed to providing safe environments for their students and employees. Most independent schools work cooperatively with the Ombudsman where we have sought information, made recommendations to address deficiencies in their systems or when Principals have consulted with us about complex investigations. Our relationship with the peak organisations is also positive and one on which we rely to gauge the current climate and identify any emerging issues in this sector.

The results of our class or kind audits indicate a continuing level of cooperation and satisfactory performance from those schools that are party to the determination with the Ombudsman. That said, there are a number of independent schools with which we have had minimal contact and other recently opened independent schools where we have had no contact.

Question

Notifications to the Ombudsman in relation to employment related child protection have increased by 11.7% from the last reporting period. What could be some of the reasons for this increase?

Answer

The increases in notifications came largely from the Departments of Education and Training (DET) (153) and the Department of Community Services (DoCS) (33). Increased populations of students and teachers in the case of DET, and foster carers in the case of DoCS, partially explain the increase. However, over time we have noticed fluctuations in reporting patterns that we can attribute to training initiatives of particular agencies. This can result not only in an increased awareness of what needs to be reported, but also a review of

complaint files and the discovery of matters that had not previously been reported. We anticipate a levelling out of notifications from these agencies in the new reporting period.

Question

While notifications to the Ombudsman generally have increased, notifications received from independent schools have dropped by 35%. What could be the reasons for this sharp decline?

Answer

The response to this question is related to the response above, but in the reverse. We note that in the reporting period 2005-2006, there was an increase of 22 notifications from the independent school sector. We attributed this increase to the training provided to principals by the Association of Independent Schools resulting in notifications from schools that had not previously reported matters to us. This pattern levelled out in 2006-2007 with 33 less than the year before.

The extended class or kind determination with the Ombudsman accounts partially for the decrease. We have also observed low numbers of repeat offending which could be linked to the decisive action, sometimes employment termination, that independent schools take when an employee is the subject of a sustained reportable allegation or otherwise considered to pose a risk to students.

The trend for this year, to date, is an increase in notifications.

Question

In the Ombudsman's opinion, would it be useful for the Commission for Children and Young People to conduct working with children checks on volunteers?

Answer

Ideally, we believe that it would be useful for the Commission for Children and Young People to conduct working with children checks (WWCCs) on volunteers. This is a large population of people who give freely of their time and make a significant contribution to many community service organisations. That said, for the most part, they have limited understanding of child protection issues and volunteer their time in contexts that provide opportunities to behave in ways that could be abusive to children.

In practice, we appreciate that conducting WWCCs for all volunteers who work in child related employment would be resource intensive and not necessarily commensurate with the estimation of risk. The benefit of screening all volunteers would not justify the huge resource commitment required to do so.

We believe however that the important consideration when determining who should be screened is the context in which that person will be working, rather than whether or not the person is a paid employee. This is the basis for determining which matters are required to be notified to the Ombudsman under Part 3A. As it stands, in some agencies, paid

employees who have minimal unsupervised contact with children are screened. On the other hand, volunteers who have unsupervised contact with vulnerable children for example, in mentoring programmes, overnight respite care, or offer 'host family' arrangements to country or overseas students, are not currently screened. This is inconsistent considering the inherent risks associated with these types of contacts. We have raised this issue with the Commission for Children and Young People and are expecting to meet shortly.

Question

Legislative reviews

The Ombudsman recently tabled a report in Parliament called the Review of Emergency Powers to Prevent or Control Disorder. The Government response to the 14 recommendations was to support or implement 12. One was not supported and a section of another was not supported. Are you satisfied with the reasons provided for not supporting a reasonable suspicion test (Recommendation 7) and not supporting detailed annual reporting by the Commissioner of Police about the use of Part 6A powers (Recommendation 14 b).

Answer

The Ombudsman has been provided with a copy of the NSW Government response to the report *Review of Emergency Powers to Prevent or Control Disorder*.

Our view as regards amendments to Section 87K of the *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA) and the desirability of detailed annual reporting by the Commissioner of Police about the use of Part 6A powers remains as outlined in the above report. It is, however, ultimately a matter for the Parliament as to whether the recommendations made to change or amend laws as a result of our legislative reviews are adopted.

Since the commencement of amendments resulting from the *Law Enforcement and Other Legislation Amendment Act 2007*, our officers have made contact with appropriate officers within NSWPF to put in place arrangements for the ongoing monitoring by the Ombudsman of powers conferred on police officers under Part 6A of LEPRA. A full report of the Ombudsman's activities under this monitoring provision will be included in our 2007/2008 Annual Report.

Chapter Four - Transcript of Proceedings

NOTE: The Fourteenth General Meeting with the NSW Ombudsman was held at Parliament House, Macquarie Street, Sydney, on 18 March 2008.

CHAIR: I formally open the proceedings for the fourteenth general meeting with the New South Wales Ombudsman and statutory officers from his office. Mr Barbour, thank you and your team for appearing before the Committee on the Office of the Ombudsman and the Police Integrity Commission. Your appearance before the committee is to provide information for the general meeting in relation to a wide range of matters concerning your office in accordance with the committee's statutory functions.

BRUCE ALEXANDER BARBOUR, New South Wales Ombudsman, level 24, 580 George Street, Sydney, and

CHRISTOPHER CHARLES WHEELER, Public Servant and Deputy Ombudsman, 580 George Street, Sydney, and

GREGORY ROBERT ANDREWS, Assistant Ombudsman (Police), level 24, 580 George Street, Sydney, and

HELEN YVONNE FORD, Acting Assistant Ombudsman (General), level 24, 580 George Street, Sydney, affirmed and examined.

STEVEN JOHN KINMOND, Deputy Ombudsman, Community and Disability Services Commissioner, 580 George Street, Sydney, and

ANNE PATRICIA BARWICK, Assistant Ombudsman, level 24, 580 George Street, Sydney, sworn and examined.

CHAIR: Mr Barbour, the committee has received two submissions from you. One is dated 15 October 2007 and the other is dated 11 February 2008. Both these submissions consist of responses you have provided in answer to questions on notice in relation to your 2005-06 and 2006-07 annual reports. Do you want those submissions to form part of your formal evidence?

Mr BARBOUR: I do, thank you.

CHAIR: Would you like to make an opening statement?

Mr BARBOUR: Yes thank you, Madam Chair. This is our first formal meeting before the new committee. Firstly, can I offer my congratulations to the members on their appointment to the committee and formally take this opportunity to reiterate my own and my officers' commitment to a positive, open and productive relationship with the committee. I look forward to working with the committee in the coming years. I believe most strongly that an interested and involved parliamentary committee is an important contributor to the continuing effectiveness of my office. The committee can provide an effective avenue of communication with Parliament, to whom ultimately my office is accountable. This helps to ensure that

members of Parliament fully understand the scope of our jurisdiction as well as the breadth and importance of our work.

There have been several changes in senior staff positions since I and my senior officers met informally with the committee at the end of last year. Simon Cohen, who held the position of Assistant Ombudsman (Police) for over four years, has taken up the role of Victorian Public Transport Industry Ombudsman. It is important for me to publicly acknowledge Simon's significant contribution to the work of this office. Greg Andrews will be undertaking the position of Assistant Ombudsman (Police) until at least August of this year. Greg, of course, as you know, is Assistant Ombudsman (General) and for a considerable period of time has brought extraordinary levels of knowledge to the office and I think it is appropriate that he act in that role. The position of Assistant Ombudsman (General) will be filled consecutively by two senior members of staff until August. They are Helen Ford, senior project officer in the general team, who is here with us today, and Monique Adofaci, the Manager (Legal) for the office. Helen is currently acting in the role and her term will conclude in May. Monique will then take over the position until August.

I have spoken on numerous occasions both before this committee and elsewhere about the changing role of my office. We are no longer just responding to individual complaints on a case-by-case basis. In order to bring about systemic change to the provision of services within New South Wales we use a range of powers to proactively review the work of both government agencies and non-government service providers. I propose to focus my opening remarks on a number of current issues of interest to the office and, I hope, to the committee. I will refer to our cross-agency team, the trial of a streamlined police complaint handling process, and a recently completed defendants survey, and provide a progress report on our unreasonable complainant project. In addition there is one matter I will raise about which I would welcome the committee's consideration and assistance—that is the issue of possible amendments to the Ombudsman Act to remove the difficulties associated with agencies' use of legal professional privilege to prevent my office accessing information.

In relation to our work to date you are familiar with our last annual report, which sets out in detail the statistics of our work. I would like to add to that information that, from the end of June last year to the end of February this year, we have received approximately 6,000 formal and 16,000 informal matters.

Recently we undertook a survey as part of our review of the Law Enforcement (Powers and Responsibilities) Act 2002. This legislation was introduced in an attempt to implement the Wood royal commission's recommendations relating to the consolidation of police powers. As well as a number of other important police powers, the Act provides for the search of individuals on arrest and while in custody. My office's survey was designed to assess the first-hand experiences of those persons searched at arrest or in police custody. Staff from my office attended nine local courts, a weekend bail court and two juvenile courts. In order to be eligible to take part in the survey, an individual had to be facing charges on the day they were spoken to and have been arrested between December 2005 and December 2007. Our staff approached 700 eligible people. Of those approached, only 190 refused to take part. It means a participation rate of 73 per cent. The information we collected during this survey relates to searches conducted by police based within five different regions and the results of the survey will be useful to our complaint handling in those areas in the future.

In addition to informing our legislative review and our future complaint handling, the survey also presented an opportunity to provide members of the community with information

about our office. Our staff spoke not only with those facing charges, but also with many family members and support people who attended court on the day. They were provided with advice about the role of our office, the process surrounding making a complaint, and any necessary referral details for relevant government agencies and community services. The reason I mention this is because the survey is demonstrative of the way in which public input and participation in our work can be achieved in a number of different ways. When assessing issues of importance to the community, wherever possible we will consult interested parties and provide them with an opportunity to contribute their opinion. It is also appropriate to note that we receive considerable cooperation from several government agencies, without whom the survey would not have been possible. Our office is in the process of analysing the information collected during the survey and will be included in our final report to Parliament.

The Unreasonable Complainant Conduct Project, as you are aware, commenced in August 2006 and is scheduled to conclude in September this year. It is aimed at developing a systemic approach to dealing with unreasonable complainant conduct across all parliamentary Ombudsman offices in Australia. The project is unique on a number of levels, but most particularly because, for the first time, it sees all parliamentary Ombudsman offices working together on an issue of common concern. I have a one-page briefing document to provide to Committee members which details the key features of the project and the work that has been undertaken since August last year and what still needs to be done.

Importantly, the level of interest that this project has generated in agencies, throughout not only Australia but also New Zealand, the United States of America and Canada, has been extraordinary. We have now conducted one-day seminars to a range of agencies throughout New South Wales, Victoria, South Australia and Queensland attended by over 300 staff and we have three seminars scheduled in July for New Zealand. The level of interest in the project is also demonstrated by the number of times our interim practice manual has been downloaded since it has been put on our website. In the month of February alone, it was downloaded 1,398 times.

New South Wales Police trial of streamlined complaint handling—Recommendation 6 of this Committee's report, following its 10-year review of the police oversight system, was that New South Wales Police should consider ways in which to encourage the informal resolution of minor complaints at local command level, particularly local management issues, without the involvement of complaint management teams. This is an issue to which both my office and the New South Wales Police Force have demonstrated a genuine commitment.

In addition to refining our class and kind agreement relating to complaints requiring referral, the New South Wales Police Force has worked closely with my office to develop an alternative approach to handling minor complaints aimed at providing complainants and subject officers with fair and timely outcomes as well as enabling commanders and senior officers to make better use of their scarce resources. New South Wales Police Force commenced the trial at 12 local area commands on 1 August last year. An evaluation is being undertaken by both police and my office. Our preliminary view is that where it has been applied to less serious matters, the trial arrangements are proving successful and we hope to be in a position after an evaluation to endorse them further so that they can be rolled out throughout the State.

Cross Agency Team—in order to respond to what is clearly the emerging whole-of-government provision of services, multi-agency or across-office issues, I established a cross

agency team [CAT] in March last year. It is aimed at strengthening communication and collaboration between the various specialist teams within the Ombudsman's office as well as targeting specific systemic issues which may involve one or more jurisdictional responsibilities. The CAT membership includes the Ombudsman's Aboriginal complaints unit and its youth liaison officer, and this allows those important specialist areas to work more effectively with a number of teams within the office. This year CAT was also responsible for the coordination and preparation of our annual report.

In April we will conduct an evaluation of CAT's operation for its first 12 months. That evaluation will be coordinated by an external consultant and will utilise information from the CAT steering committee plus the users of CAT throughout the office. If the Committee has any interest in contributing to that evaluation process, I am more than happy to keep the Committee updated.

Now to the issue of legal professional privilege: I would very much appreciate the Committee's consideration of this particular issue. New South Wales is the only Australian jurisdiction where public sector agencies can refuse access to documents to the Ombudsman on the basis of a claim of legal professional privilege. Within New South Wales, the primary oversight and accountability agencies, the Independent Commission Against Corruption and the Police Integrity Commission, are both able to require the production of documents over which a claim for legal professional privilege has been made. I believe that this is an anomaly within our Act. It serves no practical purpose and it has the considerable potential to frustrate thorough and proper investigation or inquiring into relevant matters by my office.

This issue has been brought to the attention of the Committee previously. In our submission to the 10-year review of the police oversight system, we noted that there had been a number of occasions when New South Wales Police had challenged our entitlement to access all information relevant to assessment of a complaint investigation. One basis for the objections has been legal professional privilege. As we noted in our submissions to the Committee at that time, in our view it is necessary for us to be able to access all relevant information to properly perform our oversight functions. Any obstacles should be overcome or resolved through appropriate legislative amendments. As this issue is one which continues to frustrate the proper work of my office, I thought it appropriate to raise it again with the Committee this morning. I prepared a more detailed briefing paper for your consideration, and I will hand that up to you.

Document tabled.

The briefing paper not only outlines the issues I have just addressed but also provides some specific examples of areas where we have reached negative views as they relate to the ways in which departments have claimed privilege, and it also sets out comprehensively relevant legislation in other States where this is not a problem.

In conclusion, I once stated, in answer to a question put to me by a previous meeting of this Committee, that in order to operate as effectively as possible it was essential for the Ombudsman to expect the unexpected. This remains very true, despite our considerable efforts to work proactively by assisting agencies through publications, training and developing a detailed work program for our future. It will nonetheless always be the hallmark of the Office of the Ombudsman that issues will arise or complaints or problems will come to

our attention which will require an immediate response. Priorities must sometimes be reordered and we must have flexible systems in place.

This would simply not be possible without a very talented group of staff who are committed to the office and its work. This forum provides me with an opportunity to formally thank them. Madam Chair and Committee members, I and my senior managers are most happy to answer any questions that you have of us today.

CHAIR: Thank you for that comprehensive opening statement. I shall now open the inquiry to questions. On 11 February 2008 the *Sydney Morning Herald* carried a story called "DOCS insiders blow whistle on tragedy". Have complaints been received from staff from within the Department of Community Services [DOCS]? If so, are the issues raised in the complaints of a systemic nature?

Mr BARBOUR: We do not receive very many complaints from staff members of DOCS. We do receive complaints occasionally. I have details in relation to those which I would be happy to provide to the Committee in camera. Also there is some additional information that I can provide in relation to the context of those complaints as they fit with systemic issues, if the Committee would like.

CHAIR: The Special Commission of Inquiry into Child Protection Services public forum on 15 February 2008 was about mandatory reporting. It included a question on whether or not police should report child abuse and neglect by providing the Computerised Operational Policing System [COPS] entry for the incident. What is your view on the potential benefits and weaknesses of such an approach?

Mr BARBOUR: I will commence by saying that we are in the process of preparing a very detailed submission to the commission of inquiry on mandatory reporting and the other issues that the commission is looking at. We have already provided them with a submission in relation to the Children's Court. Mandatory reporting is, as you can imagine, a very complex area. Our submission will focus on the information that we have obtained and views that we have formed as a result of our work in this area over the past five years. In terms of police involvement directly in mandatory reporting, there is no doubt that they are one of the largest reporters, if not the largest, and that is as a consequence of the operating practices. Their standard operating procedures [SOPs] require them to notify in circumstances where children are present, particularly in domestic violence situations.

There is work that is currently being undertaken by both police and DOCS in terms of research as to whether or not there are better ways that this work can be undertaken. That was the subject of consideration by Commissioner Wood when he held his forum in relation to mandatory reporting. There is a range of issues that we will present in our submission. I will not go into them in detail because I am happy to provide a copy of the submission to the Committee. I think suffice to say that we would be concerned about any changes to mandatory reporting which limit the quality of information that was necessary for a proper child protection response to be undertaken. What is often seen as being a minor matter that is the subject of a report may be so seen on its own, but when it is put together with other similar reports relating to the same family, for example, it might present a deteriorating situation in terms of neglect and circumstances which do require an appropriate response from the authorities.

The other issue that we will be focusing on is the way in which information that comes from mandatory reports is utilised by the Department of Community Services and other agencies. We have advocated for some time, and will continue to advocate, an intelligence-based system in terms of response to reports. The work that has been undertaken by the Department of Community Services suggests that of the 280,000-plus mandatory reports each year, approximately half of those relate to only 11 per cent of families. It seems to us that an intelligence-based approach in looking at those 11 per cent of families is a very good starting point to try to ensure that the application of child protection services is more targeted to those families that are in need of it. Those are some of the issues we will cover in our submission to the Wood commission. I am happy, once that is finalised, to provide a copy to the Committee.

CHAIR: Regarding DOCS policy of assisting unaccompanied children under 16 years in Supported Accommodation Assistance Program [SAAP] youth and accommodation services, your response to a question taken on notice referred to a recommendation in a report on the young people in care to replace the SAAP services. The recommendation requested that DOCS provide a report to you by 29 February 2008 on the progress in relation to this issue. Did you receive a report from DOCS?

Mr BARBOUR: We did receive a response and that response provided a timetable for its further work. However, there was very little detail in terms of what progress had been made and we have had to follow it up further with DOCS.

CHAIR: Regarding the consultant's review of the community services division, are you satisfied that 65 per cent of those surveyed felt that they were kept informed about the progress of the complaint?

Mr BARBOUR: I think all the results of the survey were extremely pleasing. They were a comprehensive set of questions that covered not only individual complainants but also stakeholders and peak agencies. The results we found to be overall extremely positive. What we have done is we have addressed what we see as being further work that we can do as a result of the results of the survey and we have looked at ways we might be able to further improve our information provision to complainants and to others who might make a complaint. Also we have streamlined some of our complaint handling processes to take up some of the concerns that were raised in the review. I am not sure whether we have given the Committee a complete copy of the survey. If we have not, I would be very happy to provide the Committee with a copy of that document.

CHAIR: That was to be my next question—could a copy actually be provided to the Committee—so thank you for that. Do other members have questions?

Mr PAUL PEARCE: Firstly, in relation to legal professional privilege, I would be interested to see your arguments in relation to that. The question that immediately springs to my mind is if the claim of professional privilege by the agency is based upon potential criminality or liability of an individual, what would be the consequence then of your overcoming that legal professional privilege if there is subsequent legal action? Would that information which has been obtained be able to be used in subsequent court proceedings?

Mr BARBOUR: No, it would not, and it certainly does not present any problems to the other agencies that have access to the information. We do not see this used frequently in

what we would regard as being genuine circumstances of the kind you are describing. What we do see happening is agencies obtaining legal advice and as a consequence of obtaining legal advice arguing that that is material or information that should not be provided to us. What we have demonstrated in the paper is that that serves no good purpose whatsoever.

Mr PAUL PEARCE: No.

Mr BARBOUR: Indeed, in our freedom of information [FOI] jurisdiction, we do not have a similar impediment and there has been no issue that I am aware of where any agency has been able to claim an adverse consequence as a result of us having access to that information.

Mr PAUL PEARCE: So you consider the agency is simply using this as a device to block access to information that is legitimate to your inquiries?

Mr BARBOUR: I do not think all agencies do, but I think in the large majority of cases where it is put forward, it is done in an attempt to prevent us from looking in more detail at a particular matter.

Mr PAUL PEARCE: In the report you have prepared, do you cite examples of when this has occurred?

Mr BARBOUR: Yes. We have actually included two case studies—one which relates to a professional standards board and one which relates to New South Wales Police—to give you an indication of the sort of flavour of the issues. I have copies here. I am happy to provide them to the Committee.

Documents tabled.

Mr PAUL PEARCE: I refer to the questions on notice on the fourteenth annual general meeting, 2006-07, page 16, question 5, covert operations, where you mentioned the issue of B-party warrants. I have a couple of issues with that, combined with the chart on the next page. Do you consider you have adequate oversight powers to ensure there are not potential abuses in relation to these B-party warrants? Possibly related to that, I notice from the number of applications for telecommunications interception warrants Australiawide that there is a general trending down in the number of warrants but New South Wales is going in the opposite direction. Are you comfortable or satisfied you have oversight powers to ensure that the various agencies are not simply going to warrants as a matter of first call rather than other forms of investigation and policing?

Mr BARBOUR: I will ask Mr Andrews to address the bulk of your questions, as he is the manager responsible for that particular area and function, however before doing that if I can just make the observation that much of our oversight responsibilities in relation to these types of operations are an audit type function. So, it is incumbent upon us to make sure that the particular legislative steps or procedures that are in place that must be complied with are complied with. So, we can look at the material and the warrants and the information to assess whether or not those steps have been complied with and bring to the agency's attention any concerns we have. As to the issue of whether there is merit in the issuing of the warrant, that is not an area we would be able to look at. Indeed, in most cases that is the responsibility, for example, where a court or tribunal has to authorise the issuing of it, up to

the member who makes that decision. But I will hand over to Mr Andrews to deal further with the numbers.

Mr ANDREWS: The telecommunications interception regime is the oldest one in terms of the Ombudsman being the authority who checks on compliance. It dates back to the early 1980s. Our compliance function there is strictly an audit of records. It does not go into the merits of whether the warrant should have been issued in the first place. As the Ombudsman said, that decision is made by a judicial authority when they grant the warrant. The biggest problem with the telecommunications interception regime is that the New South Wales Act, which empowers the Ombudsman to oversight the record-keeping of the agencies, is now out of step with the overarching Commonwealth legislation because the New South Wales Act has not kept up with amendments that have been made progressively with the Commonwealth legislation. So, at the moment, for instance, in regard to named person warrants, while they get checked at the Commonwealth level in other States, we are currently not authorised to report on that. The Act just does not require you to give the extended information and detail about them as happens in other jurisdictions.

Mr PAUL PEARCE: Hence the lack of information in the answer to the question?

Mr ANDREWS: Yes. What we can say about the trending down is that the biggest users of telecommunications interception warrants in New South Wales are the police and the Crimes Commission. Particularly the Crimes Commission works at a very high level of law enforcement investigation and you will find its effectiveness is largely dependent on information that comes from telecommunications interception, surveillance devices and controlled operations. Most of the big successes in high-level corruption and crime come from those investigative tools because the normal investigative tools are not appropriate because of the sophistication of those criminal conspiracy organisations.

Mr PAUL PEARCE: The point you made in relation to the oversight audit in relation to B-party warrants, would you be able to supply the Committee with information as to where the inconsistency lies between the Federal overarching legislation and the New South Wales legislation?

Mr ANDREWS: Yes, we can do that.

The Hon. CHARLIE LYNN: Mr Barbour, you mentioned the issue of legal professional privilege that you previously addressed to this Committee. How long ago was that and how many times have you addressed it?

Mr BARBOUR: It was raised in the context of the 10-year police oversight review that the Committee conducted at the end of 2006. It was raised as one of a raft of issues. It was not highlighted as a specific issue but that was because police were relying on it to some extent as they continue to do. The example I provided in the document we prepared for members relates to advice being obtained about whether police were able to exercise particular powers. The police denied us access to the advice on which they based their decision regarding their investigation and we then had to get supplementary and separate advice to determine what our view would be. It is unproductive. There is no reason, I believe, that that should take place. Certainly, in terms of the rationale behind the oversight role of the Ombudsman, to not have access to all that information really can potentially limit the quality and efficiency of the oversight we are able to perform.

The Hon. CHARLIE LYNN: I see that, and I see in the submission you presented to us that both the ICAC and the Police Integrity Commission have similar sections but they do not have the exemption, which is other than a claim based on legal professional privilege, that you have.

Mr BARBOUR: Yes, and interestingly that exemption does not arise in our freedom of information jurisdiction either. So, in relation to the handling of matters pursuant to our FOI jurisdiction, when we get complaints in that area we are not similarly limited.

The Hon. CHARLIE LYNN: Are you aware of any problems this causes in other States that have that exemption?

Mr BARBOUR: No. I think if it did cause any problems, those provisions would not last very long in that legislation. I think it is an anomaly. I do not know why it is there. I think it was precautionary probably from the first point of time, but time passes on and it should be amended.

The Hon. CHARLIE LYNN: You mentioned that you received 6,000 formal applications and 16,000 informal matters. How are the resources of the Ombudsman, your organisation, equipped to handle this amount of requests for investigation?

Mr BARBOUR: That number is relatively consistent with the past few years, if you extrapolate it on a 12-month basis. So, you will see from the figures presented in our annual report for the past 12-month period up until June, they would represent almost double the figures I just quoted. We have a range of systems in place to deal with those matters. Certainly the informal matters are dealt with most effectively by our inquiries area, which is our front point of call if you like. That area is now very sophisticated. It is well staffed and we try to manage that area in an effective and efficient way. I think we get results. The formal matters are those that are the subject of writing. What those figures do not indicate, of course, is the percentage of matters that might be outside the jurisdiction, where we need to refer people to other avenues. They might also present areas that we would traditionally decline at the outset and then a subset would go on to preliminary inquiries and potentially further investigation. So, the numbers are relatively similar to what we have had over the past couple of years and the systems in place are adequate to deal with those.

The Hon. CHARLIE LYNN: Are you happy with the level of cooperation you get from the New South Wales Police with regard to investigations regarding police?

Mr BARBOUR: Generally yes. That relationship has come after a considerable amount of hard work and effort on the part of our office, the Police Integrity Commission and the New South Wales Police Force. I think the system works more effectively now than it did several years ago. I think the streamlining trial that I indicated in my opening was progressing well is an example of how that process has been enhanced. The police had been advised by us for many years that we saw the processes of the complaint management teams as a potential bottleneck. They finally accepted our view that they could look at doing things that were less significant complaints in a different way, and the trial is demonstrating that we are apparently getting similar outcomes with a much quicker and much more streamlined process as a result of taking those matters out of the CMT

structure. So, that is indicative of the fact that we are working reasonably well together to try to get positive outcomes for those who have complaints about police.

The Hon. CHARLIE LYNN: One of the issues I came across was in regard to Operation Retz. As much as one could go through that extensive amount of documentation in that investigation, one of the points that seem to come up for me from time to time was that police could effectively stonewall the Ombudsman and often, given the pressure of time and the pressure of resources, it seemed to me by the Ombudsman representative investigating, they come up with recommendations such as, " Well, I should have interviewed policeman X or policeman Y, however he was not made available or I could not get around to it or I did not have the time, and therefore, based on the evidence I have, I have had to make this finding." It seemed to me if the representative got to interview them, he probably would have made a different finding. Have you any comment on that?

Mr BARBOUR: I am not sure they would have made a different finding. Certainly, the issue of delay in police investigations is something that we are very vigilant about and mindful of. We have a regular audit process in place to look at all matters older than six months that are the subject of investigation by police, and we are beginning to check very closely with police once that time point is reached what is causing the delay. Like any area of investigation, there are straightforward minor matters that do not require a great deal of work and then there are others—you mentioned Retz, which is a matter that went on for several years and involved an enormous amount of investigation. Obviously there are going to be cases of the latter kind, which will take some time. In addition to that issue, the availability of officers sometimes becomes problematic when they are off on leave, particularly when they are off on stress leave, and currently the rules require that they are not able to be forced to be interviewed unless there is the potential for criminal charges to be laid. So that standard will often not be reached in many investigations.

The investigator and also our office are then left with the task of trying to balance what is in the public interest and what is best. Should the investigation without that interview be concluded to the best of the officer's ability who is conducting the investigation or is that interview so crucial to the investigation that we need to hold off and delay the matter? Many factors will come into play in relation to that, not the least of which is the seriousness of the matter that has been referred, whether the complainant is taking legal proceedings or not, the complainant's own concern around timeliness. All of those have to be weighed up. It is not a black-and-white situation so I cannot give you a black-and-white answer but certainly we are mindful of those issues.

We have through our audit process—and we have provided information to the Committee about this—been satisfied that the deficiency is relatively low in relation to these investigations by police. Any matter where we are concerned about the outcome of the investigation—whether it be because of failure to interview someone or for some other reason—we look at that matter very closely. They are the very matters that we might investigate ourselves or send back for further work, depending on the nature of the particular problem. So, they are issues we are conscious of and we are very focused on.

The Hon. LYNDA VOLTZ: One of the first things I would like to ask is what is an Aboriginal specific genogram project? It is in response to Aboriginal, children and young people.

Mr BARBOUR: What page are you referring to?

The Hon. LYNDA VOLTZ: Page 5 of annexure B.

Ms BARWICK: It is a map of family relationships. It is like an organisational chart for a family.

The Hon. LYNDA VOLTZ: Has DADHC provided any of the completed or draft forms on its child protection policies? It advised you in August 2007 that it would?

Mr BARBOUR: We will take that on notice and get back to you. I am not specifically clear what particular policies they are, so I do not want to mislead you.

CHAIR: Mr Barbour, have you been briefed by the New South Wales Police Force regarding progress made in implementing the recommendations arising from Ms Chris Reynolds' inquiry into sexual harassment and discrimination in the New South Wales Police Force?

Mr BARBOUR: We have had ongoing contact with New South Wales Police in relation to those issues. As a result of our special report into the police college in 2006 and also that review, considerable work has been undertaken. The establishment of a workplace equity unit has occurred, and it is proposed that harassment and discrimination complaints will be the subject of consideration by that unit. We have participated in a working party examining arrangements for handling workplace harassment and discrimination matters, and we are awaiting further advice about the final proposals the police are putting forward in relation to that.

We did have some limited concern about this because it was going to take these matters out of the traditional complaint path. But, given the findings of Ms Reynolds and our own concerns about the way these matters were dealt with, there was a challenging balancing exercise to be undertaken in terms of what the appropriate mechanism would be, so we have decided to have a look at what New South Wales Police come up with and then we will assess to see whether we are happy with it or not.

CHAIR: Has the workplace equity unit been fully staffed?

Mr BARBOUR: I do not believe it is fully staffed; I think there are still positions vacant.

CHAIR: The Committee notes that you have been involved in correspondence with the Department of Education and Training regarding policy of a disclosure or school accident reports and that you intended writing to the director general in relation to this matter. Have you received a response from the director general?

Mr BARBOUR: If I could take that on notice. This has been a longstanding issue and one where the department appears to be continuing to attempt to find a way around the advice that we jointly obtained in relation to this issue.

CHAIR: You may wish to take the next question on notice. Would you be able to update the Committee on any progress the department has made in implementing the

recommendations of the review of the department's handling of freedom of information applications?

Mr BARBOUR: I have just been advised by the Deputy Ombudsman, who has had carriage of this matter, that there is a meeting scheduled soon to discuss these very issues. So we will be in a position to further advise you in due course.

The Hon. LYNDIA VOLTZ: With regard to underlying data systems, for example, under the Austrak transaction reporting regime there is an underlying data system that allows police to access bank statements, and social security and taxation details, and other agencies come up as a flag. Across these agencies, that appears to be part of the issue, does it not?

Mr BARBOUR: The quality of information exchange and access to information has come up time and time again in relation to so many areas that we are involved with. There is a range of significant impediments, unless there is the will of government and the Legislature to introduce laws to change existing situations. You run into difficulties with privacy, and you run into difficulties with agencies in terms of putting up barriers around their own areas of work and responsibility.

If I can take the area of child protection, for example, it is very clear from our across-agency work that holdings in relation to children and families that are potentially in crisis are held by multiple government agencies. The notion that those agencies should be prevented from exchanging that information where it is necessary for the care and protection of children seems extraordinary, and I have gone public on many occasions to say that every effort should be made to ensure that any limitations around those issues are removed. It is certainly one of the areas that I know the Wood commission will be looking at.

In terms of our own systems, we also approach, on a much smaller scale, the very issues which underpin the question you have asked; that is, about using our information holdings in a way which is intelligence-based. For example, in the policing area we will often use the information we have in relation to police complaints to try to do project work to identify and target problem officers so that we might identify them and speak to local area commands about what strategies are going to be in place to prevent other problems arising in relation to particular officers.

To answer your question, yes, across a whole range of areas it would be very good to have a greater degree of cooperation in terms of data and access to that data—ensuring, of course, that there is proper privacy, where it is necessary, and there are proper safeguards in place about the use of that information.

Mr PAUL PEARCE: I refer to attachment D, at page 45-46: "It is interesting to note that the UK legislation has only one ground for the making of a care order—that the child has suffered or is likely to suffer significant harm. There is then a reference to the attitude of the Children's Court on this. Do you have a view as to the appropriateness of that?"

Mr BARBOUR: Is that the Children's Court paper?

Mr PAUL PEARCE: In relation to care proceedings in the Children's Court.

Mr BARBOUR: Once again, this is a very complex area. The Wood commission just recently conducted a public forum about the Children's Court. What is interesting is that when you get a whole lot of people who are actively involved in this particular area, you can bring them in and each one will have a different view about what ought to happen, in relation to care proceedings, for example. I do not want to put a particular view in relation to that. If that is an area of particular interest to the Committee, I am certainly happy to provide you with a copy of the Children's Court paper that we have prepared for the Wood commission, which it already has.

One of the things we have found particularly challenging is looking at the relevance and applicability of what happens in other jurisdictions, whether it be within Australia or overseas. It is very hard to look at something that appears to be working in another jurisdiction without having a very good understanding of what underpins it and whether or not it is applicable here. If I could use an example—which is quite different from the one you are talking about but nonetheless of interest, I think, to the Committee—and that is around access and visiting foster carers. Our visitable service legislation prevents us from being able to do that. We have official community visitors; we have about 34 visitors with a budget of a little under \$800,000. Queensland has 175 visitors, with a support staff of 35 and a budget of \$11 million, and they do visit foster carers. There are a lot fewer of them, but it is also a much more financially supported system and one that is supported in terms of other resources than what we have here. Would that translate to here? I do not know, but it is not going to be able to unless we have double those resources, given the number of foster carers we have.

In looking at other jurisdictions and what is in place, I think we need to be very careful about how we emphasise whether or not they might be useful here. One of the things we have been cautious about with the Wood commission, for example, is to in any way put forward particular views about what ought to happen. I am much more comfortable about putting the range of options and what we are seeing as being some of the pluses and minuses in relation to those.

Mr PAUL PEARCE: At page 60-61 of the same document, there is a comment that the Legal Aid Commission reports that section 82 reports are often inadequate or incomplete, or even inaccurate. Further, the Legal Aid Commission said that while the system requires that orders are made for the long-term placement of children in out-of-home care, no actual placement is identified or even guaranteed. Would you like to comment on that?

Mr KINMOND: In terms of the monitoring of placements, last year we conducted a review of 49 children under five and we had a look at how well the monitoring of these placements was taking place. We found that on a number of occasions, whilst the court had ordered that a monitoring report be provided back to the court, that did not take place and it did not seem to be picked up by the court. So in our recent submission to James Wood in terms of his special commission of inquiry, we have raised that issue and said that if this system is to be in place, obviously there needs to be some rigour applied to it.

Mr PETER DRAPER: Mr Barbour, in the comments on the 2005-06 annual report your office suggested some methods that councils could use to reduce complaints made about developments. The response provided said that basically you are relying on general managers of councils reading your annual report and delving into it. Given the recent incidents in Wollongong, would it be appropriate to circulate that sort of information as a

matter of course to all councils, rather than just relying on the general manager reading something online?

Mr BARBOUR: I think we certainly could. We provide a lot of information to all areas of government, including local government, about appropriate codes of conduct, about appropriate investigation and complaint-handling systems, and that information we make readily available. Given the number of councils, it is very difficult for us to have a one-on-one contact with them, and also we see the Department of Local Government having a direct role in relation to this as well. But I am certainly happy to look at any opportunities we have to improve the quality of governance within local government.

Mr ANDREWS: May I also add that we make good use of our annual reports and we reuse a lot of information, so when similar complaints crop up in the future often we will quote those same suggestions back to people, sometimes fine-tuned. But just because we said something at one point in history does not mean we do not have an ongoing campaign to push those ideas forward.

Mr BARBOUR: Interestingly as well, the association at one point was very concerned that we publish the statistics we have in our report about the number of complaints and what happens with them for each council. I resisted that approach, and will continue to publish those details. Local councils do not like it. Often they are misinterpreted by the press, but if we do get 25 complaints about Gosford council or about Sutherland council, I am quite happy for that to run in the local press.

Mr MALCOLM KERR: In relation to legal professional privilege, Mr Barbour, you said you assumed it was just precautionary. Have you made any inquiries as to why that provision exists?

Mr BARBOUR: No. I do not think there is any information in any of the second reading speeches or any of the information relevant to the introduction of the legislation. I think what is very telling, of course, is the fact that it no longer is the case in any other jurisdiction for any other Ombudsman's Office. If there were problems with removing it, we would certainly be live to that from those issues arising in other jurisdictions, but we are unaware of any.

The Hon. LYNDIA VOLTZ: Community visiting officers have the ability, I understand, to take an issue to the Minister or the Ombudsman. If they were taking a complaint to the Minister, what do you believe would be the process there?

Mr BARBOUR: It is difficult for me to comment on behalf of the Minister. Technically, the official community visitors are the Minister's visitors and they work for the two Ministers that have portfolios in relation to disability and community services. We work to administer the program, and we use the information that comes in; we are involved in the training and the support and assistance to the visitors. I am unaware of the visitors regularly making complaints to the Minister. In fact, I think that probably does not happen all that often. I am aware that on a several-times-a-year basis Ministers will organise and convene a meeting with the visitors, and I think that is often used as an opportunity to raise particular concerns. But certainly any concerns that the visitors have come to us and we use that information, as well as our complaint-handling information, to gain a very clear picture of what is happening in particular services.

The visitors do a remarkable job, and in very isolated conditions in rural New South Wales, travelling long distances and visiting very challenging locations. They do a really good job in terms of keeping eyes and ears open on the ground for us about what is going on in services.

The Hon. LYNDA VOLTZ: There is that two-pronged approach with the two areas that they can report to the Ombudsman or the Minister. Is there a level—

Mr BARBOUR: It is not an either/or. Reports of their visits always come to us. It is discretionary as to whether they believe they should agitate a particular issue to the Minister or not. That would be a question best asked of an official community visitor. As I said, I am unaware of them raising particular issues with Ministers but built in to the legislation is the capacity to do that if they feel it appropriate.

The Hon. LYNDA VOLTZ: I asked the question because an official community visitor who came before the Committee said that they had raised a complaint with the Minister but had not received a response from the Minister. In fact, it had come back from the department about which they were making the complaint?

Mr BARBOUR: Yes, I remember reading a briefing about that. I cannot speak on behalf the Minister, nor are Ministers within my jurisdiction—there are often times I wish they were.

The Hon. LYNDA VOLTZ: I am just wondering whether that needs clarification. That is more my question?

Mr BARBOUR: Traditionally, my understanding is the way that Ministers work would be if a particular issue was raised by anybody, whether it be an official community visitor or a complainant or a family member, and they wrote to a Minister, the Minister would normally seek a briefing from the department and it would be up to the individual Minister as to whether they would author a response back themselves or whether they would get the agency to do it. I think different Ministers have different practices in relation to that.

Mr MALCOLM KERR: Can you give examples of the times when you wish that Ministers were under your jurisdiction?

Mr BARBOUR: I do not think the meeting could go that long.

CHAIR: Mr Barbour, regarding legal professional privilege would you be prepared to take some questions on notice from the Committee on this matter?

Mr BARBOUR: Absolutely. We would welcome the Committee taking the issue on board for us. We think that would be of advantage.

CHAIR: In relation to the brief that was provided to the Committee earlier, would you like to table that as a public document or would you prefer it to be kept confidential?

Mr BARBOUR: The legal professional privilege brief?

CHAIR: Yes.

Mr BARBOUR: I think at this stage it would be best to keep it confidential and we could consider making it public—only because of the particular examples. If we are going to be tabling things, I have an updated copy of our brochure on our legislative reviews for the Committee. The brochure gives up-to-date information about where our current legislative reviews are at and also gives the details historically of some of the reviews and what has been happening in relation to those. In addition I have a one-page briefing document on the progress on our unreasonable complainant conduct project.

CHAIR: Thank you for providing those to the Committee. That concludes the 14th general meeting with the New South Wales Ombudsman and statutory officers from his office.

The Committee adjourned at 11.19 a.m.

Appendix 1 – Committee Minutes

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 1)

10 am Thursday 28 June 2007
Room 814, Parliament House

Members Present

Ms D'Amore MP Mr Draper MP Ms Hale MLC
Mr Kerr MP Mr Pearce MP

Apologies

Apologies were received from Mr Lynn MLC and Ms Voltz MLC

Also Present

Les Gönye, Glendora Magno, Samantha Ngui, Hilary Parker, Pru Sheaves

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General Business

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- The Chair advised committee members of the need to hold general meetings to consider the most recent annual reports of the NSW Ombudsman, the Police Integrity Commission and the Inspector of the Police Integrity Commission.

The committee adjourned at 10.36 am until a date to be determined.

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 2)

10 am Thursday 27 September 2007
Room 1102, Parliament House

Members Present

Ms D'Amore MP Mr Draper MP Ms Hale MLC
Mr Kerr MP Mr Lynn MLC Mr Pearce MP
Ms Voltz MLC

Also Present

Samantha Ngui, Hilary Parker, Pru Sheaves

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Resolved on the motion of Mr Draper that questions on notice for the Fourteenth General Meeting relating to the NSW Ombudsman Annual Report 2005-06 be sent to Mr Barbour.

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The Secretariat were requested to circulate a calendar so that a day for both the Ombudsman and PIC General Meetings could be fixed for early December if possible.

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The committee adjourned at 10.15am until 15 October 2007.

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 4)

10 am Thursday 29 November 2007
Room 1254, Parliament House

Members Present

Ms D'Amore MP	Mr Draper MP	Ms Hale MLC
Mr Kerr MP	Mr Lynn MLC	Mr Pearce MP

Apologies

Ms Voltz MLC

Also Present

Nina Barrett, Jonathan Elliott, Samantha Ngui, Hilary Parker, Pru Sheaves

The meeting commenced at 10:03am

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3. General Meetings Program

The Chair confirmed that, following the circulation of calendars to members, public hearings for the statutory review of the Community Services (Complaints, Reviews and Monitoring) Act would be held on Tuesday 11 and Thursday 13 March 2008 and the General Meetings with the NSW Ombudsman and the Police Integrity Commissioner would be held on Tuesday 18 March 2008.

Resolved on the motion of Mr Pearce that questions on notice for the Fourteenth General Meeting, relating to the NSW Ombudsman's Annual Report 2006-07, be sent to Mr Barbour and questions on notice for the Tenth General Meeting, relating to the Police Integrity Commission's Annual Report 2006-07, be sent to Mr Pritchard.

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The committee adjourned at 10.10am.

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 5)

10.30 am Thursday 28 February 2008
Room 1254, Parliament House

Members Present

Ms D'Amore MP	Mr Draper MP	Mr Kerr MP
Mr Pearce MP	Ms Voltz MLC	

Apologies

Ms Hale MLC, Mr Lynn MLC

Also Present

Nina Barrett, Samantha Ngui, Hilary Parker, Pru Sheaves

The meeting commenced at 10:44am

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5. Forthcoming public hearings

The Chair briefed the Committee on the schedules for public hearings:

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- on 18 March in relation to the General Meetings with the NSW Ombudsman and the Police Integrity Commission.

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The committee adjourned at 10.52am until Tuesday 11 March 2008.

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 8)

10.00 am Tuesday 18 March 2008
Jubilee Room, Parliament House

Members Present

Ms D'Amore MP	Mr Draper MP	Ms Hale MLC
Mr Kerr MP	Mr Lynn MLC	Mr Pearce MP
Ms Voltz MLC		

Also Present

Nina Barrett, Jonathan Elliott, Samantha Ngui, Pru Sheaves

Fourteenth General Meeting with the NSW Ombudsman

The Chair opened the public hearing at 10.15am.

Mr Bruce Barbour, New South Wales Ombudsman; Mr Christopher Wheeler, Deputy Ombudsman; Mr Gregory Andrews, Assistant Ombudsman (Police); Ms Helen Ford, Acting Assistant Ombudsman (General), affirmed. Mr Stephen Kinmond, Deputy Ombudsman (Community Services Division) and Community and Disability Services Commissioner; Ms Anne Barwick, Assistant Ombudsman (Children and Young People) took the oath.

The Ombudsman's answers to questions on notice relating to the Annual Reports for the years 2005-06 and 2006-07, dated 15 October 2007 and 11 February 2008 respectively, were tabled as part of the sworn evidence. The Ombudsman made an opening statement. The Chair then commenced questioning the witnesses followed by other members of the committee.

The Ombudsman provided a briefing paper on legal professional privilege for the information of the committee, as well as an updated copy of a brochure on the office's legislative reviews and a briefing document on the progress of the office's unreasonable complainant conduct project.

The General Meeting concluded at 11.19am and the committee adjourned until 11.45am.

Minutes of Proceedings of the Committee on the Office of the Ombudsman and the Police Integrity Commission (No. 9)

10.30 am Thursday 3 April 2008
Room 1102, Parliament House

Members Present

Ms D'Amore MP	Mr Draper MP	Ms Hale MLC
Mr Kerr MP	Mr Pearce MP	Ms Voltz MLC

Apologies: Mr Lynn MLC

Also Present

Nina Barrett, Samantha Ngui, Hilary Parker, Pru Sheaves

The Chair opened the meeting at 10:40am.

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2. Correspondence

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b) *Fourteenth General Meeting with NSW Ombudsman*

Resolved on the motion of Mr Draper that the Committee write to all General Managers drawing their attention to the local government section of the Ombudsman's 2005-2006 Annual Report, in particular the list of suggestions about how to better manage complaints regarding development applications.

Mr Pearce then moved an amendment as follows: that the Committee draw attention to the following paragraph on page 84 of the Annual Report:

Councils continue to have responsibility for illegal works unconnected with the development consent, and remain ultimately responsible for serving orders on recalcitrant developers. Complainants often raise multiple issues that may require action by both council and the private PCA.

Discussion ensued, following which the Committee adopted the resolution as amended.