NSW Ombudsman

Annual report 2007–2008

We are **fair**, impartial and independent of the Government of the day.

fair

To promote good administrative conduct, *fair* decision-making and standards of service delivery, we try to visit as many communities across the state as possible.

Bangalow, NSW

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We are fair, impartial and **independent** of the Government of the day.

We are *independen*t of the government of the day and are accountable to the public through Parliament itself.

Parliament House, Sydney NSW

Letter to the Legislative Assembly and Council

22 October 2008

The Hon. Peter Primrose MLC
President Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

The Hon. Richard Torbay MP
Speaker Legislative Assembly
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Mr President and Mr Speaker

I am pleased to present our 33rd annual report to the NSW Parliament.

This report contains an account of our work for the 12 months ending 30 June 2008 and is made pursuant to ss.30 and 31 of the *Ombudsman Act 1974*.

The report also provides information about my office's functions under the *Police Act 1990* and information that is required pursuant to the *Annual Reports (Departments) Act 1985*, Annual Reports (Departments) Regulation 2005, *Freedom of Information Act 1989* and *Disability Services Act 1993*.

The report includes updated material on developments and issues current at the time of writing (July–September 2008).

Yours sincerely

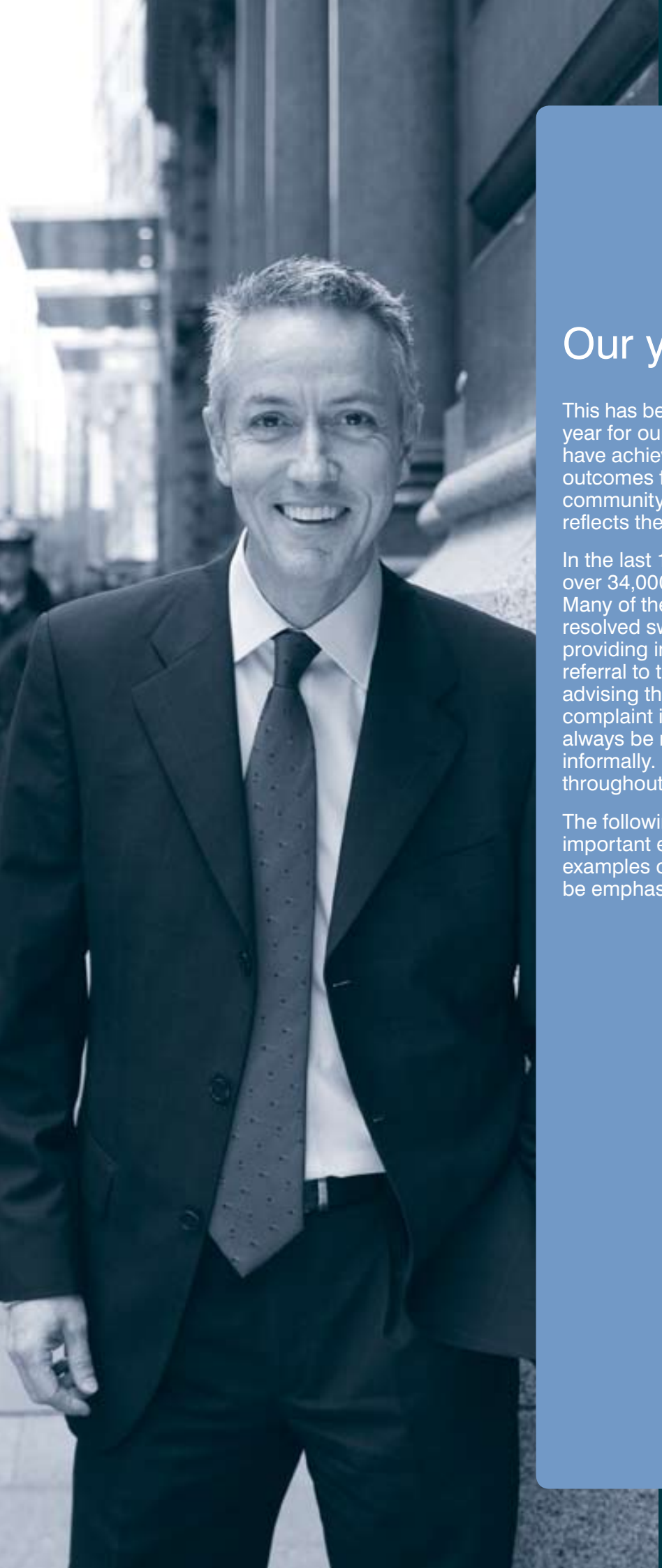
Bruce Barbour
Ombudsman

We are fair, **impartial** and independent of the Government of the day.

impartial

The NSW Ombudsman is an independent and *impartial* watchdog established by the *Ombudsman Act 1974*.

Bruce Barbour, Ombudsman
Martin Place, Sydney NSW



Our year in review

This has been another busy and challenging year for our office. I am pleased that we have achieved a large number of positive outcomes for both complainants and the community, and this year's annual report reflects these outcomes.

In the last 12 months, we have received over 34,000 complaints and notifications. Many of these matters were able to be resolved swiftly and informally, either by providing information or an explanation, referral to the relevant agency, or by advising the individual to put their complaint in writing. However, there will always be matters that we cannot resolve informally. Many of these are detailed throughout the report.

The following pages outline a number of important events of the past year, and examples of our work, that I think should be emphasised.

Our year in review

Assessing our role

In 2002, the Community Services Commission was merged with my office. In June this year, the Parliamentary Joint Committee (PJC) that oversees our work completed a statutory review of the *Community Services (Complaint, Reviews and Monitoring) Act 1993*. This review assessed, among other things, the effectiveness of the merger and the success of the community services work we do. The outcome was very positive. The PJC expressed strong support for our work and suggested that additional funds be allocated to certain areas, such as the official community visitors program.

Earlier this year, my senior staff and I met with the PJC for our 14th general meeting. These meetings allow us to provide the PJC with an update on our work, as well as answer any questions they may have. The meeting was successful, with the PJC supporting a suggested change to our legislation which will bring it into line with other Ombudsman Acts around Australia.

Much of our work relates to the adequacy of the various child protection services in NSW, and we welcome any attempts to ensure that these services and their supporting systems are operating as effectively as possible. In November 2007, the state government established a Special Commission of Inquiry into Child Protection Services in NSW, headed by Justice James Wood. The commission has conducted public hearings across the state and received a large number of written submissions. We have provided Justice Wood with a range of information he has requested — as well as a large amount of additional information that we believe to be relevant. This has included ten detailed submissions on various different topics. They are expected to issue their final report later this year. For more information about the Wood Inquiry, see pages 63 to 66 in Chapter 3: Children and young people.

Working proactively across the community

Although there are often systems in place to provide essential services, it is important to monitor these systems to ensure they are being implemented correctly and consistently. Our proactive project work allows us to identify gaps in services, as well as assess how effective existing policies and procedures actually are in practice.

These projects also give us the opportunity to speak with a range of people across the community — such as foster carers, parents, teachers, children and young people, police officers and staff from community service centres — who deal with these policies and procedures every day. In the last year, staff from our corrections unit have spent 167 days at 28 different correction centres, talking with both inmates and staff. We have also made 17 visits to the State's nine juvenile justice centres. All of these groups, either as providers or recipients, have an interest in ensuring that systems operate properly and their input is invaluable to our work.

This year we have examined the way in which people with a mental illness access and maintain social housing, the processes around suspensions in our public schools, and the level of support provided to foster carers looking after Aboriginal children. We have also commenced two reviews of the services provided to people with a disability by the Department of Ageing, Disability and Home Care (DADHC). When we have completed systemic investigations such as these, we continue to monitor the progress of our recommendations. A good example of this is our continued interest in the policing of domestic violence. Since releasing our final report at the end of 2006, we have worked with police and other involved agencies to improve interagency responses to instances of domestic violence.

Reviewing legislation

In addition to examining the way in which policies and procedures are implemented, we also review the operation of certain pieces of legislation.

In April this year, I announced that we would be conducting a comprehensive review of the NSW *Freedom of Information Act 1989*. This important legislation helps to ensure that the public are able to access information held by government, and that decision makers can be held to account for their actions. I do not believe that the FOI Act in NSW is operating as effectively as it should, and I have been calling for an independent review of the Act for some time. As there has been no response from government, we have decided to conduct our own review.

As part of our review of the *Law Enforcement (Powers & Responsibilities) Act 2002*, we conducted a survey of defendants to assess their experiences when searched by police. These first hand accounts are very useful as they provide us with a better understanding of the way in which the legislation is being applied. We have also finalised our review of the emergency powers provided to police in the wake of the Cronulla riots. Our final report was tabled in Parliament in November 2007.

Improving customer service and complaint-handling

While our proactive projects can help ensure that government services are properly implemented, it is also important to monitor the way in which agencies interact with the community. We work with agencies to improve their day-to-day contact with the public by reviewing their complaint-handling systems, conducting mystery shopper audits, and providing training to frontline agency staff.

JGoS investigation

Following an investigation involving a long term public housing tenant, we decided to conduct a broader investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). JGoS is an agreement between the Department of Housing, NSW Health, the Department of Community Services, the Aboriginal Housing Office and the Aboriginal Health and Medical Research Council. As part of our investigation, we have met with over 450 people — including those working directly in the area and acting as advocates for those receiving the services. For more information, see page 31 in 'Our organisation'.

Foster carer project

More than 30% of children and young people living in out-of-home care in NSW are Aboriginal. In the past year, we have conducted a detailed review of the services and support provided to those caring for these children. We travelled throughout the state, speaking with over 100 carers as well as service providers and others working in the area. We found that, although there were services in place, many carers had little contact with them and were often unaware of the support systems that they should be able to access. For more information, see page 49 in Chapter 1: Community engagement.

School suspensions

We have recently completed an investigation into the Department of Education and Training's procedures for school suspensions. We found that the existing procedures provide a strong framework for managing long suspensions, but they were not always fully and correctly implemented. We have made a number of recommendations that have been welcomed by the department. For more information, see page 134 in Chapter 8: Departments and authorities.

FOI review

Our review of the FOI Act involves a number of different elements. We are looking into the FOI practices and procedures of 18 government agencies. This will involve speaking with FOI staff, a random audit of FOI files, and a detailed request for information relating to processing FOI applications. We have also asked for information from councils and the Administrative Decisions Tribunal.

We are collecting as much information as possible about approaches in other jurisdictions, and released a discussion paper for public comment in early September. The information collected through this process, along with our long experience dealing with the FOI Act, will be used to prepare a final report and recommendations to Parliament. For more information about our FOI review, see page 146 in Chapter 10: Freedom of information.

Last year we reported that we had started a review of the complaint-handling systems of 350 NSW government agencies, public authorities and councils. By assessing responses to a detailed questionnaire and documents provided by the agencies involved, we have been able to draw a high level picture of complaint-handling across the state. We have also been able to identify changes over time, as we conducted similar reviews in 1994 and 1999.

Our community services division also completed a smaller, more targeted complaint-handling review of 20 agencies providing family support services. This review identified areas where further education was needed, and we have worked with the Department of Community Services and Families NSW to implement training to provide guidance to workers in this sector.

In 2006, we began work on a framework for managing unreasonable complainant conduct. Although the majority of complainants act reasonably, a small number are unwilling to accept our decision or the decisions they receive from other agencies. These individuals can become aggressive, threaten to harm themselves or others, withhold relevant information or flood us with irrelevant information, make unreasonable demands, or insist on impossible or inappropriate outcomes.

Mystery shopper audits

This year's mystery shopper audit assessed the customer service provided by 30 councils. We called, emailed and wrote to the councils, asking for information that they should be able to provide fairly easily. We have given detailed feedback to all the councils involved, and have received a number of positive responses. For more information about the audit, see page 142 in Chapter 9: Local government.

Unreasonable complainant conduct project

The trial of the interim unreasonable complainant conduct practice manual, which has involved all the Parliamentary Ombudsman offices in Australia, ended in April this year. Over the last 12 months, we have provided training to staff from all of the offices involved — as well as to a number of other government agencies both here and interstate. Several of our facilitators recently travelled to New Zealand to provide training to staff from the New Zealand Ombudsman. The feedback we have received from participants in these training courses has been overwhelmingly positive. We are currently drafting a final report for the project and revising the practice manual. It will be available on our website once it is finalised.

The framework we have developed can help reduce the level of stress experienced by staff and complainants, as well as allow agencies to better manage their time and resources. This means they will be able to deal more equitably with all complainants.

We have worked closely with the New South Wales Police Force to streamline their complaint-handling procedures. This project should simplify the management of less serious complaints, which will allow investigators to allocate greater time and resources to more serious complaints. We have monitored a trial of this new system, and support its broader use in the future.

Providing training

As well as reviewing and auditing their actions, we also offer agencies a number of practical training courses aimed at improving their customer service. Training in areas such as frontline complaint-handling, conflict management, and dealing with unreasonable complainant conduct provides complaint-handling staff with the tools they need to deal with difficult situations. In the last 12 months, we have provided training to NSW and interstate government agencies, as well as staff from other Ombudsman offices.

Our training is not only aimed at agency staff. This year our community education unit held 80 workshops and training sessions for over 1,600 consumers, staff and community service providers. It is vital that members of the public are aware of their rights, as well as the services they are able to access. This 'community contact' is an important part of our work and we plan to expand it next year through an online newsletter.

Working with other oversight agencies

Mr Bill Angrick, President of the IOI thanking Bruce Barbour, for hosting the 2007 annual meeting of the IOI Board.

Contact with other oversight agencies, both here and overseas, allows us to share our experience and learn how we can improve our own practices. We are an active member of the International Ombudsman Institute (IOI), take part in a number of federally funded regional development projects, drive nationwide improvements in Ombudsman practice, and provide information and practical training to staff from state, national and international agencies and organisations.

The IOI is the only truly international grouping of Ombudsman offices. Membership provides us with an opportunity to exchange ideas and experiences with over 150 international Ombudsman, many of whom deal with very different jurisdictions and issues to us. In November 2007, I hosted the annual meeting of the IOI Board. This was a particularly important meeting as it involved discussion of the future direction of the IOI. The Board considered the future location of the IOI head office, the IOI's relationship with other international organisations, and the type of services IOI members wanted and expected from the institute.

In addition to the IOI, we also participate in a number of projects to assist less established international oversight agencies. Along with the Commonwealth and Western Australian Ombudsman, we are involved in a three-year project aimed at developing stronger links between Australian and Indonesian Ombudsman, improving Indonesian Ombudsman practice and procedures, and increasing the Indonesian people's understanding of their rights. This year, staff from the National Ombudsman Commission of Indonesia (NOC) have spent time at our office, several of our staff travelled to Indonesia to provide assistance, and I was invited to Jakarta in August 2007 to take part in a panel discussion on the future of the NOC.

We are also closely involved with Pacific Island Ombudsman offices and work with them through the Australasian and Pacific Ombudsman Region (APOR) of the IOI, as well as the Pacific Island Ombudsman Network. The Assistant Ombudsman and I, along with staff from a number of other Ombudsman offices, have recently taken part in a scoping exercise to identify the best possible oversight model for smaller Pacific nations who currently do not have any form of oversight.

Reviewing the way we operate

We have achieved a great deal in the past year, but it is important that we are always looking for opportunities to further improve the way we work. This year, for example, we have refined our information technology systems and accounting practices to make them as efficient as possible. We are also standardising the terminology used by different parts of our office to streamline our performance management.

Our last annual report outlined the creation and initial work of our cross agency team, or CAT. The inclusion of CAT in the office has successfully driven much of our project work, and following an external evaluation, I decided to establish CAT as a permanent unit within our office.

I hope that this brief summary has demonstrated what a demanding, but productive, year it has been. None of the positive work I have described would have been possible without the high level of professionalism and dedication shown by my staff. I would like to thank all of them for their hard work and look forward to continuing to work to this high standard in the coming years.

Bruce Barbour
Ombudsman

IOI Board members at the 2007 annual meeting.

Snapshot of the year

Responding to complaints and notifications

This year a total of 34,021 complaints and notifications were brought to our attention by a variety of people — including members of the public, families of people who are receiving community services, Members of Parliament and staff who work in the public sector. They brought to our attention a broad range of concerns via 9,320 formal complaints and notifications and 24,701 informal complaints and inquiries.

This year we finalised more formal complaints and notifications than we received (see figure 1).

As we have jurisdiction over a range of agencies and specific functions under a number of pieces of legislation, we categorise matters to ensure that we provide the most appropriate response. Figure 2 shows a breakdown of the complaints and notifications we received this year.

How we handle different types of matters

We divide the complaints we receive into formal and informal matters. This determines the process we use to handle them. Generally, we define formal matters as written complaints and notifications and informal matters as complaints that are made over the telephone or in person.

If a complainant is a vulnerable member of the community and it may be unreasonable to ask them to make a written complaint, we will take their complaint verbally and treat it as a formal complaint. People who may be considered vulnerable include inmates of correctional centres, young people and people with a disability.

Informal matters

We categorise most telephone calls, visits to our office and inquiries made to our staff when they are working out in the field as informal. In these situations, we are usually able to help people by giving them information or an explanation, referring them to another agency or the agency they are inquiring about, or advising them to make a complaint to us in writing.

Formal matters

This year we finalised 9,544 formal matters. These can take anywhere from a few days to several months to finalise. Our response may be a clarifying phone call to the agency concerned or a full-scale investigation.

The main pieces of legislation that govern this aspect of our work are the *Ombudsman Act 1974* and the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. Although we have coercive powers to require agencies to provide us with documents or answer our questions, we generally try to resolve complaints without using them. Most agencies that we contact are cooperative and understand that resolving a person's dissatisfaction with their organisation is usually beneficial to the agency as well.

If we do use our coercive powers, we classify the complaint as being 'formally investigated'. The actions that we take to finalise complaints include:

- resolving a complaint by persuading the agency concerned to take some action
- resolving a complaint by undertaking a formal investigation and making findings and recommendations — this year we finalised 47 matters this way (see figure 3)
- providing detailed information or advice to the complainant
- making inquiries and finding no wrong conduct.

Figure 1 — Formal complaints and notifications received and finalised by our office — five year comparison

Year	03/04	04/05	05/06	06/07	07/08
Received	9,167	10,714	10,304	9,692	9,320
Finalised	9,159	10,866	10,096	9,576	9,544

Figure 2 — Complaints and notifications we received in 2007–2008 — by subject area

Subject area	Formal	Informal	Total
Departments and authorities*	1,348	3,962	5,310
Local government	768	1,965	2,733
Correctional centres and Justice Health	840	3,143	3,983
Juvenile justice	99	243	342
FOI	225	422	647
Child and family services	501	922	1,423
Disability services	218	216	434
Other community services**	48	238	286
Employment-related child protection***	1,920	695	2,615
Police	2,969	2,994	5,963
Outside our jurisdiction*	384	6,396	6,780
Requests for information	0	3,505	3,505
Total	**9,320**	**24,701**	**34,021**

* We sometimes receive written complaints about public sector agencies that are within our jurisdiction but the conduct complained about, on assessment, is found to be outside our jurisdiction. We initially classify these as 'formal' complaints received about public sector agencies. Written complaints received about agencies outside our jurisdiction, and oral complaints about both agencies and issues outside our jurisdiction, are dealt with informally by referring the complainant elsewhere. They are classified as 'outside our jurisdiction' from the outset.

** This includes complaints about DoCS, DADHC and non-government agencies that are funded by one of those departments.

*** This includes notifications and complaints received.

Figure 3 — Number of formal investigations finalised — five year comparison

Year	03/04	04/05	05/06	06/07	07/08
Total	**42**	**67**	**66**	**63**	**47**

Figure 4 — Formal complaints and notifications finalised — by subject group — two year comparison

Subject	06/07	07/08
Departments and authorities	1,167	1,354
Local government	837	788
Corrections and Justice Health	662	918
Juvenile justice	47	11
FOI	205	197
Community services*	569	737
Employment-related child protection	1,749	1,921
Police	3,555	3,254
Agency outside our jurisdiction	392	364
Total	**9,183**	**9,544**

* This figure includes formal matters finalised in relation to child and family services, disability services and community services.

Reviews of our decisions

When we finalise a complaint that we have been dealing with directly, we write to the complainant and give reasons for our decision. If they are not happy with the decision and ask us to reconsider we:

- explain our decision-making process in more detail — including the evidence and factors we took into account in making the decision
- respond to any requests for a further review of our decision by having a senior officer — who was not involved with the original decision — review the file and provide advice to the Ombudsman.

The Ombudsman will then consider the matter and write to the complainant explaining the outcome.

Figure 5 shows that, compared with the number of formal complaints we finalised during the year, the percentage of cases where we were asked to review our decision was very low. Figure 6 shows that in 91% of cases the Ombudsman considered that the original decision made by the delegated officer was correct.

Performance indicator

Requests for a review of our decision as a percentage of complaints finalised

Division	Target	06/07	07/08
Child protection	<6.0%	2 (2.5%)	5 (7.1%)
Community services	<6.0%	8 (1.4%)	3 (5.8%)
General	<6.0%	197 (5.9%)	211 (5.8%)
Police	<1.8%	61 (1.7%)	55 (1.5%)

Figure 5 — Requests for a review of our decision as a percentage of formal complaints finalised

Subject	No. of requests	No. of formal complaints finalised	06/07 %	07/08 %
Employment-related child protection*	5	70	2.5%	7.1%
Community services***	3	737	1.4%	0.4%
Corrections/juvenile justice / Justice Health	14	929	3.0%	1.5%
Freedom of information	6	197	3.4%	3.0%
Local government	93	788	10.2%	11.8%
Other public sector agencies	88	1,354	7.0%	6.5%
Police**	55	3,254	1.7%	1.7%
Outside our jurisdiction	3	364	1.0%	0.8%
Total	**267**	**7,693**	**3.6%**	**3.5%**

* The majority of our work in the child protection area is overseeing how certain agencies handle allegations of conduct by employees that could be abusive to children. Only a small part of our work is handling complaints made directly to our office about how those allegations have been handled. We deal with those complaints in much the same way as with complaints about NSW public sector agencies — we may decide to decline the complaint, make preliminary inquiries or investigate. This table shows that, of the 70 complaints made directly to our office, five complainants asked us to review the decision we made on how to handle the complaint.

** Although the system of handling complaints about police requires the NSW Police Force to directly investigate each complaint, and our office plays an oversight role, the police division considers all requests to review the way a complaint about a police officer was handled as request to review our decision in relation to the NSW Police Force outcome. This table shows that, of the 3,254 complaints about police officers that we oversighted this year, 55 complainants asked for the outcome to be reviewed.

*** This figure includes requests for a review of our decision in relation to child and family services, disability services and community services.

Figure 6 — Outcomes of reviews conducted

Area	Original outcome affirmed: After reviewing the file only	Original outcome affirmed: After further telephone inquiries	Resolved	Reopened	Total
Employment-related child protection	2	3	0	0	5
Community services	2	1	0	0	3
Corrections	13	1	0	3	17
Freedom of information	4	1	2	0	7
Local government	50	35	1	5	91
Other public sector agencies	56	30	1	6	93
Outside our jurisdiction	2	1	0	0	3
Police	58	0	6	0	64
Total	**187**	**72**	**10**	**14**	**283**
% of total (07/08)	66%	25%	4%	5%	100%
% of total (06/07)	70%	21%	3%	6%	100%
% of total (05/06)	70%	25%	2%	3%	100%

Compliments and complaints

Compliments and complaints help us to identify the aspects of our work that we do well, the areas of our service that need improvement, and expectations that exceed what we can reasonably deliver. We have an internal compliments and complaints policy, and we inform people who use our services about how to make a complaint about us. This year we received 211 compliments by letter, fax, email or phone about the quality of our advice, the assistance we gave to customers, and the information provided to agencies within our jurisdiction.

Against the 32,245 formal and informal complaints and notifications we finalised this year, we received 27 complaints about our work (see figure 7).

If a complaint is justified, we will generally take some form of action to resolve it. During 2007–2008, our responses to 10 complaints included apologising, providing explanations, and giving greater priority to identified files (see figure 8).

Other work of the Ombudsman

In addition to handling complaints and notifications, we undertake systemic and proactive work such as conducting audits and review work, including child death and disability death reviews, legislative reviews and visits to the community to better inform our work. Figure 9 outlines the type of work we have undertaken in this area in 2007–2008. This work is also detailed in other chapters of this report.

Figure 7 — Complaints about our office

Issue	Total
Bias/unfair treatment/tone	6
Confidentiality/privacy-related	1
Delays	5
Denial of natural justice	1
Failure to deal appropriately with complaint	11
Lack of feedback/response	5
Limits to jurisdiction	0
Faulty procedures	2
Inaccurate information/wrong decision	2
Poor customer service	5
Corruption/conflict of interest	2
Other	3
Total issues	**43**
Total complaints	27
% of all matters finalised (formal and informal)	**0.1%**

Figure 8 — Outcomes of complaints about our office

Outcome	Total
Unjustified	13
Justified or partly justified	4
Some substance and resolved by remedial action	10
Total	**27**

Figure 9 — Outline of other work of the Ombudsman

Category	Type of work	07/08
Audits	Number of police records audited	8,800
	Number of child protection audits conducted	16
	Controlled operation records audited	364
	Witness protection appeals and complaints	3
Police powers under review	Number of legislative reviews conducted conferring new police powers	6
Visits	Number of hours spent on visiting services (Official community visitor program)	9,193
	Number of visits to residential services (Official community visitor program)	3,289
	Correctional and juvenile justice centre visits	45
	Visits to regional and remote communities	68
Reviews*	Complaint-handling systems	370
	Number of individual reviews (section 13) of the circumstances of children and other persons in care	50
	Reviews (section 11(c)) of the delivery of community services	1

* The number of reviewable deaths are recorded by calendar year. In 2007, the deaths of 98 people with a disability in care and 169 children were reviewable.

Our organisation

The NSW Ombudsman is an independent and impartial watchdog established by the *Ombudsman Act 1974*. We are independent of the government of the day and accountable to the public through Parliament itself. Our central goal is to keep government agencies and some non-government organisations accountable — by promoting good administrative conduct, fair decision-making and high standards of service delivery — and protect the rights of people in NSW. We are responsible for keeping the following types of organisations under scrutiny:

- Agencies delivering public services — including police, correctional centres and state-owned corporations.
- Organisations delivering services to children — including schools and child care centres.
- Organisations delivering community services — including services for people with a disability, people who are homeless and elderly people.
- Agencies conducting covert operations — including the Crime Commission and the Independent Commission Against Corruption.

We have other specific functions that relate to:

- the causes and patterns of deaths of certain children and people with a disability
- decisions made by public sector agencies about freedom of information applications
- the administration of the witness protection program
- the implementation of new pieces of legislation conferring additional powers on people such as police and correctional officers.

We investigate and resolve complaints from members of the public and from people who work for the organisations we scrutinise. Our work is aimed at exposing and eliminating conduct that is illegal, unreasonable, unjust or oppressive, improperly discriminatory, based on improper or irrelevant grounds, based on a mistake of law or fact, or otherwise wrong.

We aim for outcomes that are in the public interest. We investigate some of the more serious complaints, but in many cases we encourage the organisation being complained about to handle the matter themselves. We monitor the progress of these matters and provide advice where necessary. Our focus is on helping organisations to satisfactorily resolve any problems identified.

We help organisations to prevent or reduce the level of complaints made about them by reviewing their systems. Our proactive work also allows us to address problems if members of the public have legitimate grievances but, for whatever reason, do not or cannot take up the complaint themselves. We aim to reduce the volume of complaints to our office by providing training and advice to the organisations we scrutinise about how to effectively resolve and manage complaints. We also provide assistance, guidance and training to other watchdog agencies.

Our office is divided into four specialist divisions — police, general, child protection and community services — and two teams that support these divisions, our corporate and cross agency teams.

The police division is responsible for work relating to the NSW Police Force and for reviewing certain legislation giving powers to police officers. The general division is responsible for performing our other legislative functions — including reviewing legislative compliance and handling inquiries and complaints about a wide range of public sector agencies. The child protection division handles notifications from organisations providing services to children about conduct of their staff that could be abusive to children. The community services division is responsible for work relating to the delivery of services by the Department of Community Services and the Department of Ageing, Disability and Home Care, as well as non-government organisations providing community services.

Our corporate team manages our personnel, financial services, public relations and publications, information and records management, library services and information technology. They provide support for the core activities of our office. The role of the cross agency team is to strengthen communication and collaboration between our specialist areas and strategically target systemic issues involving one or more of our jurisdictions. This team includes our Aboriginal Unit and youth liaison officer.

How we keep organisations accountable

Agencies delivering public services

Who we scrutinise

We scrutinise:

- several hundred NSW public sector agencies including departments, statutory authorities, boards, correctional centres, universities and area health services
- the police
- over 160 local and county councils
- certain private sector organisations and individuals providing privatised public services.

How we keep them accountable

We investigate and resolve:

- complaints about the work of public sector agencies
- complaints about the merits of agency decisions about freedom of information requests
- protected disclosures from public sector staff and complaints about the way agencies have handled disclosures.

We oversee the NSW Police Force's investigations into complaints about police officers and check their complaint-handling systems.

We visit juvenile justice centres and correctional centres to observe their operations and resolve concerns of inmates.

We scrutinise legislation giving new powers to police and correctional officers.

We hear appeals against decisions by the Commissioner of Police in relation to the witness protection program.

We provide training and guidance in investigations, complaint management and good administrative conduct.

Senior Executive Team (left to right): Julianna Demetrius, Manager (Cross Agency Team); Anita Whittaker, Manager (Corporate Team); Steve Kinmond, Deputy Ombudsman and Community and Disability Services Commissioner; Greg Andrews, Assistant Ombudsman Police; Bruce Barbour, Ombudsman; Anne Barwick, Assistant Ombudsman Children and young people; Chris Wheeler, Deputy Ombudsman.

Organisations delivering services to children

Who we scrutinise

We scrutinise:

- over 7,000 organisations providing services to children — including schools, child care centres, family day care, juvenile justice centres and organisations providing substitute residential care and health programs
- the conduct of paid staff, contractors and thousands of volunteers working for these organisations.

Child Protection Division Manager: Natasha Mewing.

How we keep them accountable

Organisations are required to notify us of any reportable allegations about, or convictions for, conduct that could be abusive to children. We oversee (and sometimes investigate) how organisations investigate these allegations about their staff, and keep under scrutiny their systems for handling such matters.

We deal with complaints from parents and other interested parties about how organisations have investigated allegations.

We keep under scrutiny the systems organisations have to prevent employees from behaving in ways that could be abusive to children.

We provide training and guidance about how to handle these kinds of allegations and convictions.

Community Services Division Managers (left to right): Gary Dawson, Michele Powell, Monica Wolf.

Organisations delivering community services

Who we scrutinise

We scrutinise:

- licensed boarding houses and fee-for-service organisations
- child protection and family support services
- out-of-home care services for children and young people
- home and community care services
- services for people with a disability
- supported accommodation and assistance program services.

The Department of Community Services and the Department of Ageing, Disability and Home Care provide many of these services. Non-government organisations providing these services also fall within our jurisdiction if they are funded, licensed or authorised by the Minister for Community Services or the Minister for Ageing and Disability Services.

How we keep them accountable

We investigate and resolve complaints about the provision, failure to provide, withdrawal, variation or administration of community services.

We review:

- standards for the delivery of community services
- the systems organisations have to handle complaints about their services
- the situation of children, young people and people with a disability who are in out-of-home care
- the deaths of certain children, young people and people with a disability in care.

We inspect certain services where children, young people and people with a disability live.

We coordinate the official community visitors scheme.

We provide information and training to consumers of community services and to organisations about complaint-handling and consumer rights.

We promote improvements to community service systems and access to advocacy support for people who are receiving, or are eligible to receive, community services.

General Division Managers (left to right): Anne Radford, Jennifer Agius, Helen Ford.

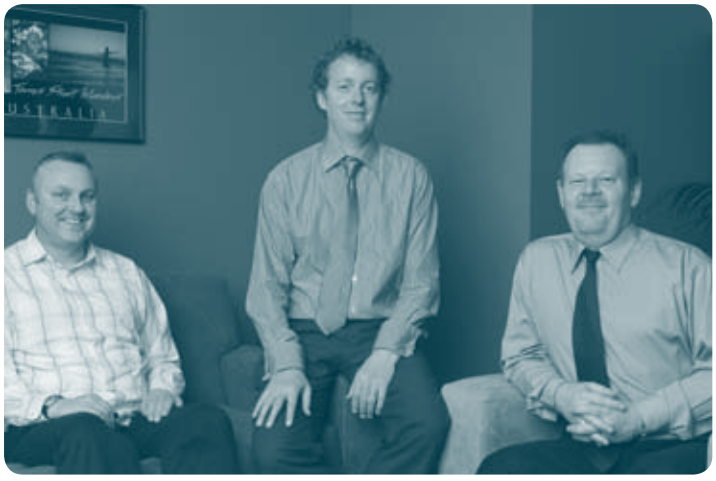
Agencies conducting covert operations

Who we scrutinise

We scrutinise law enforcement agencies such as the NSW Police Force, the Crime Commission, the Independent Commission Against Corruption and the Police Integrity Commission.

How we keep them accountable

We review agency compliance with accountability requirements for undercover operations and the use of telephone intercepts.



Police Division Managers (left to right): Vincent Riordan, Michael Gleeson, Peter Burford.

Corporate governance

We aim to be an effective organisation. One way to achieve this is by developing, implementing and maintaining a robust system of corporate governance. This also provides assurance to the Parliament, government and the public that we are using our resources appropriately and achieving our stated outcomes.

We pride ourselves on the quality of our work and the standard of our service. Our governance framework brings together policies, systems and processes that promote accountability, transparency and ethical practices. As an independent and impartial oversight agency, we are responsible for ensuring that the organisations within our jurisdiction fulfil their functions properly.

We do our best to make sure we 'practice what we preach' and work to the same standards of good administration that we promote.

Our corporate plan

Our vision is to see fair, accountable and responsive administrative practice and service delivery in NSW. We work to promote good conduct, fair decision-making, the protection of rights and the provision of quality services. Our corporate plan sets out the direction for what we do and outlines the goals and strategies that will support our vision. It consists of a statement of corporate purpose and strategic plans for each of our divisions.

The statement groups our work under four purposes. The first and second relate to our core work, the third is about working with similar agencies to promote professional work practices and improve our service, and the fourth deals with our office as an effective organisation. Each division develops their own business plan to align their activities with our overall strategic direction. These plans guide the day-to-day work of our staff.

Accountability

The Ombudsman is answerable to Parliament through the Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission (the PJC). This ensures we are accountable to Parliament rather than the government of the day and is crucial to our independence.

In March 2008, the Ombudsman and other senior staff appeared before the PJC at our 14th general meeting to answer a range of questions about our work. We also sent a detailed submission to the PJC about their statutory review of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. For more details about this review, see 'Our year in review'.

We are also accountable to the public in much the same way as any other NSW public sector agency. We come under the scrutiny of agencies such as the Auditor-General, the Independent Commission Against Corruption, the Privacy Commissioner, the Anti-Discrimination Board, State Records and NSW Treasury. We are required to provide an annual report for our office, as well as a number of other annual reports on specialised areas of our work such as reviewable deaths. These provide Parliament and the community with information about what we have achieved during the year.

We provide each complainant with reasons for our decisions when resolving or discontinuing complaints. If a complainant believes our decision is wrong, they can ask for their case to be reviewed.

Statement of responsibility

The Ombudsman, senior management and other staff have put in place an internal and external control process designed to provide reasonable assurance about the achievement of the office's objectives. The Ombudsman, two Deputy Ombudsman, each Assistant Ombudsman and the managers of the respective corporate and cross agency teams assess these controls.

To the best of my knowledge, the systems of internal control have operated satisfactorily during the year.

Bruce Barbour
Ombudsman

Our guarantee of service

We will:

- consider each matter promptly and fairly, and provide clear reasons for our decisions
- where we are unable to deal with a matter ourselves, explain why, and identify any other appropriate organisation where we can
- help those people who need assistance to make a complaint to the Ombudsman
- add value through our work.

Our vision

We want to see fair, accountable and responsive administrative practice and service delivery in NSW.

Our mission

In our own organisation and those we oversight, we work to promote:

- good conduct
- fair decision-making
- protection of rights
- provision of quality services.

Our values

We will:

- provide the same high quality service that we encourage other organisations to offer
- be fair, impartial and independent, and act with integrity and consistency
- be accessible and responsive to all who approach us, and seek solutions and improvements that will benefit the broader NSW community
- be a catalyst for change and a promoter of individuals' rights.

Our purpose

We aim to:

1. help organisations meet their obligations and responsibilities and promote and assist the improvement of their service delivery
2. deal effectively and fairly with complaints and work with organisations to improve their complaint-handling systems
3. be a leading watchdog agency
4. be an effective organisation.

Performance statement

To retain the independence of the Ombudsman, the position is not responsible to an individual minister. Instead the Ombudsman appears before the PJC to answer questions about the performance of our office. Our performance statement is a summary of our achievements against the purposes outlined in our corporate plan.

Performance statement

Purpose 1

Help organisations meet their obligations and responsibilities and promote and assist the improvement of their service delivery

Goals

- Review and report on the service, systems and conduct of agencies.
- Monitor and report on compliance with legislative obligations and responsibilities.
- Make recommendations and suggestions for agency improvements and/or for improving the circumstances of individuals.
- Promote best practice standards for agency service delivery and good conduct.
- Provide training in delivery of service, good conduct and the rights of consumers to quality services.

Performance 2007–2008

- Conducted mystery shopper audits of 30 councils in NSW to assess their customer service standards and received positive feedback from the councils audited, many of whom have made improvements to their systems and processes.
- Completed 47 investigations that assisted agencies to improve their delivery of services and complaint-handling practices in areas such as policing, local government, corrections and systems for the care and protection of children and people with a disability.
- Started an independent and comprehensive review of the implementation of the *Freedom of Information Act 1989* (FOI Act) by 18 agencies, and released a public discussion paper to provide all interested parties with an opportunity to contribute to the review.
- Clarified the use of clause 13(a) of the FOI Act to exempt documents such as employment contracts, from being released due to a breach of confidence.
- Completed an investigation into the implementation of the Department of Education and Training's policy and procedures for long suspensions, and made recommendations across four key areas.
- Completed a review of the supports provided to carers of Aboriginal children and examined the health, educational and cultural needs of Aboriginal children in care and identified critical data deficiencies.
- Prepared a report that was tabled in Parliament on the use of emergency powers to prevent or control disorder, enacted in response to mob violence at Cronulla.

- Finalised the report on our review of the implementation of the *Police Powers (Drug Detection Trial) Act 2003* and delivered it to the responsible ministers.
- Conducted a major survey of defendants in local courts to assess the experiences of victims of police searches conducted under the *Law Enforcement (Powers & Responsibilities) Act 2002.*
- Monitored the NSW Police Force's implementation of the recommendations from our 2006 report *Domestic Violence: improving police practice*, and found significant progress had been made.
- Worked cooperatively with the NSW Sentencing Council on their research into the effectiveness of fines as a sentencing option, particularly for vulnerable people.
- Made ten detailed submissions to the Wood Special Commission of Inquiry into Child Protection Services in NSW, outlining our views on topics such as assessment practices, privacy, interagency cooperation and children in out-of-home care.
- Tabled our reports on reviewable disability and child deaths in Parliament, including 16 recommendations for systemic and procedural change.
- Completed our review of the circumstances of 50 children and young people under five in out-of-home care and started a review of 36 children aged between 10 and 14.
- Prepared a detailed submission to the Parliamentary Joint Committee's review of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, and received strong support for our work. Additional funding for the official community visitors program was recommended.
- Started a major investigation into the implementation of the Joint Guarantee of Service (JGoS) for people with mental health problems and disorders living in Aboriginal, community and public housing, and conducted consultations with 450 stakeholders in 25 locations across the state.
- Ran 80 workshops and training sessions for over 1,600 consumers, staff and providers of community services and conducted 161 presentations for more than 4,000 staff of agencies within our jurisdiction, community service workers and community groups to increase awareness of our role and good complaint-handling practices.
- Presented over 40 education and awareness briefings or forums on child protection to 100 agencies, reaching more than 1,000 people.

Future plans

- Finalise our investigation into the implementation of the JGoS.
- Complete our review of the circumstances of 36 children aged between 10 and 14 in out-of-home care.
- Finalise our reviews into the adequacy of DADHC's actions to identify and meet the needs and goals of 60 people living in nine large residential centres and the complaint-handling practices of agencies providing services under the DADHC funded community participation program.
- Prepare final reports for our review of the implementation of the *Law Enforcement (Powers & Responsibilities) Act 2002* and the impact of the criminal infringement notices scheme on Aboriginal and Torres Strait Islander communities.
- Conduct mystery shopper audits of selected agencies to assess their customer service standards and complaint-handling systems.
- Report to Parliament on our review of the *Freedom of Information Act 1989*.
- Prepare final report for our review of the *Terrorism (Police Powers) Act 2002.*

Performance statement

Purpose 2

Deal effectively and fairly with complaints and work with organisations to improve their complaint-handling systems

Goals

- Implement and promote best practice investigation and complaint-handling methodologies within our office.
- Use client feedback to improve our work.
- Implement and promote best practice investigation and complaint-handling methodologies in agencies we oversight.
- Help achieve redress for justified complaints.
- Identify systemic causes of complaints and propose solutions.

Performance 2007–2008

- We participated in the Senior Officers Working Group on State Plan Priority S8: Customer Satisfaction. This group recommended strategies for improving customer satisfaction within the public sector.
- In November 2007 the Premier issued a memorandum to all agencies promoting our *Complaint-Handling Guidelines* as the standard to be used when reviewing and improving their complaint-handling systems as required by the State Plan's customer service priority.
- We provided advice and support to agencies for implementing State Plan strategies, particularly those relating to complaint-handling and customer service. We made our guidelines and other information available to agencies through our website.
- Achieved 367 positive outcomes for complainants in relation to 442 complaints we investigated involving councils, including Wollongong City Council properly investigating allegations of illegal work and setting up a regulation and enforcement division, and several councils apologising for delays or not responding to customer correspondence.
- Supported 36 official community visitors making 3,289 visits to 6,578 people living in residential services across the state, and assisted them to finalise 63% of the 3,634 issues identified this year.
- Held a complaint-handling forum for all NSW universities to discuss the implementation of our guidelines on complaint-handling in universities. A number of universities have now implemented these guidelines.
- Conducted a survey of complaint-handling systems across all NSW government departments and authorities, and analysed similarities and differences between different size agencies.
- Promoted the implementation of the recommendations of the 2006 Parliamentary review of the *Protected Disclosures Act 1994*.

- Consulted with stakeholders and worked with various child protection specialists to complete a thorough review of our guidelines for preventing and responding to reportable allegations, and incorporated updated information on areas such as interviewing children, conduct causing psychological harm and grooming behaviour.
- Conducted 15 investigations into child protection issues, highlighting the critical importance of effective liaison and communication and identifying concerns about the adequacy of responses to chronic neglect of children. A number of our investigations also examined the adequacy of certain organisations' policies and procedures to deal with allegations of reportable conduct involving their employees.
- Assisted agencies with complex child protection issues such as preserving evidence and investigating historical allegations.
- Cut red tape in police complaint-handling by introducing electronic delivery of complaint notifications and final investigation reports.
- Evaluated the streamlined complaint-handling trial in 13 NSW Police Force commands and supported its general roll out to all commands, simplifying the management of less serious complaints.
- Prompted the Department of Corrective Services to review their compassionate leave policy and procedures to include the involvement of the Aboriginal Planning and Support Unit and allow for the approval of compassionate leave at a regional level.
- Made suggestions about appropriate timeframes for responding to inmate applications for classification reviews, and had these suggestions accepted and implemented by the Commissioner of Corrective Services.
- Worked with Justice Health to address issues such as behaviour management and poor access to dental services.
- Worked with agencies on a range of FOI issues including advance deposits, applications for electronic documents, and the need for good communication with applicants.
- Intervened in a journalist's unsuccessful FOI application to eight area health services in NSW and The Children's Hospital for access to clinical indicator reports, which resulted in NSW Health directing all the reports to be released in the public interest.
- Resolved a range of complaints about disability accommodation and support services and facilitated outcomes such as new premises, an increase in staff training, and improved communication and complaint-handling.
- Travelled to 68 regional towns and communities throughout NSW to audit agency systems, provide training, visit correctional and juvenile justice centres, and examine the quality of the services provided to Aboriginal communities.
- Identified 328 police investigations where there were defects in the investigation or proposed management outcomes, and provided advice that led to over three quarters of the identified deficiencies being remedied by the NSW Police Force.

Future plans

- Work with the NSW Police Force to ensure streamlined complaint-handling procedures are used effectively.
- Undertake a systemic review of the child protection policies of public authorities, including a focus on complaint-handling systems.
- Enter into or extend class or kind determinations with agencies that have demonstrated good practice in responding to reportable allegations about employees in relation to child protection.
- Host a second forum for NSW universities to discuss complaint-handling in universities.

Performance statement

Purpose 3

Be a leading watchdog agency

Goals

- Create positive relationships and work collaboratively with other Ombudsman and watchdog agencies.
- Promote professional work practices with other Ombudsman and watchdog agencies.
- Continuously improve our work practices.

Performance 2007–2008

- Developed *Guidelines for Dealing with Youth Complaints* to assist other state and national organisations to make their complaint practices more accessible to young people, and received positive feedback from all sectors about the value of these guidelines.
- Developed a framework of management strategies to deal with unreasonable conduct by complainants, and delivered a two-stage training program to staff in all Parliamentary Ombudsman offices in Australia and staff in government agencies in six states.
- Participated in a three-year AusAID project to support the National Ombudsman Commission of Indonesia and provided technical consultancy services to the Indonesian Australian Ombudsman Linkages and Strengthening Project, funded by the Commonwealth Government Partnership Fund.
- Worked with the Commonwealth Ombudsman to scope the Regional Ombudsman Initiative for the Pacific Plan and identify the best possible oversight model for smaller Pacific nations who currently do not have any form of oversight.
- Continued our four year involvement in the Whistling While They Work project, with our Deputy Ombudsman co-authoring two chapters in the project's final report — *Whistling While They Work: Enhancing the theory and practice of internal witness management in public sector organisations*.
- Provided advice to agencies in a guideline called *Reporting of Progress and Results of Investigations*, outlining what information can be given to interested parties about the progress and results of investigations into complaints or protected disclosures.
- Conducted eight *Better management of protected disclosures* workshops with the ICAC, with over 90% of the 160 nominated disclosure officers who attended providing feedback that the workshops were very useful and relevant to their work.

- Chaired the awards committee for the Corruption Prevention Network Conference and attended regular meetings as a charter member of the multi-agency network.
- Participated in the working group on the implementation of the *Surveillance Devices Act 2007* to develop compliance tools in relation to the Act.
- Participated in a steering committee to establish the International Network for the Independent Oversight of Police.
- Developed a series of project management templates to improve consistency, efficiency and accountability in our project work.
- Accepted complaints by young people under the age of 18 as oral complaints — instead of asking them to put their complaints in writing — to help make our office more accessible to young people.
- Produced information about the work we do in 10 additional community languages — including some spoken by new and emerging communities — to ensure information about our office is accessible to cultural and linguistically diverse communities.
- Implemented a watching brief system about a range of significant issues such as homelessness, emerging communities, social housing and youth-at-risk to help us improve our understanding of whole-of-government initiatives across these areas.
- We received international recognition for our work on apologies and dealing with unreasonable complainant conduct. The Deputy Ombudsman was invited to address the United States Ombudsman's Association (USOA) conference in Alaska in September 2007, outlining our work on apologies. We conducted a number of workshops for the USOA on how to better manage unreasonable complainant conduct. We also addressed Ombudsman staff in New Zealand on our work in these areas.
- We hosted the annual board meeting of the International Ombudsman Institute (IOI) in November 2007 and played an active role in discussions about the future direction of the IOI.

Future plans

- Evaluate the unreasonable complainant conduct project trial, issue the final project report and update and publish the final version of the Interim Practice Manual.
- Revise our *Protected Disclosure Guidelines.*
- Host and help to organise the 7th National Investigations Symposium for public sector staff who want to maintain and increase their investigative knowledge, skills and techniques.
- Supported the Corruption Prevention Network Conference in September 2008.
- Host a child protection symposium in May 2009. The symposium will coincide with the planned release of our report to Parliament on the last ten years of our oversight in the employee-related child protection area.
- The Deputy Ombudsman will conduct three workshops on dealing with difficult complainants with staff from Ombudsman offices in Canada.
- Use information gathered during our unreasonable complainant conduct project to develop a risk assessment tool to assist in evaluating risks to the safety of frontline staff.
- Revise our *Apologies Guidelines*.
- Continue our support of the National Ombudsman Commission of Indonesia, providing technical advice and mentoring to staff.

Performance statement

Purpose 4

Be an effective organisation

Goals

- Have appropriate structures, policies and systems to support and enhance our service delivery.
- Attract, develop, support and encourage skilled and committed staff.
- Capture, use and share information and knowledge to support and enhance our service delivery.
- Be an effective public sector agency that complies with applicable laws and policies and is accountable and transparent for our actions and decisions.

Performance 2007–2008

- Formally established the cross agency team within our office to better respond to emerging whole-of-government, multi-agency and 'across-office' issues.
- Allocated primary responsibility for audits, training and project work to one unit within our child protection division, resulting in an increased capacity and more streamlined approach to conducting agency audits and training.
- Continued a multifaceted office-wide training program that included coordinated induction sessions, skills for supervisors, job specific training and in-house workshops delivered by external training providers.
- Developed and implemented a comprehensive Aboriginal cultural appreciation training package for all Ombudsman staff to gain a better understanding of Aboriginal culture and improve their work practices with Aboriginal complainants.
- Developed disability awareness training for our staff, focusing on attitudinal and practical issues facing people with a disability and improving our work practices when dealing with people with a disability. So far, four sessions have been delivered.
- Organised for external providers to present cultural awareness training sessions for our staff and deliver specific sessions on our complaint-handling functions and other core business activities.
- Updated the complaint-handling procedures for our community services division.
- Reviewed the current materials for our office-wide investigation training course to ensure they include current and significant issues to improve the work practices of our investigation officers.
- Provided staff with opportunities to participate in training and cross agency projects to improve their knowledge and experience of community issues and how we conduct stakeholder consultations.
- Developed a new module in our complaint case management system to enable better tracking of compliance with recommendations made in major reports.

- Created consistency in recording and reporting across the office by transferring the recording and reporting of community services complaints to our office-wide complaints database.
- Integrated intelligence information into our case management system.
- Used the information security management system model to identify all the functions we perform, the potential risk factors and the controls we should put in place to mitigate each risk, and improved our security policy to help us to better manage potential risk.
- Continued our work on developing a data classification system to better record and report on disability and out-of-home care issues identified by OCVs.
- Enhanced Resolve, our case management system, to enable more timely data capture of initial receipt and assessment information of police complaints, better tracking and timelier processing.
- Redesigned and upgraded our general division's intranet page which allows staff to access information and contact details about agencies in our jurisdiction.
- Upgraded Microsoft office products and our accounting system.
- Reviewed our performance indicators to have a consistent way of measuring our work across all business units, and started to plan new indicators for implementation in 2008–2009.
- Reviewed our complaints & compliments and review policy.
- Reviewed the terminology used throughout our office to ensure consistency across all our business areas.
- Reviewed and updated several policies — including our code of conduct and policies on occupational health and safety, performance management, delegations to special officers, and our use of office cars and access controls.
- Developed a ten year asset strategy.
- Received an unqualified audit report.
- Received a bronze award for our 2006–2007 annual report.

Future plans

- Review our statement of corporate purpose and related business plans for 2008–2010.
- Conduct a review of our publications procedures — including establishing more environmentally-friendly printing processes.
- Completing our 'computer-server virtualisation' project which aims to significantly reduce the number of servers being used.
- Upgrading our electronic document management system and delivering associated training to staff.
- Redesigning our website to ensure consistency with the NSW web directive and accessibility standards.
- Enhancing our personnel database to make it easier for staff to access and update information.
- Finalise our review of the recording and measurement of outcomes and performance indicators across the different divisions and teams in our office.
- Provide training for all our staff in Aboriginal cultural appreciation and disability awareness.

Monitoring our performance

Tracking performance

Developing appropriate measures to assess the impact and effectiveness of our work is crucial, especially with the wide range of jurisdictions and functions we cover. We have developed performance indicators to help us measure efficiency at corporate, team and individual staff levels.

We track our performance in relation to individual complaint, investigation and review files as well as our systems and structures for completing work. In particular, we look at the timeliness and quality of our decision-making. We set performance benchmarks for file turnaround times and monitor our workflow to identify where there may be backlogs, delays or inefficiencies. We also conduct regular internal audits on complaints that have been open for more than six months.

We continually review our work and use the results to improve our performance evaluation systems. Last year we reviewed our performance indicators to improve the consistency of how we record and report on performance across all our divisions. As a result, we introduced changes in July 2008 to enable us to better capture the value that we add to the provision of government services. This has included standardising our procedures, actions and outcomes for consistency and better reporting of outcomes achieved.

Managing risk

Our statutory officers are responsible for identifying and measuring risk and developing mitigation strategies for our core business-related activities. The Ombudsman and senior staff meet weekly to review the progress of work, exchange information and discuss any issues of concern. Using an information security management system model, we identify all the functions we perform, the potential risk factors, and what controls should be put in place to mitigate each risk. These controls might include appropriate plans, procedures, processes, policies, guidelines, standards, record-keeping requirements, reporting of incidents/errors, supervision or training for staff.

We achieve results in our core work through our ability to persuade organisations to adopt the recommendations we make to them about individual matters, as well as to draw generally on the principles we advocate. This ability depends on our reputation as a credible organisation. It is this credibility that constitutes the Ombudsman's primary asset, and the things most likely to damage it are our key risks. These are:

- Unauthorised disclosure of information

  Our work is subject to the secrecy provisions of the Ombudsman Act and the other legislation under which we operate. We understand that the inappropriate or unauthorised disclosure of information can have a detrimental impact on an individual, organisation or minister. It can also negatively impact on the credibility of our office and reduce our effectiveness.

- Damage to the credibility of our work or to our reputation

  We rely on our reputation for maintaining high standards in administrative conduct and focusing on practical outcomes as it helps ensure that agencies accept our advice and implement our recommendations. We continually monitor our performance to ensure our work is of a high standard. We develop relationships with agencies to make sure we understand the environment in which they operate. This helps us to provide practical solutions to the issues we identify.

- Increasing complaint levels

  To address the increasing volume of complaints to our office, our focus continues to be on addressing systemic issues. We have also negotiated 'class or kind' agreements with a number of agencies to reduce the number of matters they have to notify to us, developed training courses to help agencies improve their complaint-handling performance, and published guidelines on topics such as good public administration and giving apologies.

We also have programs to manage risk in areas such as occupational health and safety, business continuity planning, accounting, leave management and payroll. We are subject to independent reviews of some of our risk management practices. For example, our accounting, personnel and payroll activities and our information security program are audited annually.

Security accreditation

We have procedures in place to manage the physical security of our staff and our office, the security of the confidential information we hold, and the integrity of our information technology systems.

We handle an enormous amount of information about individuals and organisations within our jurisdiction — much of which is sensitive or confidential — so it is essential that we effectively manage any risks to our information security systems. After a review of our information security policy in early 2008, we identified six main information security risks. They are:

- unauthorised disclosure of information held by our office
- unauthorised access to information in agency databases to which we have access
- significantly inaccurate or incomplete information used in reports, correspondence or as the basis for findings, recommendations, suggestions or decisions
- inadequate documentation or unintended destruction of business information and/or corporate knowledge
- software and hardware problems resulting in major operating systems being out of action for significant periods
- an inability to comply with statutory obligations.

International Information Security Standard

After being accredited to the Australian Standard in 2002, we upgraded our Information Security program and were accredited to the International Standard in 2007. This accreditation brings us into line with worldwide best practice in information management security. It affirms that we have appropriate systems in place to secure our information assets.

Information is broadly defined and includes paper and electronic records. Our information security program covers our paper based systems as well as our computer network and databases, external access to the internet and supporting policies and procedures. We have also set up systems to restrict and monitor how our staff access external databases and information that we access in the course of our work.

Our information security objectives, reflected in the international standard, ensure:

- availability — authorised users have timely and reliable access to information
- confidentiality of information — we restrict access to and disclosure of information to authorised personnel only
- integrity — information is protected against unauthorised alteration or destruction and successful challenges to its authenticity are prevented.

Information security management is aimed at protecting information assets from potential security breaches. It involves reviewing risks, developing and implementing policies, processes and controls and establishing a compliance program to ensure that the goals are met. Most importantly, staff need to be aware of their responsibilities and take an active role in appropriately managing and securing information. Our staff have accepted this responsibility and we support them through a targeted induction program and ongoing training.

The success of our program is reflected in the positive audit reports we receive. The audit of our information security system is undertaken by an independent and accredited company — SAI Global.

Our security committee is responsible for ensuring risk assessments are carried out on all critical systems when major changes occur to those systems or new systems are introduced. They also ensure that there is a comprehensive review of our risk matrix at least annually.

We were accredited under the Australian Information Security Standard AS7799 in December 2002, to AS7799.2 in December 2005 and to the International Information Security Standard ISO/IEC 27001 in 2007.

We also have corruption prevention and fraud control measures, disaster recovery plans and preventative maintenance programs for our equipment. There are vigorous checks and balances in areas of high risk such as those where money, staff entitlements or our computer network could be compromised.

Making changes to how we work

During 2007–2008 we made several structural changes to improve how we work. These included:

- Reviewing the terminology used throughout our office to ensure consistency across all our business areas.
- Reviewing and developing our training courses, including a new investigations training module to improve our staff's skills in handling investigations.
- Continuing to develop a data classification system to better record and report on disability and out-of-home care issues identified by OCVs — we reported last year that we were undertaking this initiative.
- Accepting complaints by young people under the age of 18 as oral complaints, instead of asking them to put their complaints in writing — this will help to make our office more accessible to young people.
- Allocating primary responsibility for audits, training and project work to one unit within our child protection division, resulting in an increased capacity to conduct agency audits and training and a more streamlined approach to these functions.
- Developing a series of project management templates to create consistency, efficiency and greater accountability in our project work.
- Initiating a review of our complaint-handling procedures in our community services division.
- Implementing a watching brief system about a range of significant issues such as, homelessness, emerging communities, social housing and youth-at-risk to help us improve our understanding of whole-of-government initiatives across these areas.
- Enhancing Resolve, our case management system, to enable more timely data capture of initial receipt and assessment information of police complaints, better tracking and more timely processing.
- Successfully trialling and implementing the electronic receipt of notifications of police complaints and final police investigation reports — which has led to a more streamlined process.
- Redesigning and upgrading our general division's intranet page which allows staff to access information and contact details about agencies in our jurisdiction.
- Reviewing office performance indicators to have a consistent way of measuring our work across all business units. Work is still progressing, with new indicators being implemented in 2008–2009.
- Reviewing and updating several policies — including our code of conduct.

Consolidation of case management tools

We use a number of different systems to manage our core work. We have been reviewing our use of these systems and have implemented a staged plan of consolidation. We are aiming to have most of our business units and discrete functions use our main case management system — Resolve.

On 1 July 2007 the community services division's complaint-handling was transferred to Resolve. This means that all our complaints are now recorded in the one system.

We have begun a project to transfer both our child death and disability death case management functions to Resolve, which should be completed within the next reporting year. The project involves our programming staff modifying the database to ensure that the required information can be captured. Reports will also need to be developed.

We are continually enhancing Resolve. From July 2007 we introduced an agency hierarchy, which allows us to capture complaints about an agency as a whole, as well as drill down to regional and local offices. The introduction of this hierarchy required an extensive review of how our agency information was structured and extensive consultation with our divisions. We also reviewed our system for managing agency information, including how we add, change and delete it.

We also introduced a "recommendation case". This allows staff to enter details of any recommendation, suggestion or undertaking that they make to an agency when dealing with complaints and notifications. Staff use this to record whether an agency implements our recommendations, suggestions or undertakings. We can also monitor and report on the progress of implementation. The recommendation case replaced manual records kept by each business unit.

During the year we also reviewed how each of our divisions used Resolve to determine if there was any scope to implement more consistent practices. Where possible, the business processes we use and the data we collect and report on should be the same. Following input from our business units, we developed a common set of performance indicators, agreed terminology and complaints outcomes. We will be making changes to our case management system to reflect this.

Our cross agency team

In March 2007, we began trialling a new cross agency team (CAT) from within our existing resources. The team was created to help us respond to emerging whole-of-government, multi-agency or across office issues — particularly those that affect some of the more vulnerable sections of the community. Increasingly, our work involves issues that cross more than one of our traditional jurisdictions. This partly reflects the business of government, which is increasingly focused on promoting interagency approaches to service delivery.

The CAT is led by a senior officer and brings together a project team, our Aboriginal Unit and our youth liaison officer. The CAT's main functions are to:

- direct, coordinate and manage the work of our Aboriginal Unit and youth liaison officer
- provide advice and information to staff about significant Aboriginal and youth issues and initiatives
- undertake major investigations into issues that cross a number of agencies
- develop expertise in relation to whole-of-government initiatives in relevant areas, and provide ongoing advice to divisions about significant issues and progress in these areas.

An external evaluation of the CAT after 12 months found the team had achieved their agreed performance indicators. The Ombudsman subsequently decided to establish CAT as a permanent business unit within our office.

In our first year of operation, we undertook a diverse range of projects and initiatives. These included completing a review into the supports provided to carers of Aboriginal children and starting a major investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS).

Supporting carers of Aboriginal children

This year, the CAT completed a detailed review of the adequacy of supports provided to carers of Aboriginal children. The review involved interviews with 100 carers as well as Aboriginal out-of-home care agencies and other stakeholders. We also examined the health, educational and cultural needs of Aboriginal children in care. The final report was given to the Departments of Community Services, Education and Health for their consideration, as well as the Wood Special Commission of Inquiry into Child Protection Services in NSW. For more details about this review, see Chapter 1: Community engagement.

Helping people with a mental illness access and sustain social housing

Last year we reported on an investigation prompted by the eviction of a long term public housing tenant whose lease was terminated due to rental arrears. The tenant sustained serious injuries after a struggle ensued when police accompanied Department of Housing (DoH) staff to his premises to carry out the eviction. Our investigation found that DoH staff did not follow departmental procedures for dealing with tenants who have a known mental health condition, despite their awareness of the man's chronic mental illness. In particular, the investigation revealed a limited awareness by staff of the JGoS. Our inquiries also suggested that the JGoS was not being consistently implemented across the state.

Based on this information and further complaints and information received, we decided to conduct an investigation to examine the effectiveness and implementation of the JGoS.

The JGoS is an agreement between the Department of Housing, NSW Health, the Department of Community Services (on behalf of SAAP services), the Aboriginal Housing Office and the Aboriginal Health and Medical Research Council. Our investigation is examining the steps taken by the Department of Housing and NSW Health to meet the objectives of the JGoS. These objectives are to:

- better assist and enhance the wellbeing of existing social housing tenants whose tenancy may be otherwise at risk
- assist housing applicants who may be homeless or at risk of homelessness to successfully establish a tenancy.

As part of the investigation, we have consulted extensively with the JGoS agencies and relevant peak bodies. During visits to 25 regional and metropolitan locations across the state, we also consulted with more than 450 local housing and mental health workers, consumer advocates, supported accommodation providers, mental health non-government workers, community housing providers, Aboriginal housing staff, Aboriginal medical services, DoCS officers and tenant advocates. These consultations will inform our findings and recommendations and have also generated an increased awareness of the JGoS — particularly in areas of the state where engagement to date has been minimal.

We expect to issue our investigation report to the Department of Housing and NSW Health in late 2008.

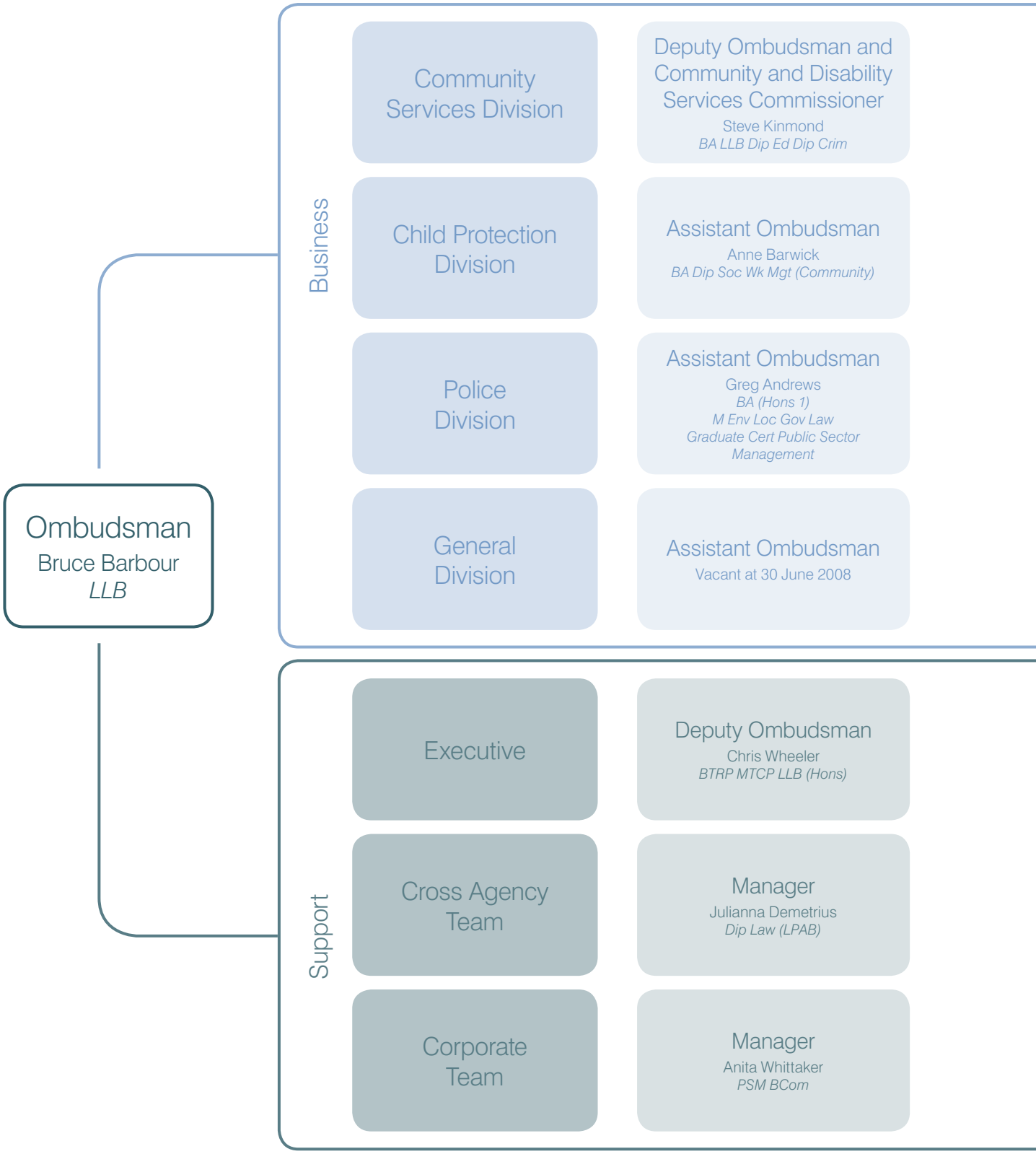
Our other initiatives

In addition to these large scale projects, the CAT has also:

- Developed *Guidelines for Dealing with Youth Complaints* to help agencies in NSW and other states to make their complaint practices more accessible to young people.
- Prepared a detailed submission in response to the Sentencing Council's interim report on the effectiveness of fines as a sentencing option. Our submission was based on observations from our research and community liaison work over several years into the impact of fines on vulnerable groups.
- Continued to monitor compliance by the NSW Police Force with the recommendations of our 2006 special report to Parliament, *Domestic Violence: improving police practice*, including participating in a steering committee established by the NSWPF to implement our recommendations and providing feedback on several operational policies.
- Made significant contributions to the Ombudsman's submissions to the Wood Special Inquiry into Child Protection Services in NSW on interagency practice, youth-at-risk and Aboriginal communities.
- Conducted consultations with community based juvenile justice staff and youth services across the state to identify current issues for youth-at-risk and increase their awareness of our work.
- Consulted nine multi-cultural resource centres about agency practices for assisting newly settled migrants.
- Conducted 29 presentations to 700 agency staff, community members and workers to inform them of our work and how to make complaints.
- Developed and implemented a comprehensive Aboriginal cultural appreciation training package for all Ombudsman staff. This training is designed to help staff gain a better understanding of Aboriginal history and culture and improve their work practices with Aboriginal complainants.
- Started a review of the Department of Ageing, Disability and Home Care's (DADHC) implementation of their Aboriginal Policy Framework and Aboriginal Consultation Strategy to meet the needs of their Aboriginal clients with a disability and their carers.
- Aboriginal Unit staff accompanied staff from our Corrections Unit on 15 visits to juvenile justice and correctional centres to speak with Aboriginal detainees and inmates. Our Aboriginal Unit also conducted visits to Aboriginal child care services to outline their obligations to notify our office about reportable allegations involving their staff.
- Drafted a fact sheet to help staff in juvenile justice centres understand the types of complaints we deal with, how we deal with them, and how they can support detainees to make complaints.

These initiatives are described in more detail in the relevant sections of this report.

Organisational chart



Division Manager
Gary Dawson
Principal Investigator & Projects Officer
Michele Powell
Manager, Systemic Oversight & Review
Monica Wolf

Division Manager
Natasha Mewing
Principal Investigation Manager
Kelvin Simon (Acting)

Division Manager
Michael Gleeson (Acting)
Principal Investigation Manager
Peter Burford
Intel & Information Manager
Vincent Riordan

Division Manager
Anne Radford
Manager, Projects & Major Investigations
Helen Ford
Manager, Corrections & Compliance
Jennifer Agius

Manager, Legal
Monique Adofaci
LLB (Hons) MBA

Our office is divided into four specialist divisions — police, general, child protection and community services — and two teams that support these divisions, our corporate and cross agency teams.

Community Service Division
- Policy and community education
- Service improvement and review
- Reviewable deaths
- Complaint resolution and investigation
- Official community visitor scheme

Child Protection Division
- Schools
- Non-schools
- Investigation and training
- Research

Police Division
- Serious misconduct
- Legislative review
- Projects, intelligence and auditing

General Division
- State and local government
- Corrections
- Universities and protected disclosures
- DoCS and DJJ
- Inquiries and resolution
- Freedom of information
- Secure monitoring unit

Executive
- Legal services
- Special projects and investigations
- Policy development
- Development of public sector guidelines and standards

Cross Agency Team
- Aboriginal Unit
- Youth liaison
- Cross-jurisdiction and cross-office projects

Corporate
- Personnel
- Accounts
- Publications
- Public relations
- Records and information management
- Information technology
- Library

Our people

We have 200 people working for our office on either a full or part-time basis. This equates to just over 175 full-time equivalent (see figure 10). These people are an energetic and diverse mix of experience and skill and come from a range of backgrounds — including investigative, law enforcement, community and social work, legal, planning, child protection and teaching. Our collective experience gives us insight into the agencies we keep accountable and helps us to be a persuasive advocate for change.

Human resources

Any exceptional movement in wages, salaries or allowances

A 4% salary increase was paid to staff covered by the Crown Employees (Public Sector — Salaries 2007) Award from 13 July 2007.

Executive remuneration

In its annual determination, the Statutory and Other Officers Remuneration Tribunal awarded increases to our statutory officers. Both our Deputy Ombudsman and each of our Assistant Ombudsman were awarded a 2.5% increase effective 1 October 2007. The Ombudsman's remuneration increased by 2.5%.

Figure 11 details the Ombudsman's remuneration which includes salary, superannuation and annual leave loading.

Chief and senior executive service

Our office has six senior positions — the Ombudsman, two Deputy Ombudsman and three Assistant Ombudsman. A woman currently holds one of those positions. There was no change in the number of senior positions during the reporting year, however one position of Assistant Ombudsman was vacant as at 30 June 2008, following the departure of Simon Cohen, who was appointed Public Transport Ombudsman in Victoria. We thank Simon for his contribution to the office. Recruitment action for this position was finalised in September 2008 and a woman was appointed. Please see figure 12 for details of the levels of our senior positions as at 30 June 2008.

Monique Adofaci was appointed to Assistant Ombudsman position, General Division in September 2008.

Personnel policies and practices

Our staff are employed under the provisions of the *Public Sector Management and Employment Act 2002*. This Act, the associated regulations and the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2006 set the working conditions of public servants. We therefore have little scope to set working conditions and entitlements for our staff. The Public Sector Workforce Office (PSWO), a division of the Department of Premier and Cabinet, is the employer for this purpose and negotiates conditions and entitlements with the relevant unions.

We systematically review our personnel related policies and systems to ensure that they help us to achieve purpose 4 of our statement of corporate purpose — to be an effective organisation. We finalised the review of our occupational health and safety (OH&S) policy in August 2007 and our performance management policy in April 2008. We began the consultation process for the review of our recruitment policy, and started reviewing our harassment, grievance and equal employment opportunity policies. These will be finalised next year. We will also be reviewing our co-lateral flexible working hours agreement.

We upgraded our human resources/payroll system in 2007–2008. This was a substantial project, requiring changes to business practice, significant testing and staff training.

Industrial relations policies and practices

We have a Joint Consultative Committee (JCC) that meets regularly to discuss how we might adopt and implement policies negotiated by the PSWO and the relevant unions and, if necessary, develop local policies. The JCC includes management and staff representatives.

During the year, the JCC discussed a number of policies that were reviewed and a range of issues relating to working conditions and entitlements — including the results and improvement plans following the staff climate survey in June 2007.

Next year, the JCC will be involved in the review of the co-lateral flexible working hours agreement as well as providing input on policy development and review.

Equal employment opportunity

We are committed to the principles of EEO and have a program that includes policies on performance management, grievance-handling, ensuring a harassment-free workplace and reasonable adjustment. Our staff come from a variety of backgrounds and experience. Figures 13 and 14 show the gender and EEO target groups of staff by salary level and employment basis — permanent, temporary, full-time or part-time.

The NSW Government has established targets for the employment of people from various EEO groups. Measurement against these targets is a good indication of how effective our EEO program has been. The performance indicator on page 36 compares our performance to government targets.

We met our targets for 2007–2008, which included:

- offering flexible working conditions
- providing student placements and work experience opportunities
- providing developmental opportunities for EEO groups.

EEO strategies

Our priority EEO strategy this year was training, although we continued our program of updating position descriptions and reviewing personnel policies. A key element of our training program was to improve our understanding of access and equity issues by developing and implementing in-house training on Aboriginal cultural appreciation and disability awareness. All staff are required to attend these two half day training sessions. We also engaged external agencies to conduct cross cultural awareness sessions.

We focused on improving the skills of our supervisors by organising training in fundamentals for supervisors, performance management, managing unsatisfactory performance and merit selection. These courses are offered on a regular basis.

We expanded our training on harassment prevention and grievance-handling to include all staff. These sessions, conducted by the Anti-Discrimination Board, were well received by staff.

In 2008–2009 we will continue to promote flexible work options to staff, promote a consultative work environment and provide opportunities for staff to participate in staff development and training activities.

Figure 10 — Staff levels

	03/04	04/05	05/06	06/07	07/08
Statutory officers	6.00	6.00	6.00	6.00	5.00
Investigative	70.11	67.12	69.60	66.17	65.90
Investigative support	37.34	30.64	30.44	34.00	35.65
Project and research	19.40	12.80	15.60	16.60	15.60
Training and community education	3.60	3.30	3.20	3.58	3.50
Inquiries	8.40	8.00	8.00	9.00	10.00
Community visitor support	1.80	2.80	2.80	3.00	2.80
Systemic review	10.40	10.29	11.70	12.10	13.40
Corporate	22.40	23.80	25.86	29.43	23.97
Total*	**179.45**	**164.75**	**173.20**	**179.88**	**175.82**

*full-time equivalent

Figure 11 — Executive remuneration

Position	**Ombudsman**
Occupant	Bruce Barbour
Total remuneration package	$399,320
$ Value of remuneration paid as a performance payment	nil
Criteria used for determining total performance payment	n/a

Figure 12 — Chief and Senior Executive Service

	2005	2006	2007	2008
SES Level 4	2	2	2	2
SES Level 2	3	3	3	2
CEO*	1	1	1	1
Total	**6**	**6**	**6**	**5**

* CEO position listed under section 11A of the *Statutory and Other Offices Remuneration Act 1975*, not included in Schedule 2 to the *Public Sector Employment and Management Act 2002*.

Performance Indicator

Trends in the representation of EEO groups

Interpretation: A distribution index of 100 indicates that the centre of the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicating that the EEO group is less concentrated at the lower levels. Where n/a appears, the sample was not sufficient to draw a conclusion. The Distribution Index is automatically calculated by the software provided by the Premier's Department.

EEO Group	Government target (%)	Ombudsman representation (%)				
		03/04	04/05	05/06	06/07	07/08
Women	50	73	72	72	71	73
Aboriginal & Torres Strait Islander people	2	1.5	2.1	2	2	2.50
People whose language first spoken as a child was not English	20	17	18	18	17	20
People with a disability	12	8	6	7	7	6
People with a disability requiring work-related adjustment	7	2.5	2.1	1.5	2	2

Performance Indicator

Trends in the distribution of EEO groups

EEO Group	Benchmark or target	Ombudsman				
		03/04	04/05	05/06	06/07	07/08
Women	100	89	88	89	90	88
Aboriginal & Torres Strait Islander people	100	n/a	n/a	n/a	n/a	n/a
People whose language first spoken as a child was not English	100	84	83	88	89	86
People with a disability	100	n/a	n/a	n/a	n/a	n/a
People with a disability requiring work-related adjustment	100	n/a	n/a	n/a	n/a	n/a

Occupational health and safety

In 2005, the NSW Government released *Working Together — the public sector OHS & injury management strategy* to improve health and safety performance in the public sector, with a specific focus on injury management. This strategy commits public sector agencies to a number of improvement targets — including reducing workplace injuries, reducing the cost of claims, and training managers on their occupational health and safety (OH&S) roles and responsibilities.

We reviewed our OH&S policies and procedures and adopted a risk management approach to our OH&S activities. Our revised policy was approved by the Ombudsman in August 2007. The policy and supporting programs provide guidance to both managers and staff in a range of areas including:

- OH&S strategies and procedures
- return to work programs
- first aid plans
- workplace inspections.

We have an OH&S action plan that brings together our OH&S activities for the year in one document. It documents responsibilities and timeframes as well as performance indicators.

All new supervisors are required to attend OH&S risk management training and are trained in how to conduct workplace inspections. They are required to inspect the work areas of their staff and identify any improvements needed. We plan to conduct formal inspections at least once a year.

During the year, we trained our wardens to respond to a number of emergency situations and participated in the building emergency evacuation drills.

We provide an employee assistance program (EAP) including a free 24-hour counselling service for staff and their families. Information sessions about the EAP were conducted during the year.

We have a number of other programs that help us to meet our health and safety obligations including:

Figure 13 — Percentage of total staff by level

		Subgroup as an estimated percent (%) of total staff at each level						
Level	Total staff (no.)	Men	Women	Aboriginal & Torres Strait Islander people	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
< $35,266	1	0	100	0	0	0	0	0
$35,266 – $46,319	10	0	100	10.0	60	50	10	10.0
$46,320 – $51,783	8	0	100	0	63	38		0
$51,784 – $65,526	33	24	76	0	33	36	6	3.0
$65,527 – $84,737	103	24	76	1.9	24	16	6	1.9
$84,738 – $105,923	37	46	54	5.4	11	11	3	0
> $105,923 (non SES)	4	25	75	0	0	0	33	0
> $105,923 (SES)	4	75	25	0	0	0	25	0
Total	**200**	**27**	**73**	**2.5**	**26**	**20**	**6**	**2.0**

Figure 14 — Percentage of total staff by employment basis

		Subgroup as an estimated percent (%) of total staff in each employment category						
Employment basis	Total staff (no.)	Men	Women	Aboriginal & Torres Strait Islander people	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
Permanent Full-time	114	31	69	2.7	30	20	5	0.9
Permanent Part-time	39	8	92	2.6	21	21	8	5.1
Temporary Full-time	37	32	68	2.7	22	22	3	2.7
Temporary Part-time	5	0	100	0	20	20	0	0
Contract – SES	4	75	25	0	0	0	25	0
Contract – Non SES	1	100	0	0	0	0	100	0
Training Positions	0	0	0	0	0	0	0	0
Retained Staff	0	0	0	0	0	0	0	0
Casual	0	0	0	0	0	0	0	0
Total	**200**	**27**	**73**	**2.5**	**26**	**20**	**6**	**2.0**

- Hepatitis vaccinations — staff who visit correctional centres are vaccinated against Hepatitis A and B.
- Eye examinations — our staff spend a lot of time using computers and this can lead to eyestrain, so we organise an eye examination for all staff every two years so that any potential problems can be detected.
- Flu shots — we organised flu shots for staff to prevent high levels of absenteeism during the flu season.

To respond to minor workplace injuries, we have appointed a number of staff as first aid officers. We cover the costs of initial and any ongoing training and pay these staff a yearly allowance for undertaking this role.

We participate in the NSW Treasury Managed Fund, a self-insurance scheme for the NSW public sector. One of the goals of *Working Together — the public sector OHS & injury management strategy* is to improve our workers' compensation performance. Six workers' compensation claims were reported in 2007–2008. This means we reduced the number of claims reported to our insurer, compared to previous years (see figure 15).

Figure 15 — Workers' compensation

Claims entered in the year	06/07	07/08
Claims brought forward	9	9
New claims	9	6
Claims closed	9	9
Open claims 30 June	9	6

Learning and development

One of the goals of our statement of corporate purpose is to attract, develop and encourage skilled and committed staff. One way of achieving this is to provide learning and development opportunities that enable staff to effectively perform their current role and gain skills to help them to progress their careers.

This year we provided staff with a multifaceted training schedule that included coordinated induction sessions, job specific training and in-house workshops held by external training providers. Staff also attended a range of external courses to gain job specific skills.

Figure 16 — Training expenditure

Year	03/04	04/05	05/06	06/07	07/08
Value	$151,000	$78,000	$117,000	$220,000	$180,000

Raising awareness

Our major focus this year was improving how we deal with the public. Two of our staff members developed and conducted disability awareness and Aboriginal cultural appreciation training sessions to improve our understanding of the needs and issues affecting these groups as well as improving how our staff interact with them. We also organised for external providers to present cultural awareness training sessions.

Carolyn Campbell-McLean (Community Services Division) providing disability awareness training to our staff.

Treating each other with respect

This year all our staff attended equal employment opportunity/harassment prevention training to highlight the importance of treating everyone with respect. These sessions were conducted by the Anti-Discrimination Board.

Supervisors training

Staff appointed to supervisory positions were provided with training in EEO and grievance-handling, recognising and assisting staff with depression, fundamental supervisory skills, performance management and occupational health and safety.

Laurel Russ and Kylie Parsons (Aboriginal Unit) providing Aboriginal cultural appreciation training to our staff.

Better equipping new staff

We have a formal induction program to make sure that all new staff receive consistent information about our office and our policies, processes and obligations. Within their first three months, all new staff are given training on security awareness and our electronic document management and case management systems. In addition, they attend an information session where representatives from across the office provide a brief overview of the role and structure of their area. We also hold 'Ombudsman What, When, Where and Why' training sessions — the first module of our investigation training program — to inform new staff about the work we do and our jurisdictions and responsibilities.

Developing professional skills

As part of our commitment to professional development, all complaint-handling staff attend our investigation training program. This is an in-house developed course that covers various aspects of investigation work — including report writing, planning, managing parties and evidence collection. One module is scheduled each month.

During the year staff also participated in workshops on presentation skills, public policy process, workplace effectiveness, communication skills, introduction to project management, and merit selection in the public sector. They also attended a number of conferences on topics ranging from reviewing child deaths, housing issues and residential care.

In addition:

- We arranged for external presenters to deliver training sessions on a range of issues specific to our complaint-handling and other activities.
- Corporate staff attended a range of courses to enhance their skills, as a result of changes to our payroll/personnel system and our accounting package.
- A number of complaint-handling staff attended public training sessions run by our own training staff on, for example, the art of negotiation and dealing with difficult complainants.

Improving our computer skills

Computer based training was also a focus this year following the upgrade of our word processing and Excel programs. All staff attended information sessions outlining the new functionality. A number of staff also attended external training in Excel, Word, Outlook and PowerPoint.

Supporting other programs

Staff development also means encouraging staff to undertake further study to enhance their skills. During 2007–2008 one staff member joined the Public Sector Executive Development Program sponsored by the Premier's Department, and a second staff member started the program in July 2008. Eight of our staff used study leave provisions to undertake tertiary education courses.

Balancing our books

Most of our revenue comes from the government in the form of a consolidated fund appropriation. Our final consolidated fund allocation for 2007–2008 was $20.069 million. The government also makes provision for certain employee entitlements such as long service leave. We were allocated $300,000 for our capital program, which was spent on upgrading our computer systems, purchasing new office equipment and updating and improving our fitout

We generated $263,000 through the sale of publications, bank interest, fees for service training courses and our consultancy services to AusAid.

Most of our revenue is spent on employee-related expenses including salaries, superannuation entitlements, long service leave and payroll tax. Last year we spent more than $17.1 million on these items. The day-to-day running of our office costs over $4.2 million a year.

Further details of our financial position can be found in our financials.

Environmental issues

Our agency, like all agencies, has an impact on the environment. Our work leads to the generation of emissions and the production of waste, and we use resources such as electricity and water. We have a number of programs in place to monitor and reduce this impact, including energy management and waste reduction programs, and have integrated environmental issues into our business plans. The success of our environmental programs depends on the commitment of our staff, so one of our key environmental activities is staff awareness and education.

Energy management

Petrol consumption

To ensure we meet public sector requirements, we have a fleet improvement plan that identifies a number of strategies aimed at improving our fleet performance score. We travelled fewer kilometres this year, reducing the amount of petrol used. We have also been replacing our fleet with smaller, more energy efficient vehicles.

Performance Indicator

Petrol consumption

	95/96	04/05	05/06	06/07	07/08
Petrol (l)	4,296	5,326	5,159	4,787	4,145
Total (GJ)	147	182	176	162	142
Distance travelled (km)	53,018	54,738	51,602	35,086	32,963

Electricity consumption

We had an increase in energy use in 2007–2008, following a significant decrease the year before. We are unable to account for this increase, but it is still lower than our 2005–2006 usage. We have engaged our electricians to review this matter. Next year, we will be installing virtual servers in our computer room to reduce the number of servers that use power and generate heat, and this should have a positive impact on our consumption.

Future direction

We are committed to improving our environmental performance and will benchmark our performance annually against government and internal targets. We will continue our staff awareness program to ensure that all staff contribute to the achievement of targets.

Performance Indicator

Energy consumption

	95/96	04/05	05/06	06/07	07/08
Electricity (kWh)	133,630	304,716	355,301	311,713	348,358
Kilowatts converted to gigajoules	481.07	1,097	1,279	1,222	1,254
Occupancy (people)	69.7	187	187	191	187
Area (m^2)	1,438	3,133	3,133	3,133	3,133

Greenhouse performance

Australian Building Greenhouse Rating (ABGR)

We are continually working to improve our ABGR rating by using more energy efficient systems/controllers throughout the office. We have also implemented a program to educate staff on ways to conserve energy.

Waste reduction program

We are committed to reducing the amount of waste going to landfill. Our waste reduction and purchasing program has resulted in a reduction in waste, increased recycling and greater purchasing of recycled content products.

Reducing generation of waste

We are continually looking at ways to improve our waste management practices. We promote email as the preferred internal communication tool and encourage staff to print double-sided. We have an electronic record system that allows staff to access information such as policies, procedures and internal forms — reducing the need for paper copies. Our publications are available to download from our website so we now print smaller quantities than in the past.

Resource recovery

We have individual paper recycling bins at workstations and larger 240 litre bins throughout the office for secure destruction. All office wastepaper, cardboard, glass, plastic and aluminium is collected for recycling. We are a member of Planet Ark Close the Loop Resource Recovery Program and recycle our used toner cartridges, bottles, drums, inkjets and ribbons. We do regular checks of our general waste and recycling bins to identify any recyclable paper in the general waste stream or any contamination in the recyclable paper bins.

Using recycled material

We use Australian recycled paper containing 80% waste fibre diverted from Australian landfills. Our stationery and publications are printed on either recycled, acid free or chlorine free paper. We purchase recycled content product when feasible and cost effective.

Reducing water usage

The owners of our building have implemented a water saving strategy throughout the building. During 2007–2008, we participated in a trial of waterless urinals. Following positive trial results, building management have replaced the urinals in the building with a waterless system.

Our publications area is currently focusing on providing more environmentally friendly publications. We are auditing our whole print process — including sourcing printers that provide cleaner print processes that use natural inks and print finishes that use water soluble coatings and processes. We currently use a digital process for smaller print runs because digital printing is better for the environment than traditional offset printing.

We are also reviewing the paper stocks we use in printing. In future, where possible, we will be using Forest Stewardship Council (FSC) certified stock. The FSC is one of the few independent bodies capable of accurately determining fibre origin by tracking it from forest to printer (see inside back cover for further information).

Paper accreditation icons we are eligible to include on printed products.

Community engagement 1

An essential part of our work involves engaging effectively with the community to develop relationships, identify and respond in a proactive way to issues and complaints, and increase awareness of the role of our office. Community consultation also forms an important part of our investigative and research work. When we talk about 'community' we include local agency staff, community workers, consumers of services, peak bodies, advocacy groups and the public.

Highlights

- Supported 36 official community visitors (OCVs) to make 3,289 visits to 6,578 people living in residential services across the state. OCVs identified 3,634 issues this year — 63% of these have been finalised.
- Ran 80 workshops and training sessions for over 1,600 consumers, staff and providers of community services.
- Worked cooperatively with the NSW Sentencing Council on their research into the effectiveness of fines as a sentencing option, particularly for vulnerable people. Our submission will form part of the council's final report.
- Completed a review of the supports provided to carers of Aboriginal children. We also examined the health, educational and cultural needs of Aboriginal children in care as well as critical data deficiencies.
- Prepared a comprehensive submission to the Wood Inquiry which outlined our views on child protection and neglect in Aboriginal communities.
- Commenced a major investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing. Consultations were held in 25 locations across the state and involved over 450 stakeholders.
- Developed disability awareness training for our staff. So far, four sessions have been delivered.
- Delivered three workshops on complaint-handling and advocacy for domestic violence workers.

A key focus of a number of our systemic investigations in recent years has been examining how well government policy is being implemented at community level. Our investigations into issues such as policing domestic violence, police work with Aboriginal communities, and supporting people with mental health problems to maintain their social housing have all involved extensive consultations with frontline agency staff, service providers and members of the public in numerous locations across the state. For example, we interviewed 100 foster carers as part of our review of the adequacy of supports provided to the carers of Aboriginal children and held over 250 meetings with agency staff, community workers and advocates to inform our investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS).

These consultations help us to understand how government service delivery can impact on individuals, identify common systemic issues that need to be addressed, and explore what works in local areas and why. They also allow us to test ideas and possible solutions to ensure that our final recommendations are workable.

As well as the community liaison and consultation work carried out by our staff during projects and investigations, we have dedicated units and positions within our office that focus on working directly with the community. These include our community education unit, Aboriginal Unit, youth liaison officer and training officer. Some examples of their activities include:

- conducting community education workshops about our role and how to make complaints
- providing training on advocacy, complaint-handling and dealing with unreasonable complainants
- attending community and cultural events and distributing information about our services.

We also gain direct access to many community members through our role in administering the official community visitor scheme (OCV). We support OCVs to visit consumers of residential services in the community and help them to address matters that fall outside the scope of their powers, particularly matters of a serious nature. Our role also provides us with valuable insights into the quality of service provision to some of the most vulnerable people in the state.

In this chapter, we discuss our community education work and our work with OCVs — as well as our work across specific groups in the community such as Aboriginal people, people from different cultural and linguistic backgrounds (CALD), young people, women and people with a disability.

Official community visitors

Official community visitors (OCVs) are statutory appointees who provide an independent mechanism to ensure that people living in residential services in NSW receive the highest standard of service provision possible. They are appointed by the Minister for Ageing and Disability Services and the Minister for Community Services for a period of up to six years.

The residents they visit live in services funded, licensed and/or authorised by either the Department of Ageing Disability and Home Care (DADHC) or the Department of Community Services (DoCS). This includes services for:

- people with a disability
- children and young people in out-of-home care
- children and young people with a disability in out-of-home care.

OCVs also visit people living in licensed residential centres or boarding houses.

They are required to:

- inform the Ministers and the Ombudsman about matters that affect the conditions of people in care
- promote the legal and human rights of residents

- consider matters raised by residents
- provide information and assistance on advocacy
- help to resolve any grievances or concerns residents may have.

OCVs try to resolve issues at the service level to minimise their impact on the daily lives of the individuals concerned. If the issues and concerns cannot be resolved — or are serious and outside the powers of the OCV — they can raise them with us or the relevant minister.

This year the Parliamentary Joint Committee of the NSW Parliament reviewed the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and recommended that:

- the resources of the OCV program be increased to enable more visits to take place
- we continue to actively recruit OCVs from Aboriginal and other CALD backgrounds
- a legislative amendment be made to impose sanctions for obstructing, hindering or restricting OCVs in the exercise of their functions.

We support these recommendations and await the government's response.

Administering the scheme

We administer the OCV scheme, set visit priorities and give support to the OCVs.

We do this by:

- recruiting and inducting new OCVs, through a six month training and mentoring program
- providing them with up-to-date information about departmental policies and procedures
- supporting them at meetings and conciliations aimed at resolving issues between services and residents
- providing training programs addressing practice issues to support their professional development
- helping them with the logistics of travel and accommodation
- coordinating meetings of OCVs at a regional level and through specific sector discussion groups
- meeting periodically with OCVs to discuss the operation of the scheme and policy initiatives to enhance its development
- coordinating an annual conference for OCVs to meet with ministers, senior public sector officials, peak agency representatives and our staff to discuss community sector matters and issues affecting the care and welfare of residents.

Figure 17 — Outcome of issues identified by OCVs finalised in 2007–2008

Target group of services	No. of visitable services	No. of issues identified	Percentage of issues identified	Percentage of issues finalised* (resolved issues)	Percentage of issues finalised** (unresolved issues)	Percentage of issues finalised*** (closed issues)
Children and young people	106	427	276 (64.6%)	105 (38.0%)	17 (6.2%)	154 (55.8%)
Children and young people with a disability	39	204	126 (61.8%)	62 (49.2%)	38 (30.2%)	26 (20.6%)
Children, young people and adults with a disability	18	67	44 (65.7%)	32 (72.7%)	0 (0%)	12 (27.3%)
Adults with a disability including residents of boarding houses	1,074	2,936	1,829 (62.3%)	1,636 (89.5%)	50 (2.7%)	143 (7.8%)
Total	**1,237**	**3,634**	**2,275 (63%)**	**1,835 (80.7%)**	**105 (4.6%)**	**335 (14.7%)**

* where services take action to remedy the issue, resulting in improved services for residents.

** where services are unable or unwilling to resolve issues. For example, issues that are beyond the capacity of services to resolve as they are affected by systemic budgetary, policy or other factors. OCVs may report such issues to the NSW Ombudsman with a view to complaint or other action.

*** where issues are no longer relevant. For example, because a service closes or a resident of a visitable service about whom an issue has been identified relocates to another service.

Figure 18 — Number of visits made by official community visitors in 2007–2008

Target group of services	No. of services	No. of residents	No. of activity hours	No. of visits 06–07	No. of visits 07–08
Children and young people	106	204	877	370	307
Children and young people with a disability	39	120	344	142	137
Children, young people and adults with a disability	18	63	123	54	46
Adults with a disability in residential care, including boarding houses	1,074	6,191	7,849	2,598	2,799
Total	**1,237**	**6,578**	**9,193**	**3,164**	**3,289**

In 2007 we undertook extensive recruitment across NSW. We received over 150 applications for OCV positions and, after an extensive process based on demonstrated skills and abilities, 12 people were appointed and started work on 1 March 2008.

Issues raised by visitors

In 2007–2008 the budget for the OCV scheme was $754,000. This enabled 36 OCVs to go to 1,237 services, conducting 3,289 visits to 6,578 residents. OCVs provided 9,193 hours of service to residents, which is a small decrease on the 9,507 hours in 2006–2007.

Some of the most common issues raised with OCVs this year included concerns about:

- provision of individualised service — 654 issues
- provision of a well maintained and home-like environment — 404 issues
- provision of appropriate and meaningful behaviour management plans and implementation of those plans — 356 issues
- provision of appropriate monitoring to ensure good health management, choice of healthy food and access to heath care — 292 issues
- provision of a service environment that is safe and has appropriate emergency procedures, is free from abuse and neglect and that also allows residents the right to make informed choices — 284 issues.

During 2007–2008, OCVs identified 3,634 issues, of which 2,275 were finalised (63%). Services, with the assistance and oversight of OCVs, resolved 1,835 (81%) of the service provision issues that were finalised (see figures 17 and 18). OCVs continue to monitor services' action about 1,359 ongoing issues that were identified during the year.

Case study 1

A man living in a residential group home with four other residents told the OCV that he wished to have some individual community access with the support of one staff member, instead of always having to go as part of a group. When the OCV inquired about whether he had raised this issue at his service's last individual planning meeting, he said that they did not have individual planning and he wanted to be able to have a say in issues that affected his life.

The OCV raised the issue with the manager of the service. The service advised that they did not see formal individual planning as an important aspect of service delivery and that residents of their service were able to set their goals informally. The OCV pointed out that, without formal individual planning, residents' issues and goals were unlikely to be addressed. The OCV also advised that the Disability Service Standards make individual planning for residents mandatory and that the service's funding could be at risk if they did not comply with this.

The service agreed to implement individual planning. However after deadlines passed with limited progress, the OCV escalated the issue as a complaint to our office. As a result, the service responded and individual plans with meaningful goals were developed for all residents.

Each year we table a report to Parliament on the work of the OCVs, providing further details about the issues and outcomes that have been achieved for residents. Case studies 1, 2 and 3 provide examples of some of the individual outcomes our OCVs have achieved this year.

Providing community education

This year our community education unit developed, implemented and consolidated a significant communication and education strategy. The aim of the strategy was to develop a systematic approach to promoting our work to consumer advocates and service providers throughout NSW. It involves placing information in publications distributed by peak body organisations and initiating direct contact with targeted special interest and consumer groups via presentations and local media.

Our general information and awareness strategies also continue to target groups that are key stakeholders or those who may be disadvantaged because of disability, location, language or other circumstances.

In 2007–2008, our program of education activities with consumers of community services and their families trained approximately 60 people. These activities are designed to inform consumers and their families of their rights, how to communicate effectively, and how to make complaints. We worked with consumers from culturally and linguistically diverse backgrounds, older people using Home and Community Care (HACC) services and families of young children with a disability.

We reprinted our Rights Stuff toolkit and distributed it to consumers and service providers throughout the year. We also undertook the 'Solving Problems — Right at Home' program with 13 residents and 14 workers at Carinya Arncliffe Licensed Boarding House to inform participants of our role and to allow them to raise individual, service and systemic issues. Another forum was held for 14 boarding house staff in the Hunter region. We also held joint disability intermediaries forums — with the Energy and Water Ombudsman (EWON) — in Chatswood, Parramatta and Sutherland. Over 150 disability workers and advocacy providers attended to learn more about our work.

Case study 2

An eleven year old with autistic spectrum disorder and severe language and behaviour deficits attends a local school with daily support from committed carers. The boy was under a joint care arrangement organised by a government and a non–government agency. This joint care arrangement had resulted in confusion about which group was taking responsibility for his recreational and leisure program. The OCV found out that the recreational program had not changed or developed over time in accordance with the boy's age, skill or ability, so raised this concern with both organisations. A review meeting resulted in the development of a specific focus program for the boy. The new program gave him a wider range of activities and resulted in significant improvements in his behaviour.

Case study 3

Four and a half years ago a boarding house closed, leaving 18 residents in interim housing for six months. Four years later the residents were still in the temporary premises, with no indication by DADHC of when they might move to permanent accommodation. Family members of some of the residents contacted the OCV, seeking assistance in finding out when and where the residents might move.

Initial attempts by the OCV to seek clarification from DADHC were not successful. There were no clear timeframes for moving residents and a lack of clarity about where they would be living in the future.

The OCV raised the issue with us and we sought confirmation from DADHC of their plans for the residents. The information we received was passed on to the residents and families by the OCV. The residents have now moved to new accommodation and the OCV reports that they are happy with the arrangements.

Our membership of the Joint Outreach Initiatives Network — which includes staff from other complaint-handling bodies such as the Commonwealth Ombudsman, Independent Commission Against Corruption (ICAC) and the EWON — enables us to exchange information about outreach activities and strategies and work together on joint projects. These include the Office of Fair Trading Community Access Program and the joint information stall at the Royal Easter Show on Seniors Day. We also hosted a one day meeting with staff from the Victorian and Queensland Ombudsman to exchange information on communication strategies and outreach initiatives.

In November 2007, we gave a presentation at the rural and remote communities drugs, alcohol and substance abuse workshop in Katherine in the Northern Territory. The two day workshop involved police drug policy coordinators from Queensland and the Northern Territory, some key Aboriginal health representatives and a number of remote area police. The aim was to put processes in place to implement recommendations from a 2005 report, *The policing implications of cannabis, amphetamine and other illicit drug use in Aboriginal and Torres Strait Islander communities*. The report, produced by the Australian Institute of Aboriginal and Torres Strait Islander Studies and the Australian Institute of Criminology, featured information about our work with Aboriginal communities and generated enormous interest from police practitioners.

Places visited 2007–2008

Albury
Armidale
Batemans Bay
Bathurst
Bega
Bellbrook
Blue Mountains
Bodalla
Bourke
Bowral
Brewarrina
Broken Hill
Cabarita Beach
Caroona (Walhallow Village)
Casino
Cessnock
Charlestown
Cobar
Coffs Harbour
Coonamble
Cootamundra
Dareton
Deniliquin
Dubbo
Eden
Fassifern
Forbes
Glen Innes
Goodooga
Gosford
Goulburn
Grafton
Guyra
Inverell
Junee
Kingscliffe
Kempsey
Lightning Ridge
Lismore
Lithgow
Maitland
Merimbula
Milton
Mogo
Moruya
Murwillumbah
Muswellbrook
Narooma
Newcastle
Nowra
Oberon
Orange
Parkes
Port Kembla
Port Macquarie
Queanbeyan
Quirindi
Singleton
Tamworth
Taree
Tingha
Tweed Heads
Wagga Wagga
Walgett
Wallaga Lake
Wellington
Wilcannia
Wollongong

One outcome of this workshop was to create a network for practitioners involved in remote area policing issues. This network has the potential to give us direct access to significant developments in other jurisdictions, particularly in relation to addressing issues such as substance abuse, family violence and more effective protective responses for children and young people in rural and remote communities.

The more than 240 information and education activities we undertook during 2007–2008 included:

- Running 80 workshops and training sessions — reaching over 1,600 providers, staff and consumers — including complaint-handling for frontline staff, protected disclosures, unreasonable complainant conduct, art of negotiation, responding to allegations against employees, dispelling the myths (for senior police managers) and Rights Stuff (for consumers of disability services).
- Conducting 161 presentations to agencies and community groups to increase awareness of our role and complaint-handling.
- Publishing several articles and stories in community sector publications about our work and specific projects — including sector specific overviews of our annual report.
- Participating in a range of conferences, community expos, cultural events, and international days for women and people with a disability.
- Producing several new resources — including guidelines for dealing with youth complaints, a community languages poster, complaints policy information kits, a fact sheet for juvenile justice workers and an 'Easy English' brochure for people with low literacy or an intellectual disability.
- Distributing information to over 1,000 sector workers and managers through conference satchel inserts and post conference mail-outs — as well as information to community and neighbourhood centres, councils, legal centres and libraries.

Visiting regional and remote communities

Over the past 12 months we have travelled to 68 regional and remote towns in NSW — to visit correctional centres and juvenile justice centres, conduct consultations for investigations and audits of agencies and services, and deliver presentations, training sessions and forums.

Our official community visitors also visited 120 regional and remote towns in NSW while visiting people in residential services.

A significant initiative this year was the introduction of our regional outreach program facilitated by the Deputy Ombudsman. This program was delivered in Wollongong, Tamworth, Dubbo, Coffs Harbour and Wagga Wagga.

Each forum consists of two sessions — one for workers in child and family services and another for those in disability and other community services. The Deputy Ombudsman provides a general overview of the role of our office and then outlines our specific work in the relevant community service sector. Time is allowed for questions from the floor and informal discussion about local issues.

The program is intended to provide information and resources to rural and regional workers in a direct and meaningful way, to encourage the community services sector in rural and regional areas to share their views, and to provide an opportunity for the Deputy Ombudsman to hear first hand the unique experiences and concerns of people living and working outside the metropolitan area.

Working cooperatively with other agencies

The impact of fines on vulnerable members of the community — such as young people, Aboriginal people and people with a disability — was a recurring theme that emerged during our audits of the NSWPF's implementation of their *Aboriginal Strategic Direction* (ASD). We also received feedback about this issue from our youth liaison officer (YLO) and from complaints and inquiries received by our office.

Last year we were alerted to research by the NSW Sentencing Council into the effectiveness of fines as a sentencing option. There was significant overlap between the council's research and a project we planned to undertake. Rather than pursue this project directly, we decided to contribute our own research to the work of the Sentencing Council.

Our submission to them addressed issues such as:

- the use of discretion by transit officers, police and revenue protection officers when dealing with the community — particularly vulnerable groups
- available alternatives for issuing officers — such as warnings, cautions and diversionary programs
- the adequacy of training for issuing officers about the use of discretion and dealing with vulnerable groups
- options for internal review of a fine by different agencies
- public scrutiny of issuing agencies
- the quality of information provided by issuing officers to recipients — such as the consequences of receiving the fine
- State Debt Recovery Office strategies for community education about the consequences of fines and how to negotiate the enforcement system
- corporate strategies to measure the effectiveness and adequacy of compliance with relevant procedures and diversionary options
- the need for policies to be consistent across agencies.

In February this year the Sentencing Council advised us that our submission 'concisely captures the key issues facing vulnerable groups.' They intend to refer to it extensively in their final report and plan to include our full submission as an appendix.

Aboriginal communities

This year, much of our work with Aboriginal communities has focused on addressing child protection issues. The need for agencies and the community to work together to address family violence and child protection is repeatedly raised during our consultations with Aboriginal community members and service providers across the state. Our work in this area is, as well as several of our other activities, aimed at improving service delivery to Aboriginal people.

Responding to child protection issues in western NSW

In response to a specific complaint made to us by a prominent member of a remote community in western NSW, we held discussions with DoCS about how they might improve their caseworker presence and service delivery in the region. We also sought specific advice from the NSW Police Force about their plans for responding to Aboriginal child sexual assault, and consulted with the Department of Aboriginal Affairs about their coordinating role for the *NSW Interagency Plan to tackle Aboriginal child sexual assault.*

From these discussions, we are aware that DoCS is considering particular strategies to both increase caseworker numbers to cover high-need areas and provide their staff with better infrastructure and support. We have asked DoCS to identify the communities likely to benefit most from this approach and the anticipated increase in the number of operational positions. We have also asked them to consider this planned increase in child protection case workers in the context of their other work in this region, such as out-of-home care, family support and early intervention services.

An increased child protection presence, without a corresponding strengthening of family support services, may result in a community backlash. Increased child protection intervention is also likely to require more out-of-home care options across the region. We await DoCS' response to our suggestions.

We were pleased to see the $22.9 million allocation in this year's state budget to combat child sexual abuse through the expansion of the 'Safe Families' program to the Orana Far West Region. We are hopeful that this announcement is linked to a broader response for dealing with serious child abuse and neglect issues in these areas.

Special Commission of Inquiry into Child Protection Services

In June this year, we outlined our views on child protection and neglect in Aboriginal communities in a submission to the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry).

Our submission noted that an obvious starting point in addressing Aboriginal child protection issues is to undertake a frank assessment of the needs of Aboriginal communities, find out whether those needs are being adequately addressed through either mainstream or Aboriginal specific services or programs, and look for opportunities to build on positive initiatives already in place. This means accurately determining the nature and extent of the need and evaluating which programs actually work.

An important first step is to consider whether essential services are available where and when they are needed. The delivery of policing, health, welfare, housing and other essential services in high-need areas can often be hampered by skill shortages and high staff turnover. In many cases, these can be successfully addressed by providing better incentives to attract and retain suitably qualified and experienced staff — especially in remote locations where vacancies can take time to fill. This is critical if agencies are to make improving Aboriginal access to mainstream services a priority.

A key challenge is making services more responsive to and accessible by local Aboriginal people. Meeting this challenge does not involve a 'one size fits all' approach in the design and delivery of services. Instead, service delivery needs to be tailored to suit the needs of particular communities. Enhancing services to Aboriginal communities should also involve establishing or extending the capacity of Aboriginal-specific or community-controlled organisations, and helping those bodies to collaborate with other agencies to deliver a coordinated suite of services.

Our submission to the Wood Inquiry highlighted the need to examine:

- the quality of current planning, implementation and accountability processes — including the alignment of these processes with state and federal objectives
- existing data collection practices and agency performance measures — including the need to provide more detailed information about results, rather than activities and outputs
- the type of partnerships that need to be built between agencies, Aboriginal services and communities to deliver a broad range of holistic services
- the complexity of current funding arrangements and whether there is sufficient flexibility to promote genuinely innovative local initiatives
- what kind of service models are required to respond to the complexity of need, particularly in high need communities
- workforce capacity and other requirements to make these models work, including an expansion of the Aboriginal workforce.

We also noted that progress reports from agencies need to present a realistic picture, not only of the successes but also the unmet challenges in individual communities.

Caring for Aboriginal children

In 2007, we undertook a detailed review of issues affecting carers of Aboriginal children and the adequacy of services and supports in place to help them to provide quality care. Our report, *Supporting the carers of Aboriginal children*, was based on interviews with over 100 Aboriginal and non-Aboriginal carers, Aboriginal out-of-home care service providers and health/education professionals.

Supports for carers

We found that carers emphasised the value of regular, quality contact with caseworkers. They also generally had realistic expectations of the ability of DoCS to help them provide quality care. We suggested that DoCS tries to ensure there is appropriate, regular and ongoing communication between caseworkers and carers. Good support to carers not only encourages their retention, but well-supported carers are an effective recruitment tool. We also suggested improving coordination of carers' training needs, strengthening and monitoring carer support initiatives, and ensuring a prompt and appropriate response to any complaints raised by carers.

Cultural support

If children have to be placed with carers with no kin connection, then care planning — especially cultural care planning — is crucial. We asked DoCS about the steps they are taking to develop, implement and monitor appropriate and consistent cultural support planning processes to foster cultural identity and connectiveness for Aboriginal children in out-of-home care.

Consultation processes

We also asked DoCS to develop, implement and monitor clear and consistent guidelines for how they consult with communities about placement decisions for Aboriginal children to ensure proper compliance with the Aboriginal Placement Principles.

Health

Good health screening and coordinated follow-up is critically important as poor health issues disproportionately affect children in out-of-home care. As Aboriginal children in care are particularly susceptible to certain health problems, we found significant benefits in DoCS establishing formal agreements with out-of-home care service providers and public health services to provide comprehensive health assessments for all Aboriginal children entering out-of-home care placements.

Education

Few of the carers we interviewed considered that caseworkers had an active interest in meeting the educational needs of children in care, except to help respond to particular incidents or crises that threaten the viability of a school placement. We suggested that urgent consideration be given to:

- individual education case planning
- strategies to bring carers, caseworkers and schools together to address any learning impediments or schooling problems
- collecting, analysing and reporting on the education participation and performance of all children in out-of-home care
- tracking performance over time to determine the effectiveness of strategies to enhance learning outcomes.

Data collection

Our review showed that DoCS needs to address critical deficiencies in their data on carers of Aboriginal children. For example, although DoCS could provide figures on the number of Aboriginal children in out-of-home care, they had no reliable data about the ratio of non-Aboriginal and Aboriginal carers of Aboriginal children.

The Wood Inquiry is examining a number of the issues that we canvassed in our report. We have asked DoCS to provide us with formal advice on how they intend to respond to our observations within two months of the Wood Inquiry findings. However, DoCS has already taken steps to address several of our recommendations. For full details of our report, see our website at www.ombo.nsw.gov.au.

Policing Aboriginal communities

In the early days of our Aboriginal Unit, much of the field work we conducted was reactive. This changed in late 2002 when we began our policing Aboriginal communities audit program. Since then, we have reported on police efforts to create and strengthen partnerships with local Aboriginal communities. Last year, we finalised our four year program of audits of 36 local area commands to assess the implementation of the NSW Police Force's *Aboriginal Strategic Direction 2003–2006.* We now intend to start a new audit program that will focus on police work to address child sexual assault and substance abuse in Aboriginal communities. Given the sensitive and complex nature of this work, our Aboriginal Unit has spent time visiting several communities this year to talk with community members about the impact of these issues and the type of strategies and supports currently in place. This information will help inform our audit strategy. For more details about our work in this area, see page 109 in Chapter 5: Policing.

The impact of criminal infringement notices

Since 1 November 2007, police across NSW have been able to issue on-the-spot fines or criminal infringement notices (CINs) to adults for certain minor offences such as offensive language, offensive conduct and some stealing related offences. CINs give police an additional way of dealing with a person suspected of committing any of these offences. Before the introduction of CINs, police either cautioned or warned the person about the offence, or they may have charged them. Anyone who is given a CIN can pay a fine and avoid going to court. If the fine is paid, the offence is not put on the person's criminal record. We reviewed a trial of the CINs scheme several years ago and found that it had been largely successful. It provided police with another option for dealing with minor criminal offences in a quick and simple way, without taking away the option of having a matter heard in court.

As our initial trial did not include areas with large Aboriginal populations, it was unclear how CINs might affect them. For instance, analyses of past data showed that Aboriginal people were up to 15 times more likely to be prosecuted for offensive language. On the one hand, CINs may help reduce the number of criminal prosecutions for offensive language. On the other, CINs could also lead to more people being fined — instead of just receiving a warning or caution. As it may be difficult for some Aboriginal people to pay a fine, this may result in further consequences — such as their driver's licence or vehicle registration being suspended or cancelled.

Parliament has again asked us to review the CINs scheme, this time focusing on its impact on Aboriginal communities. During our review, we plan to talk to a range of people and organisations to gain a better understanding of the impact of CINs — and fines generally — on Aboriginal people. We are keen to hear about people's experiences with the police who issue CINs and the State Debt Recovery Office — the organisation responsible for collecting fine payments.

Reviewing services for Aboriginal people with a disability

This year we commenced a review into the implementation of the Department of Ageing, Disability and Home Care's (DADHC) *Aboriginal Policy Framework* and *Aboriginal Consultation Strategy* which aims to help staff in their work with Aboriginal people and their communities.

So far, we have monitored the implementation of these key documents through regular meetings with peak Aboriginal bodies such as the Aboriginal Disability Network and the NSW Aboriginal Community Care Gathering Committee and, more recently, meetings with senior representatives from DADHC.

In August this year we commenced our program of reviews in each DADHC region to explore the adequacy of consultation mechanisms in place between DADHC, relevant service providers and Aboriginal communities at a local, regional and state level. We also want to find out if these mechanisms are providing Aboriginal people with better access to DADHC's services and to the services they fund.

Our region reviews involve holding consultations in selected locations within DADHC's six regions, including interviews with DADHC staff, local partners and service providers, consumers, carers and community groups.

Community outreach work

Our staff attend a range of regular liaison meetings with peak Aboriginal bodies, Aboriginal service providers and Aboriginal staff in key agency roles. We distribute our Aboriginal fact sheet and information packages at these meetings and when we visit communities for consultations. Our police audit program in particular has increased our profile and has led to regular requests for us to take part in conferences, community working party meetings, training sessions and workshops.

This year we participated in several NAIDOC Week events across Sydney and the North Coast and more than 2,400 members of Aboriginal and Torres Strait Islander communities were informed about our role. We also participated in 'Good Service Forums' at Broken Hill, Wilcannia and Lismore. These forums involve staff from a range of agencies — including the Office of Fair Trading, EWON and the Commonwealth Ombudsman — visiting selected Aboriginal communities to explain how to access services and make complaints.

Juvenile justice and correctional centres

We regularly visit juvenile justice and correctional centres in NSW. A representative from our Aboriginal Unit attends visits to those centres that have high numbers of Aboriginal detainees or inmates. This is to ensure that inmates have the opportunity to speak with another Aboriginal person about any concerns they may have associated with their detention. It also helps us to find out if their cultural needs are being addressed.

Mental health and housing support

This year we started an investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). JGoS is an interagency agreement to help people with mental health issues access and sustain social housing. The Aboriginal Housing Office and Aboriginal Health and Medical Research Council of NSW are signatories to the agreement, and Aboriginal housing providers and health services may become members of local JGoS committees.

In 2007, an independent evaluation of the JGoS found a low level of participation by Aboriginal organisations. During our extensive consultations across the state, we met with a number of Aboriginal housing and health providers to canvass their experiences and ideas about how to improve Aboriginal participation in the JGoS. Our final report will address how this section of the Aboriginal community can be better supported to maintain and/or access social housing.

Aboriginal cultural appreciation

This year our Aboriginal Unit developed and began implementing Aboriginal cultural appreciation training for all Ombudsman staff. The aim of the training is to help our staff learn more about Aboriginal culture and identity and develop strategies for communicating effectively with people from Aboriginal and Torres Strait Islander backgrounds. The training allows participants to:

- better identify Aboriginal and Torres Strait Islander people
- appreciate the impact of European colonisation on Aboriginal people
- identify and develop strategies for effective communication with people from an Aboriginal background
- develop skills required to work effectively with Aboriginal people
- appreciate the diversity of Aboriginal culture.

The training has been extremely well received by the 100 staff who have participated so far. It has been particularly beneficial for our frontline complaint-handling and research staff who come into frequent contact with Aboriginal people. We aim to have 80 per cent of our staff trained by the end of 2008.

Culturally and linguistically diverse communities

Newly emerging communities

This year we conducted preliminary research into government responses to newly emerging communities from countries such as Sudan, Iraq and Burma. We looked at the types of programs that are in place to assist newly settled migrants at a federal, state and local level.

One of the most significant documents we considered was the Community Relations Commission's (CRC) September 2006 report, *Investigation into African Humanitarian Settlement in NSW.* The CRC found a lack of communication and coordination between agencies, sometimes resulting in duplication of work. For example, there are often multiple meetings about the same issues without any formal ways to share information or create a consistent response. The report made 41 recommendations aimed at federal and state agencies. We are exploring how these recommendations are being implemented by relevant agencies and what sort of monitoring process is occurring in NSW.

Overall, it appears that the issues for humanitarian entrants are well known and there is recognition that a whole-of-government response is required. Of particular interest to us is whether individual agencies are responding in a planned, appropriate and coordinated way to address these issues. To assess this, we conducted some preliminary consultations with nine migrant resource centres across Sydney, Newcastle and the Illawarra and met with several multicultural interagency groups and health and youth multicultural services.

We also conducted presentations on the role of the Ombudsman to seniors groups at St George Migrant Resource Centre and to over 200 new arrivals who attend English classes at the Bankstown Adult Migrant English Services. These consultations allowed us to improve awareness of our office among culturally and linguistically diverse (CALD) communities as well as respond to individual complaints that arose during the meetings.

Information expos

During the year, we attended several information expos across Sydney including the Youth Harmony Day in Darling Harbour run by the Community Relations Commission and expos at Bankstown, Holroyd and Cabramatta. These events enabled us to distribute information to people from Arabic, Chinese, Korean, South East Asian, Middle Eastern, African and Spanish communities.

Multilingual brochures

Information about our office is available in 16 community languages. This year we contacted 1,851 community organisations, individuals and public libraries to promote our multilingual brochures and seek information and comments about community language needs. The response was overwhelming. As a result, we produced our brochure in ten more community languages — including some languages spoken by new and emerging communities. We have also been given opportunities to promote our services to CALD communities via a range of other media, including websites and radio programs.

Cross cultural training

This year we invited the Parramatta/Baulkham Hills/Holroyd Migrant Resource Centre to provide training to approximately 60 of our staff on cross cultural issues and skills for communicating effectively with CALD communities. The half day African communities session raised awareness of the various African cultures and the issues faced by the emerging African communities. The Middle Eastern communities session included a particular focus on relationships between young people and adults within these communities. Feedback from our staff was positive and the combination of presentations by community workers and personal experiences by new arrivals was particularly well received.

Young people

We recognise the importance of communicating with young people and their advocates to ensure their voices are heard and their opinions considered. Our staff, and particularly our youth liaison officer (YLO), engage with young people and youth workers using a range of community education and consultation methods. Through these contacts, we are able to identify common issues affecting young people and then use this information to inform our projects, submissions and investigations. For more details about our work in this area, see Chapter 3: Children and young people.

Consultations

This year our YLO has assisted with consultations in regional and metropolitan NSW to inform investigations and projects that involve young people and youth services. For example, as part of our investigation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS), the YLO conducted interviews with youth accommodation services and other non-government agencies. These contacts also provided the opportunity to explain our role and bring information back to our investigative staff about particular local issues. For more details about this investigation, see page 31 in 'Our organisation.'

The YLO also worked with our police division to ensure young people's experiences were taken into account as part of our review of the *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA). After discussing consultation methods with members of the Youth Justice Coalition, we approached young people attending Bidura Children's Court and asked a series of questions about their experiences of police searches following arrest. We also surveyed a number of young people who we met while accompanying youth workers in Cronulla, Marrickville and Riverwood during their regular outreach walks.

Young people 'at risk'

Many of our investigations into the reviewable deaths of children have revealed a lack of effective coordination between agencies and services coming into contact with young people reported to be at risk. Late last year our YLO visited youth services in the Kings Cross/Darlinghurst area to discuss issues affecting vulnerable young people at risk of homelessness and substance abuse. One of the key projects operating in the area involved a number of local services working together and sharing resources to improve the efficiency and effectiveness of the services they provided to these young people. A key feature of the model was that it involved close collaboration between local services and government agencies.

Our YLO began to conduct research into other interagency initiatives and collaborative service delivery models. We spoke to the coordinators of many programs in NSW and Victoria, as well as staff from key government agencies. We also attended and presented at several conferences addressing issues for young people 'at risk'.

Our research into collaborative service delivery models at a federal, state and local level formed the basis of our submission on young people at risk to the Wood Inquiry. The submission highlighted several programs that we consider particularly noteworthy. For more details about our submission, see page 64 in Chapter 3: Children and young people.

Young offenders and accommodation

This year our consultations with youth services, particularly juvenile justice community service officers across NSW, alerted us to the issue of young people being held in detention because suitable bail accommodation was not available.

There is a growing challenge for the Children's Court when making bail decisions for young people facing criminal charges who do not have stable accommodation. If a young person is homeless, the court may be forced to consider the welfare of the person and how he or she will be supported if they are released back into the community on bail. There seems to be a gap in accommodation for accused young people who don't have stable homes, especially as many of them are hard to place in youth refuges and other temporary accommodation because of their complex needs.

To find out more about this issue, we have started to identify relevant complaints to our office and are continuing to meet with relevant agencies. After the findings of the Wood Inquiry have been reported, we will start to plan our response.

Legal Aid and the police

In 2005, widespread concerns were raised by police and youth advocates about the quality of legal advice provided to young people in police custody. Young people were often being advised by solicitors not to make admissions, leaving police with few options other than to press charges. Although the Young Offenders Act allows police to take action other than charging a young person, the young person must first admit the offence. Following our involvement, the NSW Police Force (NSWPF) and Legal Aid took some steps to improve communication with each other, and this appeared to make a difference. However, we were subsequently advised that the problem had resurfaced again in certain locations.

After we requested information from the Aboriginal Legal Service (ALS), Legal Aid Hotline and NSWPF about this issue, it became apparent that high staff turnover, lack of resources, and lack of corporate level support were all contributing to the problem. Legal Aid are taking steps to improve the service provided by their Hotline, but the ALS is considering shutting down some of their services — including their telephone advice line — because of expected funding shortfalls. Unless the Legal Aid Hotline takes over this role, this would potentially further reduce the number of young offenders able to be diverted through the *Young Offenders Act 1997.* We are continuing to work with these agencies to ensure the principles of the Act are being followed.

Education and awareness

Our YLO regularly conducts education sessions with youth work students at TAFE colleges and legal studies students in Year 11 and 12 at school. These sessions are designed to increase the students' awareness of the role of the Ombudsman and the importance of young people speaking up when they have complaints.

People with a disability

We recognise how important it is for our office to be accessible to people with a disability and responsive to their needs and concerns. One way we demonstrated our commitment this year was to develop disability awareness training for all our staff. This training aims to develop a general awareness of disability and focuses on attitudinal and practical issues for people with a disability.

We make sure our information brochures are accessible to people with a disability by making them available in a number of accessible formats — including large print, Braille, discs with Braille labels, audiotapes and Compic symbols.

People in residential care

Many people in residential care are highly vulnerable because they rely on their service provider for all aspects of their needs. Our community engagement work, and the work of official community visitors, is critical to ensuring these people have access to our services and their concerns are addressed.

This year we started a review of the adequacy of DADHC's actions to identify and meet the needs and goals of 60 people who currently live in their nine large residential centres. For more details about this review, see page 92 in Chapter 4: People with a disability.

Youth Week 2008

This year, to help students learn more about the Ombudsman, we ran a Youth Week competition asking them to answer in 100 words or less the question, 'Why is it important for young people to have access to the NSW Ombudsman?' We received 57 entries from 15 schools across the state. The winning entrant was Gabrielle Yeomans from Stella Maris College, Manly who contributed the following:

youth *(noun)*

1 young person. 2 not always believed. 3 inexperienced. 4 easily misled by others. 5 unaware of their rights. 6 unequipped to deal with legal process and complaints. 7 vulnerable to those in authority.

ombudsman *(noun)*

1 government watchdog. 2 independent body. 3 unbiased. 4 educator. 5 listener. 6 assists youths, (and other persons) in the investigation of complaints against government bodies.

importance of access *(noun)*

1 fundamental right and opportunity to be heard. 2 solves issues in appropriate and structured forum. 3 may help others in similar positions. 4 identify problems within organisations and individuals. 5 satisfaction.

Women

In December 2007, we wrote to the Commissioner of Police to commend the progress made by the NSWPF domestic and family violence steering committee in implementing the recommendations of our 2006 report to Parliament, *Domestic violence: improving police practice*. For more details about our work in this area, see page 110 in Chapter 5: Policing.

This year, as part of a focus on child and family issues, we have delivered workshops on complaint-handling and advocacy to people who work in the area of domestic violence. So far we have presented to three groups of workers in Newcastle, Liverpool and Mt Druitt — with plans to deliver the workshop in other parts of the state. Workers who participated identified the need for effective advocacy and complaint-handling/management to ensure the best outcomes for their clients. We also give advice to workers about the best way to take up their concerns directly with agencies such as the NSWPF and DoCS, and how to advocate for systemic change. The workshop component on advocacy skills was particularly well received.

We frequently consult with women, and workers who provide services for women, as part of our project and investigative work. For example, this year we consulted a number of women's refuges as part of our investigation into the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). One outcome of these consultations is that we are regularly contacted by women's services we have visited — such as domestic violence court assistance schemes and women's refuges — to provide advice about issues affecting their clients.

To inform women about our services and to respond to individual complaints, we conduct presentations and attend relevant information days. This year we gave presentations on the role of the Ombudsman to the Assyrian, Middle Eastern, Turkish and Arabic Women's Groups at the Fairfield Immigrant Women's Health Service and spoke to 35 newly arrived women migrants and refugees from various African and South East Asian communities. We also attended the annual International Women's Day event at Hyde Park where we spoke to approximately 100 women about our work and their individual concerns.

Inquiries 2

We receive over 24,000 inquiries a year from members of the community contacting us to complain or inquire about a wide range of NSW public sector agencies. Providing access to information and assistance in relation to complaints and inquiries is the key function of our inquiries and resolution team.

Tips for making a complaint

Briefly explain your concerns in your own words. You should include enough information for us to assess your complaint and determine the most appropriate response.

When writing your complaint, consider:

- What happened? Where did it happen? When did it happen (time and date)? Who was involved?
- Were there any witnesses? (include details)
- What evidence is there to support your complaint?
- Is there any medical evidence? Are there photographs or documents that may be relevant?
- If police officers were involved, can you identify the officers?
- Have you complained to another agency or taken any other action (include details)?
- What action or outcome would you like to see as a result of your complaint?

Not all of these questions may be relevant. However, you should include all relevant information so we have a clear picture of the problem.

As soon as the phones are turned on at 9am each week day, a steady stream of calls arrive. A 'typical' call may come from a correctional centre inmate complaining about segregation, a resident complaining about council failing to act against a neighbour's noisy dogs, a person arrested over the weekend complaining about police treatment or a parent complaining about the removal of their children.

There are times when people call us to complain about an agency and we assess the agency's action as reasonable. In these cases, we assist the caller by explaining why this is the case. A sound explanation from an independent agency with reference to specific policies, procedures and the law can often satisfy a complainant.

Case study 4

A public housing tenant called us after the Department of Housing had issued her a notice of termination for outstanding rent. The department set a meeting time with the tenant to discuss resolving the arrears. The tenant had recently started a job, and believed she would risk losing it if she had to attend the meeting at the time set by the department. She spoke with her client service officer, but could not resolve the issue. We contacted the client service officer who agreed to meet with the tenant at an alternative time.

On other occasions, we provide advice to callers about the process they should follow to allow an agency the chance to address their problem. We also have specialist knowledge about a number of agencies and specialist staff who handle calls about the provision of community services, child protection allegations, policing and corrections. If we are unable to help a caller directly, we can draw on our extensive referral network to find the right person to deal with a problem or complaint.

However, when a caller has a problem that warrants action by our office, we do one of two things:

- We explain the need to make a formal complaint to us in writing, particularly if we need relevant documentary evidence or the complaint does not require urgent attention.
- We accept an oral complaint.

Many of the complaints we accept orally are from people who need help complaining. Generally these are community members who are more vulnerable than most — through homelessness, age, poverty, disability, incarceration or a combination of these factors. They often have a greater need than others in the community to contact and rely on public services.

Case study 5

A woman called to say that she had been stopped for a random breath test by police and they subsequently discovered her driver's licence was cancelled. The woman was unaware of this, but was fined for unlicensed driving. She needed her licence to drive her children to school and other activities. The woman contacted the Roads and Traffic Authority (RTA) and said she was advised that the problem had resulted from someone with the same licence number moving interstate and cancelling their NSW licence. The RTA was waiting for documentation from interstate before taking any action.

We recognised the immediate needs of the woman and contacted the RTA. The RTA confirmed that the problem had been generated interstate and the licence was immediately reinstated. The RTA also told the woman how to request a waiver of the fine.

In other cases, we may recognise an immediate need for action to address conduct that might cause unreasonable detriment or hardship to the caller. These matters often relate to housing, correctional centres, police and the fine enforcement system and are usually managed by large administrative organisations. Individual people and their specific problems may not always be properly dealt with by these organisations. Other people have problems with residential and other community service providers and we do what we can to help these people.

We pursue these matters like any complaint we act on — until we are satisfied the agency understands the problem and takes action to address it, or provides a reasonable explanation for their actions. We often receive inquiries about matters where the agency has already resolved the problem or given an alternative and satisfactory explanation for it. In these cases, we explain and/or confirm the agency's action. Hearing this information from an independent source often satisfies any remaining concerns people may have.

Systemic issues

This year a number of callers complained about the Registry of Births, Deaths and Marriages and their guaranteed timeframes for issuing certificates and providing other information to applicants. The complaints were that the registry was not meeting these timeframes and people paying for priority applications were actually receiving them later than the regular application timeframe. It also appeared that the registry did not inform all applicants about the delays. We contacted the registry about these concerns and they agreed to review their guarantee of service and ensure all applicants were adequately informed of delays.

We also received a number of complaints this year about councils dealing with tenants of properties that had overdue water charges. The law in NSW makes owners of properties responsible for the rates and charges that apply to their land. The owner recoups some of these charges through their lease with a tenant. However, we found some councils were dealing directly with tenants about water rates and charges — and restricting or cutting off their water supply because of outstanding payments. In our view, councils do not have the legal authority to make direct contact with tenants about water charges. We are also concerned that this contact may interfere with the civil legal relationship between owner and tenant. At the time of writing, we are awaiting a reply to our suggestion that this practice cease.

Case study 6

A correctional centre inmate complained that three months had lapsed since it had been recommended that his classification security level, and that of another inmate, be lowered. The recommendations, if approved, would allow the inmates to apply for access to leave to begin the process of reintegrating with the community. They spoke with staff at their centre about the delay in approval, but could not resolve the matter.

External leave opportunities are usually for short periods before release. A delay of three months is therefore a significant period of time. We decided to contact the centre to find out the status of the recommendations, and found the delay had been caused by miscommunication between staff members.

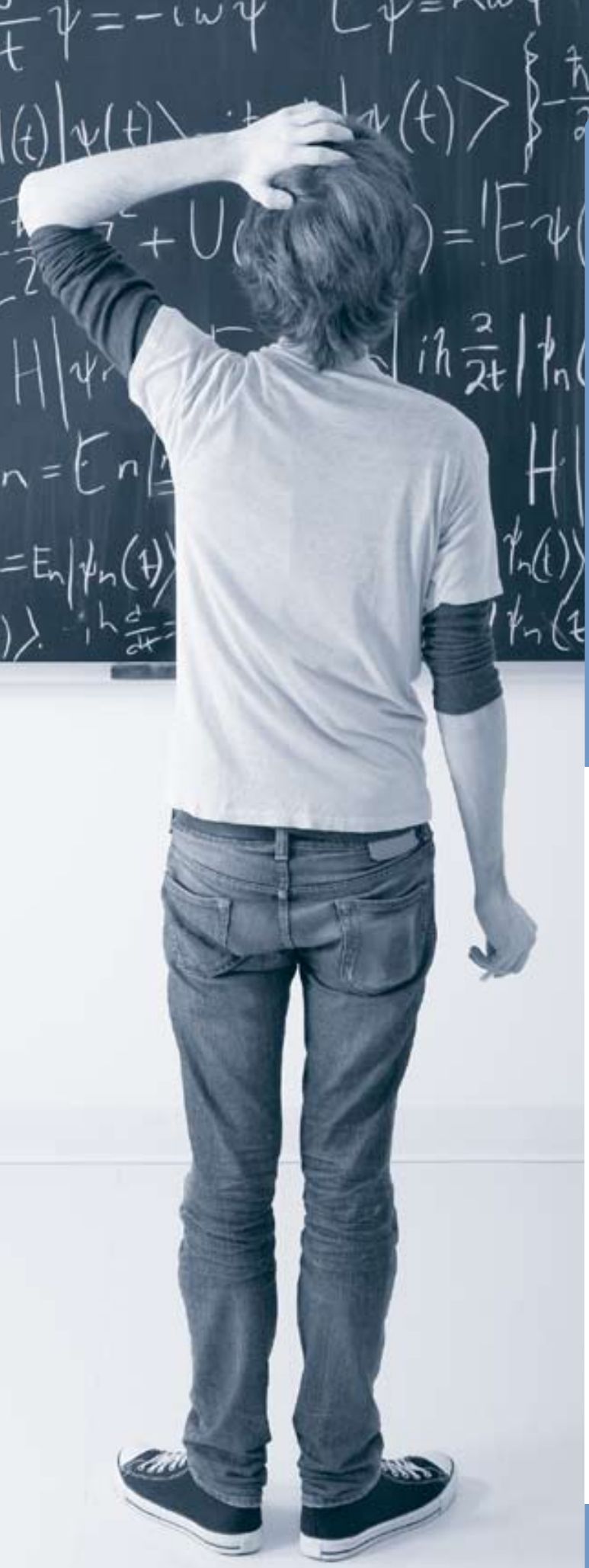
Following our inquiries, the recommendations were approved and the inmates were allowed to apply for external leave.

Case study 7

We took a telephone call from an officer of a council who had made a disclosure to the general manager about another officer's conduct which, if proven, was criminal in nature. The police were called in to investigate the matter and this led staff at the council, perhaps naturally, to be curious about who had blown the whistle. The circumstances surrounding the matter seemed to make it clear that the whistleblower had information only an 'insider' would know, and so they could easily be identified by others. The whistleblower was extremely distressed by the thought that her identity could be revealed.

We contacted the council immediately. The acting general manager agreed to issue an urgent instruction to all staff that no one was to take any action or seek further information about the matter.

This case illustrates the importance and need for swift and decisive action by senior management to appropriately manage what can be extremely difficult workplace situations after a protected disclosure has been made.



Children and young people 3

In previous annual reports we have reported on our work with children and young people in two separate chapters — community services and employment-related child protection. This year, we have dedicated a single chapter to children and young people to provide a stronger focus to this important area of our work.

Highlights

- Provided detailed submissions to the Wood Special Commission of Inquiry into Child Protection Services in NSW, outlining our views on a range of different topics such as assessment practices, privacy, interagency cooperation and children in out-of-home care.
- Reviewed the circumstances of children and young people in care, with a particular focus on Aboriginal children, children between 10 to 14 years and children under five.
- Finalised 15 child protection related investigations.
- Undertook a consultative process with stakeholders and worked with various child protection specialists to complete a thorough review of our guidelines for preventing and responding to reportable allegations, incorporating updated information on areas such as interviewing children, conduct causing psychological harm and grooming behaviour.
- Developed *Guidelines for dealing with youth complaints* to assist other organisations to make their complaint practices more accessible to young people.
- Tabled in Parliament our *Report of Reviewable Deaths in 2006 Volume 2: Child deaths*, including eight recommendations for systemic and procedural change.
- Presented over 40 education and awareness briefings or forums on child protection to 100 agencies, reaching more than 1,000 individuals.
- Assisted agencies with complex issues such as preserving evidence and investigating historical allegations of offences against children.

Our responsibilities for protecting children

Community services

The Ombudsman has broad ranging responsibilities in relation to children and young people and people with a disability under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA) and Part 3A of the *Ombudsman Act 1974*.

Under CS-CRAMA, we are required to:

- Review the deaths of certain children and people with a disability. This includes children, or siblings of children, who were reported to the Department of Community Services (DoCS) as being at risk of harm at some time in the three years before their death, children in statutory care and children living in disability accommodation services (Part 6).
- Review the situation of children and people with a disability in care (s.13).
- Handle complaints about the provision of community services (Part 4).
- Review the complaint-handling systems of community service providers and provide advice and training about making and handling complaints about community services (s.11 and s.14).
- Coordinate and oversee official community visitors who visit out-of-home care services for children and accommodation services for people with a disability (s.9).
- Monitor, review and inquire into the delivery of community services and make recommendations for improvements in service delivery (s.11).
- Promote the development of standards for the delivery of community services and provide education in relation to those standards (s.11).
- Promote access to advocacy supports for people receiving community services (s.11).

Our work under CS-CRAMA covers two main areas:

- Community services provided to children and young people and their families.
- Community services provided to people with disabilities and their families.

For services provided to children and young people, our jurisdiction includes DoCS and services licensed, funded or authorised by the Minister for Community Services.

For services for people with a disability, our jurisdiction includes the Department of Ageing, Disability and Home Care (DADHC) and services licensed, funded or authorised by the Minister for Disability Services. Our work in the disability area is discussed in Chapter 4: People with a disability.

Employment-related child protection

We are also responsible for overseeing investigations into allegations against employees of certain agencies. Part 3A of the Ombudsman Act requires or enables the Ombudsman to:

- Scrutinise the systems put in place by designated agencies and other public authorities for preventing reportable conduct by employees, and for handling and responding to allegations of reportable conduct or convictions by those agencies and authorities (s.25B).
- Receive and assess notifications concerning reportable allegations or convictions against an employee (s.25C).
- Monitor investigations of reportable allegations and convictions against employees (s.25E).

- Conduct investigations concerning reportable allegations or convictions, or any inappropriate handling of, or response to, a reportable notification or conviction (s.25G).
- Conduct audits and education and training activities to improve understanding of, and responses to, reportable allegations (s.25B).

All public authorities are subject to the requirements of Part 3A if the reportable conduct arises in the course of a person's employment. Some public authorities are designated agencies and also need to notify reportable allegations if they arise from conduct that takes place outside of employment, such as the Department of Education and Training (DET) and DoCS. Some non-government agencies are also subject to Part 3A requirements and must notify reportable allegations that arise both within and outside of employment.

Special Commission of Inquiry into Child Protection Services

Last year we contributed to a review by DoCS of the *Children and Young Persons (Care and Protection) Act 1998*. In that review, DoCS identified a number of challenges for the child protection and out-of-home care systems in NSW.

In November 2007, this review was suspended when the NSW Government established the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry) to undertake a wholesale review of the child protection system.

We have provided the Wood Inquiry with a substantial body of child protection related information from our child death review, investigative and inquiry work. In addition, we have made detailed submissions on the following child protection issues. For full details of our submissions to the Wood Inquiry, see our website at www.ombo.nsw.gov.au.

Mandatory reporting

In this submission we acknowledged the challenge presented by the massive numbers of child protection reports — approaching 300,000 annually. In NSW, the legislative threshold for determining when a risk of harm report should be made to DoCS is expressed as 'reasonable grounds to *suspect* that a child is at risk of harm'. We have suggested the commission consider supporting a legislative amendment requiring reasonable grounds to *believe*, rather than suspect, risk of harm. Also, to provide a greater focus on the degree of perceived risk, the legislation could be amended to refer to *substantial* risk of harm rather than just risk of harm.

The NSW Police Force (NSWPF) have consistently been the biggest reporting group by a substantial margin. NSWPF policy requires police to immediately notify DoCS when a child has been present at a domestic violence incident. Our submission notes that this requirement goes beyond legislative provisions for mandatory reporting and does not provide for professional judgement about whether a child is at risk. In this regard, we discuss the scope for a risk assessment tool that is currently being developed to assist police to make sound professional judgement about reports to DoCS, and potentially reduce the number of child protection reports that police make. A more detailed discussion of this issue can be found on page 73.

There is also a need to improve the level of feedback that DoCS provides to reporters. They are currently trialling electronic reporting with certain agencies, and we support exploring whether they could provide electronic feedback to key reporting agencies. DoCS have already indicated that they are keen to develop this capacity, but will need additional resources.

Our work has shown that chronic truancy is a particular risk factor for children. We have therefore suggested that there may be merit in amending the legislation to specify habitual non-attendance at school as specific grounds for reporting that a child is at risk of harm.

Assessment practices

In discussing DoCS' assessment of child protection reports, we highlight in this submission poor assessment practices identified through our work.

We also discuss weaknesses in assessment practices arising from current resource constraints. In this regard, we note that for a very large number of matters which are closed at various stages under the current risk assessment framework, the closure decision is not made on the basis of a determination that the matter warrants closure or that there is no ongoing risk, but rather on the basis of 'current competing priorities'. In our submission we argue that this issue presents one of the greatest challenges for NSW in achieving a strong child protection system.

Against this background, we have supported an initial trial of a structured decision making assessment tool which DoCS has suggested may assist in determining the relative risks of certain matters over others. However, we note evidence put to the commission indicating that an early evaluation of this tool in Queensland suggests that overall it did not promote consistency in decision-making.

To assist DoCS' assessment practices, we have also argued for a shift towards intelligence driven child protection practice. We refer to DoCS' own data which indicates that 11% of sibling groups generate close to 50% of the total reports received by the department.

We argue that in order to develop intelligence based practice, the department would need to provide its frontline staff with the capacity to run reports which identify families subject to multiple reports. A further prerequisite for the development of more intelligence based practice would involve providing frontline staff with the reporting tools that provide real time, consolidated child protection family history reports.

We also note that it is important to recognise that possessing the necessary information technology capacity represents only one component of developing intelligence driven practice.

Other components include:

- a sound intelligence policy framework
- structural and governance arrangements capable of driving DoCS' intelligence practices, particularly at the corporate and local Community Service Centre levels
- skilled staff at the corporate and local level dedicated to use and develop the department's intelligence practices.

Early intervention and prevention services

In our submission we acknowledged that — even if DoCS is able to strengthen their assessment practices and adopt sophisticated intelligence based practices — they will still not be able to meet demand. We therefore support the need to expand service capacity.

Our work has highlighted a number of cases in which families have been referred to Brighter Futures — DoCS' major early intervention and prevention program — but were rejected on the basis that their presenting risks were too serious. However when these cases were referred back to DoCS' child protection staff, they were closed on the basis of competing priorities.

Young people at risk

In our submission we also made a number of general observations about the challenge of meeting the needs of young people at risk. In particular, we referred to the need:

- to provide early intervention in the lives of vulnerable children to put them in a better position to navigate adolescence
- for an overarching policy position, and related practice, for young people at risk
- for adequate services for these young people in areas such as accommodation, mental health and substance abuse.

We support the trend towards a coordinated, multi-agency approach for responding to young people at risk and their families, and recognise the important role that schools can potentially play in identifying and supporting vulnerable young people.

For at risk young people in out-of-home care, additional supports may be needed for the children and their carers in the often difficult period leading up to and during adolescence.

For at risk young people before the Children's Court on criminal matters, we have supported giving the court the power to require a report from DoCS on the care and protection issues of these young people. We have also supported the need to strengthen the availability of accommodation options for young people accused of committing offences.

Child protection issues in Aboriginal communities

In our submission we discussed issues such as:

- Aboriginal children and young people in out-of-home care
- the practical application of the Aboriginal child placement principle
- cultural support case planning
- enhancing the capacity of Aboriginal organisations
- attracting and retaining suitable carers for Aboriginal children
- Aboriginal participation in care and protection decisions.

Aboriginal children make up over 30% of children in out-of-home care, so there is a need to:

- expand the Aboriginal out-of-home care sector
- strengthen the role of the Aboriginal Child, Family and Community Care State Secretariat (AbSec) as the peak body
- increase the number of Aboriginal carers
- promote cooperative arrangements between well established non-Aboriginal service providers, DoCS and AbSec to help build the capacity of the Aboriginal out-of-home care sector
- explore the development of flexible accommodation models, particularly models that may help to keep Aboriginal children close to their families and communities.

We also canvassed the 'building blocks' that we believe need to be in place for progress to be made in responding to child abuse and neglect within Aboriginal communities. These building blocks include:

- building partnerships with community to address child protection issues
- frameworks to guide planning and service delivery
- building an evidence base
- workforce development measures to enhance frontline capacity.

Children in out-of-home care

In our submission we:

- canvassed a number of issues relating to the delivery of out-of-home care services in general
- provided some broad observations about practice issues relating to DoCS' care placements
- summarised the key findings from specific out-of-home care reviews and inquiries conducted by the Ombudsman over the past five years
- discussed some of the key issues that need to be considered if there is to be a significant expansion in the non-government sector providing out-of-home care services
- commented on issues such as recruiting sufficient numbers of carers, better supporting children leaving care, and improving arrangements for children with a disability who are voluntarily placed in care.

Privacy and the exchange of information

This submission outlines problems associated with the current privacy laws that inhibit the effective exchange of information between agencies about child protection matters. We proposed a specific legislative solution that would enable the ready flow of information between agencies to promote the safety, welfare and wellbeing of children and young people.

Interagency cooperation

In this submission we argued that it is important to understand the different dimensions of interagency practice if we are to improve service delivery. Good interagency practice should operate on both case management and systemic levels.

Case management

Joint agency discussions are critical for individuals or families with complex needs to ensure a planned, coordinated and high quality agency response.

One of the major challenges is to identify those cases that require a jointly planned and coordinated response. If the net is cast too wide, significant resource problems may arise because of the potentially resource intensive nature of this kind of response.

Systemic

Agencies should continually review the strengths and weaknesses of local interagency practice to improve the way they work together.

Our submission mainly focused on local and regional interagency case management practices, but we also discussed some of the structural and governance arrangements required to drive interagency child protection work from both within and across agencies.

Children's Court

In this submission we made comments about:

- the need for greater use of alternative dispute resolution at the pre and post court stages
- concerns about contact orders
- the need to trial models that involve more meaningful participation by Aboriginal people in child protection matters, including genuine participation by Indigenous representatives in care and protection decisions
- the absence of systems for capturing accurate and reliable data about critical aspects of care proceedings and the impact this has on our capacity to make informed decisions about court related practices and outcomes
- the handling of significant care and protection issues involving juveniles appearing in the criminal jurisdiction of the Children's Court.

The role of oversight agencies

We made two submissions on this topic — one discussed our broad oversight role in the child protection field and the other responded to specific concerns raised by DoCS about aspects of our oversight.

A national child protection framework

In May 2008, the Federal Government released a discussion paper on establishing a national child protection framework. Our submission on this discussion paper is available on our website.

We strongly support the key child protection themes emphasised in the discussion paper. These include:

- a stronger prevention focus
- better collaboration between services
- improving responses for children in care and young people leaving care
- improving responses to Indigenous children
- attracting and retaining the right workforce
- improving child protection systems.

However, we have argued that the areas of education and disability should also be included within a national child protection framework.

Child protection investigations

In 2007–2008, we started 15 new child protection investigations (not including employment-related child protection investigations) about seven matters and finalised 10 investigations of seven matters. A number of matters involved the investigation of multiple service providers, so the number of investigations is greater than the number of matters. We also monitored the implementation of recommendations we have previously made to agencies as a result of our earlier investigations.

Our investigation work has continued to highlight the critical importance of effective liaison and communication — both between and within agencies which are part of the state's child protection system. In a number of cases, we identified communication failures within health services — including mental health and early childhood services — that contributed to inadequate assessments of risks to children. We also continued to see examples of health services making unfounded assumptions that DoCS would provide services to certain children who were at risk.

Some of our investigations have also identified concerns about the adequacy of responses to chronic neglect of children, including the failure to give certain matters sufficient priority. Through our work we have been able to assist agencies in improving their ability to respond to child protection issues. See case study 8 for an example.

Case study 8

This year we finalised an investigation into the conduct of DoCS and an area health service (AHS) in relation to a baby who died and an older sibling.

The baby died in the family home at the age of five weeks and police contacted DoCS to report concerns about neglect of the baby's sibling. There had been three previous reports made by the hospital where both the baby and the older sibling were born.

The first report had been made following the birth of the older sibling. Concerns were raised about the mother's lack of antenatal care and problems with her capacity to parent. The second report was made after the birth of the second child in response to the mother discharging herself and the child, against medical advice. A nurse midwife subsequently visited the family home and observed that the house was filthy and unhygienic. This led to a third report to DoCS on the basis of the nurse's concerns about the mother's capacity to care for both children.

The nurse midwife also referred the family to an early childhood service, noting that an urgent home visit was required and advising that the matter had been reported to DoCS.

An early childhood nurse visited the family 10 days after the referral. The condition of the house remained unchanged and the baby had severe nappy rash. In her record of the visit, she noted that the family was known to DoCS but there were no child protection concerns and closed the case. She made no arrangements to provide feedback to the midwife who had made the urgent referral. We were also concerned that the early childhood service had assessed that there was no risk of harm to the baby and assumed that DoCS would be following up on the matter.

The DoCS Helpline transferred the hospital reports about the new baby to a Community Services Centre (CSC) for further assessment, noting that assessment and support to the family was urgently needed.

We found that the CSC took no action to assess the risks to the children until after police told DoCS the baby had died. Caseworkers removed the baby's three year old sibling on the same day. Subsequent assessment showed the child had severe health and developmental problems.

In response to this and similar investigations, the AHS has comprehensively reviewed their child protection policy and procedures and provided training to their staff. There is now a new child protection service structure within the AHS that will improve the level of expertise and leadership at a senior level. These measures are designed to significantly improve their capacity to respond to child protection issues in the future.

DoCS also told us that they were acting to ensure that all staff at the CSC received training on the department's neglect policy.

Case study 9

A father complained that DoCS had improperly taken his children from their paternal grandmother's house and placed them with their mother.

The mother of the children had previously taken them to New Zealand to live, against their father's wishes. In response, the father took court action under the Hague Convention seeking the children's return to Australia. He was successful in obtaining a court order that required the children to be returned to Australia so the Australian Family Court could decide which parent they should live with and make other related orders about their lives.

The children's paternal grandmother went to New Zealand to chaperone them back to Australia. For the next few days, they lived with their father and grandmother at her home.

The mother arrived in Australia the day after the children. She immediately contacted DoCS, seeking assistance to have the children returned to her.

While the mother had been in New Zealand and the father in Australia, she had obtained a 'protection order' against him. When she returned to Australia, she had the order registered in NSW so that it operated like a NSW apprehended violence order. This happened on a Friday afternoon and had the effect of prohibiting the father from having contact with his children until such time as he could obtain family court orders permitting him to live with, or contact, them.

On the Saturday morning, police went to the grandmother's house to advise the father of the order. He agreed to stay with a friend until Monday, when he could start Family Court proceedings. The police believed the children were safe at their grandmother's house and that it would be unlawful to remove them.

Later that morning, DoCS workers forcibly took the children from their grandmother's house to their mother — even though the paperwork shows that the workers did not believe the children were at risk of harm living with their grandmother. DoCS then lost contact with the mother and children.

The father asked DoCS why they took the children and where they were, but DoCS did not know. He had the matter urgently listed at the Family Court. The judge was extremely concerned about DoCS' actions, particularly as the mother and children were missing. DoCS was unable to provide an adequate explanation for removing the children. The court made interim parenting orders, placed the children on the Airport Watch list, and made recovery orders allowing federal police to locate them.

When the father complained to us, we decided to investigate. We found that DoCS had made two separate errors. The first was believing that the mother had some kind of court direction from New Zealand that required the children to live with her, when she did not. The second error was the belief that such a court direction gave DoCS the legal authority to forcibly remove the children and return them to their mother. This was not the case. DoCS has no role to play in enforcing such court orders. They can only remove children if, as provided under s.43 of the *Children and Young People (Care and Protection) Act 1998*, there are identified serious and immediate risks of harm. DoCS also did not take into account the fact that the mother had previously taken her children to New Zealand without their father's consent.

In response to our recommendations, the Minister and DoCS have accepted the errors made and provided a formal apology to the father and grandmother. They also made an ex-gratia payment to cover the cost involved in restoring the children to their grandmother. DoCs also intend to use this matter as a case study for staff training.

This year we also investigated a matter that showed what can happen if child protection agencies are unclear about their specific statutory role and responsibilities in a situation involving family breakdown and possible family law proceedings (see case study 9).

Handling complaints and inquiries

As in previous years, the highest proportion of complaints we received this year involving children and young people were about child protection services. In 2007–2008, 51% of the formal complaints we received were about DoCS' child protection services and 40% about out-of-home care services provided or funded by DoCS (see figure 20).

For child protection services, the most common complaints were about the adequacy of DoCS' casework, in response to risk of harm reports about children and young people. These concerns primarily relate to DoCS' decisions about whether or not to intervene following a risk of harm report, and the adequacy of DoCS' investigation, assessment of, and decisions in response to allegations that a child or young person has been abused or neglected.

Other issues that were the subject of complaint included DoCS' handling of complaints about its activities and the professional conduct of staff.

For out-of-home care services, the most common complaints were about the adequacy of services' assessment, planning and provision of services relating to meeting the needs of children and young people in out-of-home care. Particular issues of this kind included the appropriateness of placements for children and young people; the supports provided to children in care and their carers; decisions to move children between care placements; and arrangements for contact between children in care and their families. Other issues that were the subject of complaint included the quality of 'customer' service provided by service staff, the responses of services to complaints about children in care, and payment of allowances and fees to foster parents to support children in care.

Case study 10 is an example of one complaint we resolved this year that shows how vital it is for foster carers to be given up-to-date and accurate information about the children they foster.

Sometimes, we are able to resolve complaints by acting as an independent mediator or by making inquiries directly with a service. Case studies 11 and 12 are examples of matters that were able to be dealt with to the satisfaction of both parties without the need for a formal investigation.

Figure 19 — Outcomes of formal complaints finalised in 2007–2008 about agencies providing child and family services

- Referred to agency concerned or other body for investigation (1) **0.2%**
- Direct investigation (10) **2.2%**
- Service improvement comments or suggestions to agency (13) **2.8%**
- Complaint outside jurisdiction (22) **4.8%**
- Complaint declined at outset (40) **8.7%**
- Complaint resolved after inquiries, including local resolution by the agency concerned (182) **39.5%**
- Complaint declined after inquiries (193) **41.9%**

Reviews of children and young people in care

Supporting carers of Aboriginal children

Last year we started a project to better understand issues affecting carers of Aboriginal children and the adequacy of the services and supports to help them provide quality care. We completed this project during 2007–2008. Our report, *Supporting the carers of Aboriginal children*, noted issues based on interviews with service providers and feedback from face-to-face surveys of 100 Aboriginal and non-Aboriginal carers of Aboriginal children in care.

As more than 30% of all children and young people living in out-of-home care in NSW are Aboriginal, many of the issues in our report are likely to apply to children in out-of-home care generally. In our report, we made detailed observations about key areas such as:

- supports for carers
- consultation processes around placement of Aboriginal children
- cultural support planning
- health and education
- data collection.

We gave our final report to DoCS in April this year. However, given that the Wood Inquiry is examining a number of the issues canvassed in our report, we recommended that DoCS provides us with their response for addressing these issues within two months of the Wood Inquiry reporting its findings.

For more details about this review, see page 49 in Chapter 1: Community engagement.

Case study 10

A woman complained that DoCS had made arrangements for her to care for her 14 year old nephew under a kinship placement without telling her about his sexualised behaviour. After he was placed with her, he allegedly sexually assaulted the woman's six year old daughter.

The woman was distraught and demanded answers from DoCS, which initially were not forthcoming. However, they did refer the matter for a JIRT investigation which found there was insufficient evidence to prosecute the boy. The woman sought DoCS' assistance for counselling for her daughter, but was informed that she was not traumatised and did not need this.

The boy was moved from his aunt. A short time later, she saw him with a group of unsupervised younger children at a local pool. She contacted our office as she was concerned her nephew still posed a risk to young children.

We made inquiries and found that the local CSC had not provided the information about the boy's behavioural traits to the aunt. They had also not developed a structured case plan or any real assistance for the boy.

As a result of our involvement, DoCS conducted a comprehensive assessment of the boy. They found he had a disability which, in part, led to his behavioural traits. Because of his age and behaviour, they considered he could not be placed in another foster home so DoCS placed him in a refuge and provided intense supervision and counselling.

DoCS also provided the complainant with counselling and support. Her nephew's behaviour has improved and they appear to be re-establishing their relationship.

Figure 20 — Number of formal and informal matters received in 2007–2008 about agencies providing child and family services — by agency category

As a formal or informal complaint may involve concerns about multiple community services program areas, there are more complaints by program area than the 501 formal and 983 informal matters received in 2007–2008.

Agency category	Formal	Informal	Total
DoCS			
Child protection services	412	737	1,149
Out-of-home care services	333	463	796
Children's services	7	10	17
Family support services	0	6	6
Adoption	3	6	9
Sub total	**755**	**1,222**	**1,977**
DADHC			
Out-of-home care services	0	5	5
Sub total	**0**	**5**	**5**
Other government agencies			
Child protection services	14	3	17
Out-of-home care services	0	1	1
Children's services	2	1	3
Family support services	0	0	0
Adoption	0	0	0
Sub total	**16**	**5**	**21**
Non-government funded or licensed services			
Child protection services	13	14	27
Out-of-home care services	39	28	67
Children's services	9	10	19
Family support services	7	1	8
Adoption	0	0	0
Sub total	**68**	**53**	**121**
Other (general inquiries)	0	54	54
Agency unknown	0	39	39
Sub total	**0**	**93**	**93**
Total	**839**	**1,378**	**2,217**

Case study 11

We received information that a 15 year old boy had been exited unreasonably from a Supported Accommodation Assistance Program (SAAP) funded refuge late in the afternoon with no referrals to other services.

During our inquiries, the refuge questioned whether we had jurisdiction over the complaint because the young man had been accommodated as a 'respite client' and they did not receive any government funding for providing such a service. They defined 'respite clients' as those who need a break from their family situations but can return home afterwards.

In this matter, the young man did not return to his family home and it did not appear that staff knew where he was going when he left.

We believed the process of exiting the young man had not been in line with the agency's own policies and procedures.

Following our involvement, the agency decided to review their policies and procedures for respite clients, their intake and exit procedures, and the documentation required during a client's stay.

We are monitoring the review and will assess the outcome.

Children and young people aged 10 to 14 years in out-of-home care

This year we started a review of 36 children and young people aged between 10 and 14 in out-of-home care. The children had orders made in 2005–2006, allocating all or some aspects of parental responsibility to the Minister for Community Services. Each review involves examining the child's DoCS or service file, as well as interviewing their DoCS caseworker, carer and any other relevant service providers.

Our aim is to identify the common issues and needs of these children, and whether or not current practice is meeting those needs. We are particularly interested in:

- the children's health and educational needs and whether these needs are being adequately identified and responded to
- whether the children, and their carers, are given the opportunity to participate in case planning and reviews
- service delivery to the children, particularly for those who have complex needs
- specific case work practice and management issues.

A report on the results of our review for each child will be provided to DoCS and other service providers. In 2008–2009, an overarching report will also be prepared which outlines systemic issues which come to light from this work.

Children under the age of five in out-of-home care

Last year we started a review of a group of 50 children under five years of age in out-of-home care. We completed this review during 2007–2008 and provided DoCS and industry bodies with a report detailing our observations.

We found that significant improvements had been made in systems and practice for children in this age group since our last review in 2002. We also found several areas that still needed to be improved, including the following:

- Insufficient attention was paid to children's health and developmental needs when they entered care.

- Adoption practice for children who enter the statutory care system was not effective.
- Placement reviews were not occurring consistently or regularly for all children, particularly for those in kinship care.
- Statutory requirements for providing information and documentation to carers were often not met.
- There was limited consultation between child protection and out-of-home care teams within DoCS and difficulties or delays in transferring cases.

As a result of our recommendations, DoCS is developing initiatives to improve policy and practice to support very young children in care. They will advise us on progress and results of this work during 2008–2009.

Case study 12

A young woman who was accessing an early intervention program alleged that staff threatened to make a risk of harm report to DoCS if she left her child with the child's father while she was away for ten days. She was very distressed by this and complained that her attempts to resolve the situation with the service were unsuccessful due to poor complaint-handling processes and poor communication.

The young woman also alleged that the service had contacted her counsellor without her consent. This she also found very distressing.

Since raising these issues with the service, the young woman felt that she could not return to access the support she needed. She was then notified that her file was closed due to the difficulty the service had contacting her.

In this case we felt that the best approach would be to try to repair the relationship between the complainant and the service. We facilitated a conciliation meeting and were able to resolve the issues to the complainant's satisfaction. The service made a commitment that the young woman could contact them again if she needed support in the future.

Young people in statutory care living in SAAP services

Last year we reported on our review 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 Supported Accommodation Assistance Program (SAAP). The review highlighted the need for DoCS to finalise their policy on young people living in SAAP services. In February, DoCS told us that they anticipated the finalisation of a protocol between the Department and the Youth Accommodation Association of NSW by July 2008.

Guidelines for dealing with youth complaints

Last year we developed guidelines for dealing with youth complaints and training for our staff to improve service delivery to young complainants. Following the success of these internal guidelines, we decided to develop a version for external agencies and services that have contact with young people. Several agencies — including the Children's Guardian, Commission for Children and Young People, the NSW Youth Advisory Council and the National Children's & Youth Law Centre (NCYLC) — encouraged us to develop these guidelines.

The guidelines have now been distributed to over 3,000 oversight bodies, government agencies and community services across the country. Their aim is to:

- enhance the abilities of agencies to effectively communicate with young people
- assist young people to feel a part of the complaint process
- improve the handling of youth complaints
- complement and strengthen agencies' existing complaint procedures.

The Director of the NCYLC stated *"This guide is a landmark publication — a clear and practical aid that should be required reading for any government or community agency that makes decisions that impact on children and young people. The office of the NSW Ombudsman is to be congratulated."*

After our initial distribution of the guidelines, we received another 2,000 requests for copies from juvenile justice officers, police, high schools, universities, TAFE colleges, health services, councils and DoCS Community Service Centres.

Our youth liaison officer (YLO) was also invited to Melbourne to train staff at the Public Transport Ombudsman (Victoria) on the guidelines. Our complaint officers can now refer agencies to these guidelines when we oversee their handling of youth complaints.

Reviewable deaths of children

The Ombudsman's statutory responsibilities include reviewing the deaths of certain children, including:

- children and the siblings of children reported to DoCS as being at risk of harm at any time in the three years before they died
- children whose deaths were a result of abuse or neglect, or occurred in suspicious circumstances
- children in care
- children in detention.

The objective of our reviews is to identify any shortcomings in agencies' policies, systems and practices and make recommendations to prevent and reduce the risk of deaths in future. We scrutinise records and information from various government agencies, including the State Coroner and NSW Health, and non-government agencies that provide services to children.

An advisory committee contributes to our review function. In 2007–2008 the committee met twice. There is a list of committee members in Appendix M.

Our annual report

We table a report to Parliament each year about our work reviewing child deaths in the previous calendar year. In the past four years, we have reviewed the deaths of 496 children. In December 2007 we released our fourth report, *Report of Reviewable Deaths in 2006 Volume 2: Child deaths*, which is available on our website. It covers the circumstances of 123 children who died in 2006.

Most recently, we have focused on how the child protection system responds to risk factors we have consistently identified since 2003. These factors include parental substance abuse, parental mental health problems, domestic violence and neglect.

In many cases, we found that agencies identified children at risk and responded appropriately.

However we also found some cases where risk was either not identified or was identified but not reported to DoCS. We also have significant concerns about the number of reports that do not receive the recommended level of assessment and are closed by local DoCS offices because of competing priorities. Some of our reviews found inadequate risk assessment and a lack of effective liaison and information exchange between agencies. There was also sometimes a lack of effective discharge planning for babies born in hospital to substance-using mothers.

The deaths in 2007 that we reviewed

In 2007 we reviewed the deaths of 169 children. If we identify concerns in particular reviews, we report these to agencies or service providers. We may also initiate preliminary inquiries or, where appropriate, investigate the conduct of agencies. We took action in relation to 37 of the 169 deaths (22%), including seven matters that we investigated and five where we made preliminary inquiries. In 26 cases, we prepared reports for agencies about the issues we identified.

Deaths of children not known to DoCS

In 2007, we initiated a group review of children who died between 2003 and 2007 and who had no, or no recent, child protection history. By definition, most of the children whose deaths are reviewable each year will be children or siblings of children who were reported to DoCS at some time in the three years before their death. Each year, however, some children whose families are not known to the department die in suspicious circumstances or in circumstances of abuse or neglect.

Between 2003 and 2007, 48 children who were not known to DoCS died in these circumstances. Our aim is to find out the demographic profile of these children and their families and to address key questions — such as whether there are any notable differences in demographic profile and circumstances of death between the children not known to DoCS and those who were. This information could then help us identify and respond to risk.

We have engaged the National Centre for Classification in Health to conduct a literature review relating to fatal abuse and neglect, including the manner of death and associated risk factors. We will include the results of this work in our *Report of Reviewable Deaths in 2007*. This report will be tabled in Parliament and available publicly in early 2009.

Mandatory reporting of domestic violence incidents

According to DoCS, mandatory reporters were responsible for approximately three quarters of all child-at-risk reports made in 2006–2007. The single biggest reporting group is the NSW Police Force (NSWPF), with domestic violence the most frequently reported risk factor identified in these reports. The operation of the current mandatory reporting system is a key consideration for the Wood Inquiry.

NSWPF policy requires police to immediately notify DoCS when a child has been present at a domestic violence incident. This requirement goes beyond legislative provisions for mandatory reporting and does not provide for professional judgement about whether a child is at risk. At a public forum conducted by the Wood Inquiry, the NSWPF commented that this approach was designed to ensure no child 'missed out' and to remove subjectivity from reporting.

In the context of ever increasing numbers of child-at-risk reports being made, we have suggested the NSWPF needs to consider moving towards a system in which police use a standard risk assessment to decide if a mandatory report is warranted. This will require individual police officers to have a clear set of risk indicators and use a greater level of discretion.

There are a number of current initiatives that should help improve reporting — including joint work between DoCS and the NSWPF to improve the quality of information communicated between them, finalisation of a DoCS /NSWPF memorandum of understanding, and the use of a standardised Helpline 'intake' form for faxing risk of harm reports.

A cross agency reference group has also been set up to develop a shared risk assessment tool to guide agencies in responding to domestic violence incidents. This group includes members from the NSWPF, DoCS, NSW Health and the Attorney General's Department. We have held several meetings this year with a number of these agencies to discuss the tool and how police report domestic violence matters to DoCS.

Employment-related child protection

Our child protection division oversees investigations of allegations against employees that involve abusive behaviours towards children, and scrutinises the systems employers have in place to prevent child abuse in the work environment. Heads of government and some non-government agencies are required to notify us of 'reportable allegations' and convictions against persons they employ or engage within 30 days of becoming aware of them. Reportable allegations include alleged sexual offences, sexual misconduct, physical assault, ill-treatment, neglect, conduct causing psychological harm or misconduct that may involve reportable conduct against a child.

Figure 21 — Number of formal notifications received and finalised — five year comparison

	03/04	04/05	05/06	06/07	07/08
Received	1,620	1,815	1,786	1,995	1,850
Finalised	1,908	1,760	1,541	1,749	1,921

In 2007–2008, we received 1,850 notifications of reportable allegations and finalised 1,921. Notifications decreased by 7.3% on the previous year (see figure 21). The most significant decrease (30%) came from our largest notifier, the Department of Education and Training (DET). They attribute this decrease to the class or kind determination and to training initiatives for sector, regional and school heads, education students in NSW universities and casual employees via a new online training program. Our records confirm a significant drop in the notification of reportable allegations involving DET casual teachers. We commend the DET for these initiatives to prevent reportable conduct.

Children and the internet

We are currently undertaking a project, funded by the Department of Immigration and Citizenship, on the vulnerabilities of young people online — including grooming for sex offences, recruitment by violent extremist groups, and involvement in sites encouraging self harm and anorexia.

Assessing and managing risk

To help develop a tool that agencies can use to decide what action to take at the end of an investigation to minimise future risks, we have researched the risk assessment tools used in the forensic arena. Key distinctions with our work include the variability of workplace environments, the limited access of agencies to critical information about the personal background of employees, and the differing standards of proof. Any risk assessment model developed in the civil arena must address these distinctions. We plan to start an in-depth longitudinal study of risk factors in various work environments, with an initial focus on the distinctive pattern of grooming and sexual misconduct in the school environment.

Repeat offenders

We have started an analysis of our data holdings on repeat offending in the workplace. Of the 1,921 notifications finalised this year, 449 involved employees who had been the subject of at least one previous reportable allegation. Of these, 348 were within the previous two years. A comprehensive analysis of repeat offending variables over time — including nature of employment, allegation type, findings and risk management strategies used — will provide insight into best practice and further inform our risk management advice to agencies.

Receiving fewer notifications enabled us to increase our scrutiny of high risk notifications. This year we monitored 16% more of these notifications than the previous year. It has also enabled us to increase our project-based activity and develop best practice guidance for agencies in key areas. Our project work has included scoping the development of a risk assessment tool that will assist agencies to manage employees who have engaged in reportable conduct, analysing our data holdings on repeat offenders in the workplace, and exploring the vulnerabilities of young people online. Our oversight work has highlighted these as challenging areas confronting agencies in preventing and responding to reportable allegations.

We also completed a review of our child protection guidelines and incorporated updated information on areas such as interviewing children, conduct causing psychological harm to children and grooming behaviour. Additionally, we are organising a child protection symposium to be held in May 2009. The specific focus will be the response of employers to reportable allegations and we will bring together child protection experts, practitioners and investigators to share their experience and knowledge.

Inquiries and complaints

The majority of the 695 inquiry calls we received in 2007–2008 were from agencies with jurisdictional queries or requests for guidance with their investigations of reportable allegations. We also received a number of inquiries from people who were the subject of reportable allegations. Of these, the majority were resolved by providing information — although a number proceeded to informal inquiries following a complaint from the caller. Informal resolution avoids a lengthy investigation and provides a quick outcome for complainants. We also receive a small number of complaints each year, usually from employees against whom allegations have been made or families of alleged victims.

Although handling inquiries is a relatively small part of our work, case study 13 demonstrates the value of using informal techniques to resolve even complex and sensitive matters.

Figure 22 — Number of formal notifications received by agency — two year comparison

Agency	06/07	07/08
Department of Education and Training	819	628
Department of Community Services	469	575
Substitute residential care	255	195
Catholic systemic and independent schools	109	133
Department of Juvenile Justice	91	74
Independent schools	56	77
Child care centres	77	60
Department of Health	27	29
Councils	24	16
Family day care	13	17
Department of Ageing, Disability and Home Care	27	9
Other public authority — not local government	13	22
Department of Corrective Services	13	14
Department of Sport and Recreation	1	0
Other prescribed bodies	1	0
Agency outside our jurisdiction	0	1
Total	**1,995**	**1,850**

Case study 13

We received an inquiry from the partner of an adult Aboriginal male (the complainant) who alleged he had been sexually assaulted as a child by a priest, currently employed by a designated agency. We had been notified of this matter, but had not received the agency's investigation report. The agency had reportedly told the complainant the allegations could not be sustained because of insufficient evidence. The agency told the complainant that we had a role in monitoring the investigation and provided the contact details of our case officer. The partner called us because of the complainant's distress about the agency's finding and their poor communication with him during the investigation — including misinformation about police involvement. We accepted the oral complaint and the complainant eventually consented to our making further inquiries.

The complainant had not been adequately informed about the progress of the investigation, so we consulted with the agency about the information needs of alleged victims in these matters. We also criticised the agency's misinformation to the complainant about the involvement of the police. He had signed a statement he believed gave his consent for police to investigate, when in fact it waived this option. Further, when we received the agency's investigation report we assessed it as flawed. We believed a better quality investigation could have obtained sufficient evidence to sustain sexual abuse. We asked the agency to undertake further lines of inquiry that we had identified and report the results to us.

The complainant told us he had a criminal history and a drug and alcohol addiction, which he attributed to the alleged sexual abuse by the priest. Although he had been stable for some time, his distress over the initial investigation findings resulted in him abusing alcohol again and being imprisoned. He was reluctant to approach police about his allegations as he thought his history would diminish his credibility. Our Aboriginal Unit made contact with the complainant and arranged for a Joint Investigation Response Team (JIRT) officer to take a statement from him. We also liaised with the complainant's partner and drug and alcohol counsellor to support him when making his statement.

The agency conducted further inquiries and uncovered additional evidence that sustained the allegations. The complainant decided not to pursue criminal action because the sustained outcome provided him with the resolution he had been seeking. The agency, which had provided counselling and other support to the man throughout, continued to support him. He and his partner thanked us for our involvement indicating they could start to move on from the effects of the childhood abuse.

Case study 14

We were notified of the alleged neglect of supervision of a 12 year old child with disabilities that resulted in him absconding twice from his Department of Ageing, Disability and Home Care (DADHC) residential facility, giving rise to serious risks to the child. On the first occasion, the child's whereabouts were unknown for over an hour until he was returned to the facility by police. The child absconded again the same day and hitchhiked with a passing stranger. His whereabouts were unknown for two hours.

We were satisfied with DADHC's response to the reportable allegations, but considered it important to ensure that systemic concerns about the client assessment process and management of security within the centre were properly addressed. An independent investigator had appropriately identified the concerns and made recommendations to address them. However, DADHC had not advised us whether or not they would implement them. We suggested to DADHC that the investigator's recommendations were sound and should be adopted, and issued a formal request for information about how DADHC intended to address the systemic concerns. DADHC agreed to implement the investigator's recommendations and we monitored this. The strategies, now fully implemented, will improve the safety of children at the residential facility.

Case study 16

Allegations against a teacher of sexual misconduct towards a 16 year old female with intellectual and developmental vulnerabilities were sustained and notified to the CCYP under Category One. We assessed the investigation action as satisfactory. However, the teacher subsequently requested a review and the agency withdrew the CCYP notification. We did not support this, as in our view there was evidence the teacher had engaged in grooming behaviour with the girl and no new evidence had been presented to alter the original finding. We were concerned that information about the alleged sexual misconduct would not inform any future risk assessment if the teacher applied to work with children in other agencies. We asked the agency to provide the CCYP with all relevant information about the matter and discuss the appropriateness of the CCYP withdrawal. As a result, the CCYP reviewed the investigation documents and agreed with our view and the agency reinstated the CYCP notification. Since that time, three further allegations of a similar nature have been made against the teacher and he has been placed on alternative duties pending investigation.

Case study 15

Twelve reportable allegations, including physical assaults resulting in bruising and welting, were made over three years against a foster carer of a seven year old girl. None were notified to us when they arose. Despite the number of reports that were sustained, the girl and her brother remained in the placement because the agency assessed that she did not present as frightened. We wrote to the agency and expressed concern that they had not considered the child's or the carer's history, and had not provided us with information about risk management strategies to prevent further abuse of the children. The agency completed a risk assessment and an alternative placement was found for the girl. However, the agency considered there were no risks to her brother and he stayed in the placement. We obtained a copy of the boy's case plan and inquired about supports for him and the carer. We are currently following up the outcome of carer training and reassessment to ensure that any risks to the boy are managed.

Case study 17

A non-government school investigated allegations that a teacher used inappropriate language and made a sexually inappropriate comment to a student. They sustained the allegations as sexual misconduct and notified the teacher to the CCYP under Category One. We did not agree that the teacher's actions, although inappropriate, met the threshold of reportable conduct. We asked the agency to review their finding and CCYP notification. They amended their finding to 'not reportable conduct' and withdrew the teacher's CCYP notification.

Case study 18

A foster care agency sustained three allegations of neglect against a foster carer and notified him to the CCYP under Category One. Our assessment identified a deficient and flawed investigation, including a denial of procedural fairness to the carer. We asked the agency to undertake further inquires and provide us with additional information to support their findings. After receiving the further information, we still felt the findings were not supported by the evidence. We outlined our reasons and requested a review. The agency amended their three sustained findings to 'not sustained', 'false' and 'not reportable conduct' and arranged for the Category One CCYP notification to be amended to a Category Two.

Assessing notifications

We assess the adequacy of agency investigations of reportable allegations to make sure that:

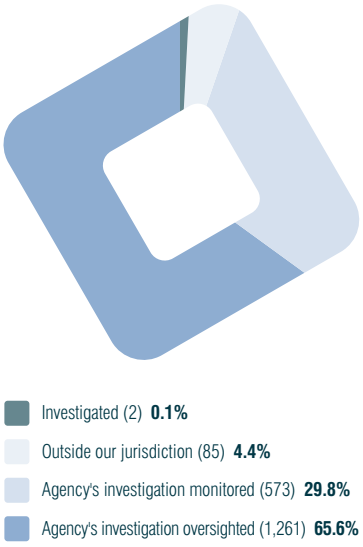
- risks to children have been appropriately addressed
- procedural fairness has been afforded to employees
- systemic concerns about agencies' child protection systems are identified and remedied.

Of the 1,921 notifications finalised during the year, 87% were finalised as satisfactory — 15% of these only after our significant intervention. In the 13% of matters finalised as unsatisfactory, we provided detailed feedback to inform future investigations by those agencies.

If it is in the public interest to remedy agency deficiencies, we may ask for further information, suggest additional lines of inquiry or request a review of the finding. If it appears that risks to children have not been addressed, or an employee has been denied procedural fairness, we will attempt to mitigate this. This reflects our balanced approach to child protection — ensuring employees are treated in a fair and just manner as well as minimising risks to children.

We also take further action if a notification highlights systemic issues that have not been adequately addressed by an agency (see case study 14).

Figure 23 — Action taken on formal child protection notifications finalised in 2007–2008



Addressing risks to children

Case studies 15 and 16 outline two different examples of addressing risks to children.

Ensuring procedural fairness for employees

Case studies 17 and 18 outline two different examples of ensuring procedural fairness for employees.

Monitoring agency investigations

One of our strategies for minimising deficient investigations by agencies is to use our s.25E monitoring powers under the Ombudsman Act. These enable us to have more direct input into an agency's investigation — from the initial planning and risk identification stage through to the completion of the matter.

The high volume of notifications means we are not able to scrutinise all investigations to this degree, so we focus our resources on the highest risk notifications.

The types of matters typically monitored from the outset involve alleged sexual offences (29%), sexual misconduct (28%) or serious physical assault (38%) of a child. Examples of investigations we monitored during the year are included in case studies 19 and 20.

Case study 19

A high school teacher had a sexual relationship with a 12 year old student over a three year period and was grooming other young students for sexual abuse. The investigation was lengthy and complex due to police involvement, the refusal of the teacher to cooperate with the investigation, and some reluctance by the alleged victim to be formally interviewed. The teacher was on alternative duties to mitigate risks to other students, but there was evidence he may have been grooming other children over the internet. To manage risk to children while ensuring procedural fairness to the employee, we worked closely with the agency to improve timeliness without compromising the quality of the investigation. Ultimately the agency sustained the allegations and placed the teacher on the list of people never to be employed in NSW government schools.

Case study 20

A foster carer sexually abused his 13 year old foster child daily for a year. The child made a clear disclosure after leaving the placement and JIRT investigated. We sought immediate advice about risks to another child who was still in the placement — and who had severe disabilities and a history of being sexually abused. A risk assessment was done and the child was removed. JIRT discontinued their investigation after the alleged victim withdrew her cooperation, but we monitored the investigation by the substitute residential care agency. This involved identifying additional avenues of inquiry and ongoing liaison. The allegations were sustained and the carer de-authorised. We were concerned that the carer's wife retained her authorisation, even though she lived with her husband who had been de-authorised. After making further inquiries of the agency, we were advised both carers would be de-authorised.

Investigating

We work with agencies to improve their investigative skills so they can conduct satisfactory investigations of reportable conduct. This means that we only occasionally directly investigate using formal powers. We generally use these powers to address systemic issues if our attempts to work with an agency have not brought about desired changes or it is in the public interest to do so.

This year, we finalised five direct investigations involving five separate agencies. These agencies complied with all the 37 recommendations we made. For example, significant improvements in child protection were achieved in two substitute residential care agencies we investigated. One had been providing care to children with disabilities and at the end of our investigation the head of the agency acknowledged they were not sufficiently qualified or equipped and withdrew their service to children. The head of the agency undertook to inform us immediately if they decide to provide services to children in future and, if they do, they will implement a number of strategies we identified to ensure risks to children would be minimised.

The other agency is one of our largest notifiers and has undergone rapid growth in a short period of time. Our investigation found that their systems had not kept pace with their growth and required significant overhaul. As a result of full compliance with our recommendations, the agency has revised their child protection policies, provided widespread child protection training to their staff, improved their compliance with employment screening and notification responsibilities, and raised the standard of their investigations into reportable allegations. All of these measures will improve the safety of children in the agency's care.

In another investigation completed this year, we made ten provisional recommendations for systemic change within a large designated agency. The agency is in the process of responding to our recommendations. We also started two other systemic investigations. One is focused on the probity checking systems of a large substitute residential care agency, and the other is investigating the specific and systemic issues arising out of an agency's handling of a reportable allegation. In this case, it was alleged the agency 'covered up' indecent assault allegations against an employee and failed to notify our office.

'I found the audit process most useful, for clarifying issues that clouded previous communications, and improving our policies which can only result in better care for the young people we serve.'

The CPD staff 'who conducted the audit did so in a most professional and non-threatening manner and we found their suggestions very useful. Thank you for the support your office gives us in this work.'

'With the Director… and relevant staff, I appreciate the time and care with which the [audit] report has been prepared and am pleased to receive the audit information. I welcome the opportunity the report provides to review process and practice to ensure that we maintain standards.'

Auditing

Section 25B of the Ombudsman Act requires us to scrutinise the systems agencies have in place for preventing and responding to reportable allegations. Auditing agencies is one way we do this.

We conducted 16 agency audits in 2007–2008, twice as many as last year. These audits fell into two categories — 'class or kind' and systemic audits.

Agencies with a class or kind determination with us have already demonstrated they have good systems in place for preventing and responding to certain kinds of reportable allegations. Our audits of these agencies therefore specifically focus on compliance with the determination.

- Our initial audit of the Department of Community Services' (DoCS) class or kind exemptions concluded they have sound systems in place for investigating exempted matters to a satisfactory standard. We considered excluding other conduct from notification, but were unable to progress this due to delays by DoCS in completing investigations of higher-risk allegations.
- Our audit of the Department of Education and Training (DET) concluded that exempted matters had been handled appropriately and there had been a marked improvement in the handling of 'local management' matters since we raised concerns about these in last year's report. As a result, we provided an extended class or kind determination to DET. This means that in future only allegations of serious reportable conduct will be notified to the Ombudsman.
- We also audited and extended the same class or kind determination to the eleven Catholic Dioceses in NSW as they have demonstrated good practice in preventing and responding to reportable allegations.

When auditing an agency's child protection systems, we review policies and other documents, interview stakeholders, inspect premises and visit a number of sites in large agencies. We specifically focus on agencies that care for highly vulnerable children (see case study 21) or respond to information suggesting the agency's systems could place children at risk (see case study 22).

The 'class or kind' and systemic audits include a thorough review process and a detailed report with findings and recommendations for improvement. Some agencies are initially apprehensive about being audited by the Ombudsman. However the process is consultative and feedback from agencies has confirmed that they see it as valuable.

Case study 21

We received information from DoCS about systemic child protection concerns in a remote independent boarding school for Aboriginal children. Numerous allegations of physical abuse and neglect had not been notified to us and there were concerns about the agency's understanding of their child protection responsibilities. We liaised with DoCS and our Aboriginal Unit to ensure we approached the head of agency in a culturally sensitive manner. We travelled to the school to meet employees and gauge their understanding of the reporting obligations and, as a result of this visit, decided to audit the agency.

We reviewed the agency's policies, which were outdated and contained no reference to the Ombudsman's jurisdiction. When we revisited the school, we interviewed the head of agency who had a good understanding of reporting responsibilities to DoCS and the police — but limited understanding of the role of the Ombudsman. We therefore took the opportunity during our site visit to provide a briefing on the Ombudsman's child protection jurisdiction and what this meant for the agency. This was well-received. The two visits to this remote school enabled us to provide information to the head of agency about the school's legislative obligations and establish a relationship that will help them comply with their reporting responsibilities in future.

Case study 22

We received concerning information from former employees of an agency providing substitute residential care to high-needs children. These concerns included inadequate supervision and safety practices within the agency and a culture that discouraged employees from reporting misconduct. We audited the agency and found they had no child protection policy or code of conduct and many of their existing policies contained incorrect, outdated or incomplete information. We reviewed relevant files at the agency's premises and identified poor records management as systemic. A significant concern was that we were unable to locate records of the Prohibited Employment Declarations and Working with Children Checks for most employees. Interviews with employees identified a lack of understanding about the agency's responsibilities under Part 3A of the Ombudsman Act. We asked for records of reportable allegations and were told the agency had never notified the Ombudsman, which we knew to be incorrect. We made a number of recommendations to the agency to improve their systems and will monitor their compliance with our recommendations.

During the audit, we were alerted to the poor standard of care being provided to a 14 year old male resident with multiple disabilities, including autistic tendencies. We interviewed employees and the child's family and were informed about inadequate supervision and safety practices, poor case management, and low standards of hygiene and medical care for the boy. We also identified a lack of induction, training and support for employees. We recommended the service immediately assess the safety issues at the home and implement strategies to mitigate risks to the boy and employees. We further recommended the service consult with DoCS about the boy's safety and care needs and the difficulties they were experiencing meeting them. We began inquiries into DoCS' case management and decision-making for the child. The child has since been placed in the care of another service and DADHC has become involved with his care.

Engaging with agencies

Education and information sharing are critical if we are to meet our objective of helping agencies to improve their systems for preventing child abuse. We work with agencies on a number of levels and this includes:

- hosting industry forums that bring together disparate agencies to discuss common practice issues and share information
- providing training or briefing sessions on child protection responsibilities and/or topical issues
- holding liaison meetings with the larger agencies in our jurisdiction to address systemic issues in a consultative manner
- holding case conferences with agencies we oversee and third party agencies such as the NSWPF, DoCS and the CCYP.

This year we presented over 40 education and awareness briefings or forums to more than 100 agencies across industry sectors, reaching more than 1,000 individual stakeholders.

In cooperation with NSW Health, we began a two year program for health services in NSW which included a combination of strategies to bring about major systemic improvement in work related child protection practices. This year, for example, we:

- Hosted two health forums, attended by eight separate area health services. At each forum we presented an analysis of reportable investigations from the health sector to encourage discussion about key issues. A guest speaker on 'Decision Making and Risk Assessment in Reportable Allegations' at the second forum was well-received.
- Used discussions at these forums to inform our planning for audits of area health services (AHSs) in NSW during 2008–2009. We did two audits this year (North Coast Area Health Service and South Eastern Sydney and Illawarra Area Health Service), and identified policy development areas and organisational changes that would enable an integration of general child protection issues and the management of reportable allegations. A further seven audits are scheduled.
- Conducted joint training with NSW Health's Employment Screening and Review Unit (ESRU) in all AHSs — with early signs suggesting increased competence in managing reportable allegations and convictions. The ESRU has played a key role in facilitating cooperation between the AHSs and our office and improving child protection systems within health facilities.

Agency liaison

We encourage agencies to meet with us to discuss policy issues and complex cases. Examples of the meetings we have held this year are outlined below:

- We had productive meetings with senior staff of the Department of Community Services to address our concerns about significant delays in finalising their investigations. In the last quarter, DoCS trebled their investigation finalisation rate of the previous quarter and provided other information that had been outstanding for some time. If this improved performance is maintained, we will consider extending our class or kind determination.
- We held meetings with the NSWPF about their investigation of historical sexual assault allegations against a casual teacher. The allegations had been notified to us by the teacher's employer, but they were unable to investigate pending the outcome of the criminal investigation. In the meantime, the teacher was not offered teaching duties because of the serious nature of the allegations. The time lapse since the alleged conduct, and the many vulnerabilities of the alleged victim, impacted on the progress of the police investigation. The agency had concerns about their inability to progress employment-related decisions and we discussed these with the police. Our police division also became involved to help ensure the criminal investigation was progressed and to minimise

procedural fairness concerns for the teacher. At the end of the police investigation, we guided the agency to obtain police documentation via a freedom of information request and this expedited their own investigation. This was a positive outcome for all parties involved.

- Over the year we contacted those NSW public authorities with whom we have had limited contact to gauge their awareness of child protection reporting responsibilities. Initial responses indicated a number of public authorities, some with significant contact with children, had inadequate understanding of reportable allegations and the requirement to report them to the Ombudsman. This is mainly due to the attrition of key staff with whom we engaged early in our jurisdiction. We have started addressing this through policy reviews and planned agency visits and audits. We have given detailed feedback to a number of key public authorities on aspects of their child protection policies that need amending or updating. We will also host the first of our new biannual public authorities forums in the last half of 2008.

Case conferences

A large number of the investigations we monitor are highly complex and we will often organise case conferences with agencies to guide them through difficult processes. This is generally at the agency's request or because we have identified that they would benefit from such a conference. The following are some examples of case conferences held this year:

- An agency notified us of serious historical sexual assault allegations that had been investigated by an independent investigator. We assessed the investigation report as seriously flawed. We met with the agency and outlined a number of concerns, suggested further inquiries, and provided advice on how to avoid similar problems in future. The agency acted on the advice and undertook to consult with us early in the course of future complex investigations. Soon after, the agency asked for a case conference to help them plan their investigation of historical sexual assault allegations against another employee. We met and talked through the relevant issues with the agency and the assigned investigator, agreed on the appropriate course of action, and continued to liaise closely throughout the investigation. Following further inquiries about the first matter, we suggested the agency conduct an audit of specified archived files. They were initially reluctant to do this, but agreed after further discussion. During the audit, the agency identified another sexual assault allegation that had not been investigated and notified it to us. We are currently monitoring their progress.
- An agency asked for a case conference about a complex investigation of historical child sexual assault and grooming allegations against one of their employees. It involved numerous alleged victims and conduct alleged to have occurred over a five year period in the 1990's. The agency had obtained overwhelming evidence of grooming behaviour, and sufficient evidence to sustain the indecent assault allegations. An independent investigator had recommended findings to this effect, which would have significant consequences for the employee. The agency wanted to make sure they had been procedurally fair to the employee before they finalised the investigation. We met with the agency and discussed their concerns about the employee's response to the preliminary findings. We also provided guidance to ensure the employee was given a fair opportunity to respond to the allegations and that concerns raised by the employee were given due consideration. The agency formally wrote to thank us for the case conference and the 'valuable advice [we] offered' which enabled the agency to finalise their investigation.

Figure 24 — What the notifications were about — breakdown of notifications received, by allegation

Figure 25 — Who the notifications were about — breakdown of notifications received, by sex of the alleged offender

Issue	Female	Male	Unknown	Total
Physical assault	573	482	36	1,091
Sexual offences	31	128	8	167
Neglect	126	49	8	183
Sexual misconduct	23	98	4	125
Behaviour causing psychological harm	47	29	3	79
Outside our jurisdiction	21	53	8	82
Misconduct — that may involve reportable conduct	19	56	1	76
Ill-treatment	31	13	0	44
Other matters	0	2	1	3
Total notifications received	**871**	**910**	**69**	**1,850**

Case study 23

We were notified that a male youth worker at a substitute residential care agency had allegedly formed an inappropriate relationship with a young male client. The child had a history of sexualised behaviour and was considered vulnerable to abuse. The agency made a preliminary finding that the allegation was false, based largely on the child's denial that anything untoward had occurred. We consulted the agency about our view that there was evidence the employee had engaged in a pattern of conduct consistent with grooming the boy — including daily mobile phone contact with him, giving him personal information, offering him accommodation, inviting him to his home and socialising with him. These acts constituted breaches of the agency's code of conduct and were corroborated by a number of witnesses. The agency undertook to review their finding, and soon after police informed the agency that they had charged the employee with aggravated sexual assault of the child. The grooming behaviours of the employee — that had not been identified and addressed by the agency — had escalated to sexual abuse.

Case study 24

We were notified of allegations that a trainee teacher had formed an inappropriate relationship with a 10 year old boy he met through his casual employment. The teacher's conduct included favouring the boy, visiting his home, inviting the boy to his own home, asking the boy's mother to leave him in his care, persisting with this request when the mother refused, and writing an intimate letter to the boy. The letter included personal information about the teacher, encouraged the boy to remain in contact with him, provided his email address and invited the child to his home. The boy's mother gave evidence her son had frequently asked that the teacher be invited to their house and that the teacher had taken a lot of photos of the boy. The boy had cried when he learned he would not see the teacher anymore, demonstrating an apparent emotional attachment that concerned his mother. The agency noted the teacher had admitted and explained the conduct and concluded the behaviour was the result of naivety. We did not agree and advised the agency we considered there was some evidence the teacher had been grooming the boy. The agency did take steps to ensure the teacher was not employed at the child's school and counselled him about appropriate conduct with students. However they took no further action and did not make a CCYP notification. Four months later, the teacher was arrested and charged with child pornography offences including production, dissemination and possession. The teacher pleaded guilty and will be prohibited from working with children. It was fortunate the mother of the boy in this matter had been alert to grooming behaviour, exercised protective strategies and reported her concerns.

Trends and patterns

Our analysis of trends, identification of systemic issues in the workplace and research into emerging issues enables us to keep ourselves and agencies well informed about practice issues (see figure 24 and 25).

Update on grooming behaviour

Our last six annual reports have provided progressive updates on our study of grooming behaviour in the workplace. Grooming allegations remain little understood by some agencies and poorly investigated by others. Some agencies readily identify grooming behaviours and take appropriate action when allegations are made. Others treat conduct that is consistent with grooming as misconduct if there is no direct evidence that the conduct was aimed at sexually abusing children. This has implications for the NSW workplace child protection system as misconduct that is deemed 'not reportable' is not notifiable to the Commission for Children and Young People (CCYP).

Although the definition of grooming behaviour in our guidelines and the CCYP's includes conduct 'aimed at engaging … a child as a precursor to sexual abuse', there is no requirement that such an intention be 'proved'. Grooming is an escalating process. Our objective is to improve the ability of agencies to identify grooming conduct early and interrupt the process before there is 'proof' of an intention to sexually abuse a child.

If there is some evidence of conduct consistent with a pattern of grooming behaviour, agencies should be implementing risk management strategies to prevent the conduct from continuing and escalating (see case studies 23 and 24). We are conveying this message to agencies through our forums and briefings, as well as on a case by case basis.

Psychological harm

Grooming can take place in the absence of a consciously formed intention on the part of the perpetrator to sexually abuse a child. Many perpetrators of grooming are situational offenders. Although aware their conduct breaches child protection policies and codes of conduct, they may not have formed a conscious understanding of their motives or the impact of their behaviour. This does not lessen the risk of sexual abuse of a child, nor the harm suffered by the victims of grooming.

Notifications to us increasingly reflect that conduct consistent with grooming behaviour can cause serious psychological harm to a child, whether or not the grooming escalates to a sexual offence. A common component of the grooming process is isolation of an already vulnerable child from their family and social network — often to the extent that the child relies exclusively on the groomer for emotional and other support. The child is led to believe a special relationship exists with the groomer, and the child's trust and affection is garnered. This 'special relationship' becomes meaningful to the child and can inform their sense of self. The process also often involves treating the child like an adult, including confiding personal information and discussing inappropriate topics. These factors of isolation, dependence and distorted boundaries combine to make the child highly vulnerable not only to sexual abuse but to psychological harm, particularly when the perpetrator's 'affection' is withdrawn (see case study 25).

Case study 25

Allegations of sexual misconduct (grooming) were sustained in relation to a female teacher found to have formed an inappropriate relationship with a vulnerable male student. The teacher entered into a sexual relationship with the student when he turned eighteen, which was not a sexual offence. However, the agency clearly established the teacher had groomed the student for the sexual relationship in the year before his eighteenth birthday. The boy had formed a close and dependent relationship with the teacher during the grooming process. This included the teacher spending time alone with him at school, frequently contacting him by telephone, socialising with him outside of school, and being his confidante during difficulties with his family. The teacher was aware the boy was suicidal and did not seek appropriate support for him. When the teacher ended the sexual relationship and withdrew her support, the student was particularly vulnerable to psychological harm and manifested his hurt and confusion through violence aimed at the teacher. His subsequent actions resulted in an apprehended violence order (AVO) against him. The boy breached the AVO and is now in gaol as a result of further threatening the teacher. The teacher is no longer working with children and will be risk assessed if she applies for child-related employment in NSW in the future. However the victim in this matter has suffered psychological harm, obtained a criminal record, and spent a portion of his early adulthood in prison — all causally linked to the abuse of the teacher who had groomed him as a vulnerable child.

Preserving evidence

Securing the integrity of evidence can pose difficulties for agencies if reportable conduct is alleged to have occurred outside the work environment. Employers have little control over the evidence in these circumstances, but need to try to minimise risks to the evidence if possible. This is particularly difficult when employers are faced with reportable allegations involving the use of technology and conduct that may be the subject of a criminal investigation.

For example, an independent school received information one of their teachers was accessing child pornography on his school-issued laptop. The school seized the teacher's laptop for forensic testing and confronted the teacher. The teacher reportedly admitted he had accessed child pornography on his personal laptop, but denied he had done so on his school computer. In response to the reported admission, the agency suspended the teacher and asked him to leave the school premises. Only then did the school contact the police and our office.

Case study 26

In 2005, the DET's employee performance and conduct unit (EPaC) became aware a teacher had engaged in a sexual relationship with a 17 year old student in the 1980's. The conduct was investigated at the time and the teacher was charged with breaching the *Teaching Service Act 1980*, cautioned and reprimanded. His assurance that his conduct would not occur again resulted in his continuing employment as a teacher. EPaC reviewed the investigation and although they had concerns about the department's action earlier, were not able to intervene any further. In 2007 the DET notified us that the teacher was allegedly in a sexual relationship with an 18 year old woman that had started when she was his 17 year old student. Notwithstanding the earlier incident, the teacher was assessed as a low risk to students and continued teaching based on an apparent absence of concerning conduct in the intervening years.

We contacted the DET to discuss our concerns with this decision. The DET then obtained strong evidence that the teacher had groomed the student and sexually assaulted her before she turned 18. They informed the police and placed the teacher on alternative duties. Soon after, the teacher was charged with sexual assault, special care and was dismissed from teaching. (Section 73 of the *Crimes Act 1900* renders sexual intercourse with a person who is under his or her special care and who is of or above the age of 16 years and under the age of 17 years a sexual offence. A 'special care' relationship includes that between a teacher and a pupil). It was only after the teacher's dismissal that DET became aware of other unreported conduct that was alleged to have occurred from the 1980's–2007 and had not been adequately risk assessed at the time. This included the teacher allegedly intimidating, stalking and indecently assaulting female students, accessing pornography on a work computer, and making sexually inappropriate comments about females. One of the alleged victims continues to suffer psychological trauma including self blame as a result of the alleged abuse, and has been unable to continue her studies. She is fearful that the teacher will continue to stalk and intimidate her, despite an apprehended violence order.

When police executed a search warrant on the teacher's home, a flatmate informed them the teacher had left home with his laptop. The teacher refused to surrender the laptop and it was never located. Potential evidence of the teacher's conduct — or connections to other people who may have accessed, possessed or distributed child pornography — was lost. This matter highlights the importance of careful planning, alerting the appropriate authorities to criminal allegations before taking any investigative action, and assessing risks beyond those in the immediate workplace environment. We obtained copies of the school's child protection policies and guidelines for responding to reportable allegations and provided guidance on improving these documents and future practice.

Assisting agencies to keep their policies and procedures in line with advancing technology has been a key focus of our work over the past few years. Technology plays an increasingly significant role in many of the more serious reportable allegations agencies are asked to investigate. The updated guidelines we are issuing later this year will include supplementary material to help agencies respond to such matters. Meanwhile, we continue to advise agencies to contact the police immediately if there is reason to believe that a criminal offence has taken place, and be guided by the police to preserve evidence and the integrity of any criminal investigation.

Investigating historical allegations

Ten percent of notifications closed this year involved historical allegations — that is, allegations against current employees involving conduct that allegedly occurred more than 12 months before being reported. Of those, 26% involved conduct that allegedly occurred more than ten years before notification — and 88% of these involved alleged sexual offences.

Investigating historical allegations against current employees is difficult. Often agencies are required to investigate conduct that allegedly occurred before the person was an employee, and often in a home or different work environment some years before. However, the real risk the employee may pose to children currently under their authority supports Parliament's stated legislative intention that historical allegations must be notified to us and investigated.

Most employers respond appropriately to historical allegations. Good practice has been increasingly demonstrated by many non-government organisations, which typically have scope to take decisive action to minimise risks to both children and the employee. Most agencies exhaust all avenues of investigative inquiry before drawing conclusions. Some employers are less rigorous in their responses to historic allegations against employees if there have been no other allegations made against them. Our data analysis and experience in these situations confirms that the simplistic and subjective risk assessment undertaken by some agencies has two major flaws. An absence of allegations or complaints against an employee cannot be equated to an absence of inappropriate and concerning conduct. Nor does an actual absence of concerning conduct over a period of years automatically reflect a low risk of re-offending. Case study 26 provides an example of this.

We recognise that differing legislative frameworks and other pressures affect the way agencies can risk manage these kinds of matters. However, there is a need for an appropriate response to ensure that children are protected when historical allegations are made. We will continue to monitor such matters.

People with a disability

4

This section of the report discusses our work in reviewing services for people with a disability and their families. In the children and young people section of this report, we have outlined the Ombudsman's broad ranging responsibilities under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-RAMA). These responsibilities mean that we review community services provided to children and young people and their families, as well as people with disabilities and their families.

Highlights

- Resolved a range of complaints about disability accommodation and support services and facilitated outcomes such as new premises, an increase in staff training, and improved communication and complaint-handling.
- Assisted area health services and disability services to develop protocols and agreements to confirm their relevant roles and responsibilities.
- Started a detailed review of the adequacy of DADHC's actions to identify and meet the needs and goals of 60 people living in nine large residential centres.
- Began a review of complaint-handling in agencies providing services under the DADHC funded community participation program to help service providers better understand and fulfil their responsibilities under the *Community Services (Complaints, Reviews and Monitoring) Act 1993.*
- Tabled our *Report of Reviewable Deaths in 2006 Volume 1: Deaths of people with disabilities in care* in Parliament, including eight recommendations for systemic and procedural change.

Figure 26 — Outcomes of formal complaints finalised in 2007–2008 about agencies providing disability services

- Service improvement comments or suggestions to agency (3) **1%**
- Direct investigation (4) **2%**
- Referred to agency concerned or other body for investigation (6) **3%**
- Complaint outside jurisdiction (6) **3%**
- Complaint declined at outset (13) **6%**
- Complaint declined after inquiries (54) **24%**
- Complaint resolved after inquiries, including local resolution by the agency concerned (135) **61%**

Resolving complaints

In 2007–2008 66.5% of the formal complaints we received were about disability accommodation services and 33.5% were about support services for people with disabilities and older people. Disability accommodation and support services are provided or funded by the Department of Ageing, Disability and Home Care (DADHC) (see figure 27).

The most common concerns about disability services raised in complaints were the extent to which services assessed, planned and provided for the needs of people receiving services. This included the provision of appropriate and relevant accommodation placements, and providing for the developmental, health, community access and participation, and other needs of people with disabilities receiving services.

Other issues complained about included:

- services' responses to allegations of assault and abuse in care, particularly for residents of disability accommodation services
- the quality of service management, systems, and staff recruitment, training and support, as they relate to services for people with disabilities.

Agencies supporting people with disabilities are required to plan and deliver services that will meet individual needs. Many of the complaints we received this year were about individual needs not being met. These include the need for behaviour support (see case studies 27 and 28) and for health care (see discussion on page 91).

Figure 27 — Number of formal and informal matters received in 2007–2008 about agencies providing disability services — by agency category

As a formal or informal complaint may involve concerns about multiple community services program areas, there are more complaints by program area than the 218 formal and 216 informal matters received in 2007–2008.

Agency category	Formal	Informal	Total
DoCS			
Disability accommodation services	3	2	5
Disability support services	7	10	17
Sub total	**10**	**12**	**22**
DADHC			**0**
Disability accommodation services	135	76	211
Disability support services	58	68	126
Sub total	**193**	**144**	**337**
Other government agencies			
Disability accommodation services	6	1	7
Disability support services	1	3	4
Sub total	**7**	**4**	**11**
Non-government funded or licensed services			
Disability accommodation services	143	73	216
Disability support services	82	32	114
Boarding houses	7	7	14
Sub total	**232**	**112**	**344**
Other (general inquiries)	0	3	3
Agency unknown	0	35	35
Sub total	**0**	**38**	**38**
Total	**442**	**310**	**752**

Case study 27

Some parents raised concerns about an agency providing accommodation services for adults with disabilities, particularly their ability to manage the difficult and complex behaviours of one resident in the group home. Staff time and attention was increasingly being spent in trying to manage this one resident, and this was impacting on the time staff were able to give the other residents. The complainants also raised their concerns that their complaints to the provider about these issues were not being addressed.

We decided to refer the matter to DADHC to investigate.

DADHC reviewed the home and identified some underlying issues. These included the level of staff training and knowledge, clinical recommendations for clients not being acted upon, inconsistent data collection and incident reporting, clients' health care needs and inadequate complaint resolution.

DADHC recommended to the agency that they:

- consider whether alternative accommodation models would be better suited to meet the needs of each of the service users
- review their complaint-handling policy
- ensure all staff receive induction and training
- review clinical assessment recommendations for clients and develop an action plan to incorporate these recommendations
- review all behaviour management plans and documentation systems.

DADHC advised they will remain involved throughout the implementation of the recommendations.

Case study 28

An official community visitor had concerns about a group home licensed by DADHC to house residents with severe disabilities or challenging behaviours. At the time the contract was awarded to the agency running the home, the parents of the female resident objected on the grounds that the agency did not meet the criteria and had no experience in the field. There were two men and one woman living there.

Over the next 12-18 months, one of the men and the woman were both violent towards the third resident. The man was also violent towards staff.
On some occasions the house was damaged and the police were called. The male resident who behaved violently refused to take his medication. It appeared that staff did not have the skills or training to deal with his serious behavioural problems.

DADHC only became aware of these issues when we contacted them to discuss how this complaint could be resolved. At a meeting with DADHC and the agency, DADHC agreed to take measures to consider increasing staff ratios, improve the residents' participation in day programs, and better meet the needs of the resident who had been assaulted. In particular, DADHC agreed to look for somewhere they could move him. The resident was eventually moved after eight months to another home.

After that, the parents of the female resident complained that she continued to feel threatened by the remaining male resident. Very little progress seemed to have been made in controlling his behaviour.

We met with DADHC and they agreed to take over responsibility for the day-to-day functions of the service for at least six months and only house two residents there for the time being. They also agreed to put in place immediate steps to improve the safety and security of residents and staff. During those six months, they would re-assess the needs of the resident behaving violently, look at purchasing or building more suitable premises so that residents could be separated in safety if and when required, and provide training and mentoring to the staff. After the six months was over, they would arrange to provide ongoing training and support.

DADHC agreed to give us quarterly progress reports. So far they have built new premises and provided training. No incidents have been reported since DADHC took over responsibility for the home. We will monitor the handing back of responsibility to the agency later in 2008.

In some complaints, concerns were raised about the support provided by agencies to meet the overall needs of the people with disabilities in their care (see case study 29).

Case study 29

A rural supported accommodation service for adults with an intellectual disability has been the source of numerous complaints over recent years. Lack of behaviour management plans, inadequate staffing, lack of access to and consultation by management with residents and their families, poorly maintained housing and vehicles, and an inappropriate mix of residents were some of the complaints received from families and official community visitors (OCVs).

We asked the service and DADHC to clarify what they were doing to address these concerns. A particular concern was the decision of the service's parent body not to keep a manager with decision-making responsibilities at the service. When the service was unable to resolve or rectify the problems, we asked DADHC to investigate individual complaints and report back to us. DADHC and the service agreed on an action plan for improving the service's systems and quality of care, including appointing a local manager.

During this time the service's auspice changed twice, although the parent body remained the same. This meant funding agreements and the service improvement action plan had to be renegotiated.

We increased the frequency of OCV visits to the service to obtain first hand information about the impact of the service improvement plans on residents — and compared this feedback with the information from DADHC. The OCV's direct observations of what was happening in the group homes — and discussions with staff and families about their experiences of the service — showed serious problems remained. The OCV told us that the service's management was again restructured and the key local management position was moved out of the area. This was continuing to adversely impact on the quality of care provided to residents.

We wrote to DADHC last year setting out our continuing concerns and they agreed a more holistic approach was needed. They engaged consultants to do a financial audit and quality reviews of each of the group homes. These were finalised earlier this year. The parent agency has since notified DADHC that it will relinquish its auspice of the service — and other services it has auspiced in NSW. We are now monitoring DADHC's planning and management of the transition of the service to the interim and eventual permanent new auspice. We have also arranged for the OCV to visit the service frequently over the next 12 months.

Case study 30

We received a complaint from the mother of a young man with an acquired brain injury and various other medical conditions about the quality of drop-in support services he was receiving in his home. The family's dissatisfaction arose following a change in the service provider. Their relationship with the new service provider was difficult and we felt this was a matter where conciliation could be useful. Because the young man was not able to be present at the conciliation, we initially met him in his home.

The following day we held a conciliation between the service provider and the mother and daughter of the family. The family was able to articulate their concerns about the services being provided and the difficulties they had communicating their expectations and needs, and the service provider was able to explain their position to the family.

During the conciliation, the service provider made a commitment to consider viable options for resolving the family's issues and report to us on their capacity to address these.

The parties held another meeting approximately two months later to review the effectiveness of new strategies and draft an action plan to address the outstanding issues. The service manager agreed to hold regular phone meetings with the mother, and the key worker organised a fortnightly meeting with the young man to provide feedback on the progress of changes to his service provision.

The service also agreed to provide more training to staff working with the client and develop staff tools, such as a duty checklist and staff information folder. These actions will be reviewed again in three months time and we will continue to monitor the outcomes.

Case study 31

We recently conciliated a longstanding dispute between an advocacy service and a disability accommodation service provider. The two parties had been in conflict for several years. A key issue was the advocate's perception that the service provider was not promoting or supporting advocacy involvement in the lives of residents with intellectual disabilities. The advocates complained that they were not invited to relevant meetings, had limited access to the service and sometimes to their clients, and were not allowed membership of the service or included in information mail-outs. They argued this stopped them from performing their role effectively.

We first tried to resolve this matter in 2006 with 'shuttle conciliation', as the heads of the agencies would not meet face-to-face. Although an agreement was reached, the advocacy service subsequently decided that the complaint had not provided the outcome they expected and asked for a review.

The outcome sought was not one we could provide. To try to progress this matter, we requested further information from both parties and, despite significant reluctance from both sides, persuaded them to attend conciliation — this time face-to-face.

Through the conciliation, we were able to help the parties reach an agreement that detailed their respective roles and responsibilities, clarified expectations in relation to communication and consultation about resident needs and related decision-making and, importantly, outlined how complaints and disputes would be addressed in the future.

Case study 32

An OCV approached us concerned about statements made by DADHC representatives during a meeting about the eligibility of a resident in a large residential centre to access an accommodation program for which he had previously been funded.

The question of the man's eligibility was the central issue in two previous complaints to the former Community Services Commission and the Ombudsman in 2002 and 2004. These complaints were closed on the basis that DADHC deemed the man as eligible for the program and committed to meeting with the man's guardian to discuss plans for moving him into the community.

At the time each of these complaints was made, the man explicitly expressed his wish to live independently in the community.

We reviewed departmental files and met with the service provider and the OCV. We met separately with DADHC to discuss the resident's eligibility for the program and his desire to live independently. During these meetings we were able to get an assurance from the department that the man still remained eligible and a project officer would be assigned to develop and implement an exit plan for him to move into the community.

Although in some cases we find the quality of a service could be improved, in other cases a complaint results from a difference between what the individual (or their family) expects and what the service is able to provide. This is often combined with a breakdown in communication. Sometimes complaints arise from disputes between service providers and others who play a role in supporting people with a disability, such as advocacy groups. We can sometimes resolve these kinds of complaints by playing an 'honest broker' role — listening to both sides of the story and trying to bring the parties together to reach a mutually satisfactory outcome. This year we were able to resolve a number of disputes in this way (see case studies 30, 31 and 32).

In 2007–2008 we also resolved a complaint from a father with a disability who was having trouble gaining access to his three children who were living with a relative (see case study 33).

Meeting health and medical needs

People with a disability who need help and support from community services often have complicated needs. Some critical elements to ensure these needs are met include proper planning, effective communication and cooperation between the agencies involved, and participation from the person and their family or advocate.

One fundamental need is the need for health and medical services. Adequately meeting these needs can require a well-coordinated response from both health and disability services. This is particularly the case if the person's health needs are complex, there are frequent hospital admissions, or their support needs have increased as a result of a decline in their health (see case studies 34, 35 and 37).

Case study 33

A father with an intellectual disability complained that DoCS was not adequately helping him to see his three children, all under 11 years old. They were removed from his care in 2004 and placed with a family member who subsequently moved interstate.

Final care orders had been made placing the children under the parental responsibility of the family member until the age of 18. These orders provided for monthly contact with the father, to be supervised by DoCS for 12 months. The family member had been planning the interstate move for several months and had tried to arrange access with the father before moving, but he did not agree to the changed arrangements. It seemed clear to us that the father did not understand the nature of the care orders or DoCS' role with his children.

We felt that the best way to resolve the complainant's concerns was for DoCS to meet with him to explain the orders, his rights and their role. We suggested that DoCS should arrange for an independent support person to be present to assist the father.

At the meeting, DoCS explained the court processes that needed to be followed. They told him they were writing a report for the court to recommend that he still be able to see his children because that was in the children's best interests. They also explained the way he could go about asking the court for the current care orders to be changed.

A fortnight after the meeting DoCS contacted the father to make sure he understood what had been explained and to answer any further questions he had. They told us they are still following up these issues.

Case study 34

In 2006, we reviewed the deaths of two men who had lived together in a regional group home. Both men had very high medical and overall support needs, profound intellectual and physical disabilities, and chronic and complex health issues. They both experienced significant complications associated with their tube feeding, and had been to hospital 13 times in the 12 months before they died.

After our reviews of their deaths, we investigated the adequacy of the response by the disability service and the relevant area health service (AHS) to the critical health issues of both men — and the adequacy of the interagency work undertaken by both agencies to meet their health needs.

We found that actions taken by the AHS were inadequate in relation to:

- assessments to determine whether the disability service would be able to continue to meet the men's needs on discharge
- discharge planning for one of the men, including communication with the disability service about post-surgery care
- working cooperatively with the disability service to clarify agency responsibilities and ensure appropriate support for the two men.

Our recommendations to the AHS referred to existing NSW Health policy requirements about support for people with disabilities during hospitalisation — including the development of area and local protocols with the disability service and training for relevant staff. The AHS has accepted the recommendations and we are continuing to monitor their implementation.

Case study 35

Information from a hospital social worker raised concerns about the adequacy of mental health support for a young man living with an intellectual disability and a mental health condition in a disability group home. The information suggested that the service was not adequately supporting the young man — based on his repeat admissions to hospital for mental health treatment.

We sought advice from both the treating hospital and the disability residential service about these issues. The information provided indicated that adequate discharge planning was occurring when the young man left the hospital, though there had been some instability in his accommodation situation.

We also noted that communication between the hospital and the accommodation service was often difficult, and ineffective in meeting the young man's needs both while he was in hospital and after discharge.

We suggested that the hospital and the accommodation service develop a protocol detailing their relevant roles and responsibilities, including effective ways of communicating and sharing information. This suggestion was supported by both agencies and we received a commitment that a protocol would be developed.

Case study 37

A mother complained about the adequacy of care and supervision her son received at a respite facility for people with a disability. The son has physical disabilities, requires daily medication and needs help with personal care. On the second day of his stay, staff found him unconscious in bed. He was taken to hospital where he remained in intensive care for several weeks. The mother alleged the facility had not given her son his medication and had not notified her of the incident.

We found that the facility was not fully informed about the client's support needs, so it was difficult to meet their duty of care. They relied on previous information provided by a brokerage agency, and did not check with the family if the information was accurate and up-to-date. We also found that improvements could be made to their compliance with certain policies and procedures — including health care and medication administration, responding to critical incidents, respite planning and staff communication.

After a meeting with the manager, the facility agreed to review their policies and procedures to clarify what was required to fulfil their duty of care towards clients and to give ongoing training to staff on these. They also agreed to change a number of practices, including obtaining comprehensive and current information about each client and having a staff member with a first aid certificate on every shift.

Case study 36

A resident of a disability service was admitted to hospital for two weeks and needed additional support while he was in hospital, due to his disability. The disability service organised additional support for the person after what they considered to be a verbal agreement with the hospital. The service complained to us about the hospital's decision not to reimburse them for the additional support they provided during the hospital admission.

We found that — as there was no written protocol or agreement between the hospital or area health service (AHS) and the disability service — the hospital's decision was not inconsistent with NSW Health policy. In response to our inquiries, the AHS advised that they would develop an agreement with the disability service and review their existing policy.

The importance of developing protocols between health and disability services was also illustrated in a complaint we received this year about the provision of in-hospital support to people with disabilities (see case study 36).

People living in large residential centres

A fundamental part of the NSW *Disability Services Act 1993* (DSA) is the requirement that services meet the individual needs and goals of the people with disabilities they support. Our work in recent years has raised questions about whether, and how well, DADHC does this in their large residential centres. These centres typically accommodate more than 20 residents on one site.

This year we have started a review of the adequacy of DADHC's actions to identify and meet the needs of 60 people who currently live in nine large residential centres. The review has involved audits of files and meetings with DADHC staff, residents and relevant disability agencies. The review is expected to be completed this year.

The NSW Government's 10-year plan for disability services, *Stronger Together,* includes plans to close some large institutions, redevelop others, and develop new models of accommodation services.

This year we sought legal advice about:

- whether the maintenance of institutions or their redevelopment can comply with the DSA
- any particular challenges that would need to be met to comply with the DSA
- 'transition plans' for services that did not comply with the DSA when it was introduced.

The advice we received raises some questions about the nature of compliance and how this is determined. We are having ongoing discussions with DADHC about this issue and the implications of our legal advice for the redevelopment of large residential centres.

Children with a disability

In 2004 and 2006 we released reports on DADHC's services for children and young people with disabilities. These reports highlighted significant deficiencies in service provision for many families.

This year, we have contracted Early Childhood Intervention Australia (ECIA) to examine:

- programs and services for children with disabilities and the administration of funding
- eligibility criteria for these programs and services
- access of children with disabilities to mainstream/universal services and targeted support services, including early intervention services
- the current system of case management for children with disabilities and their families.

People with an intellectual disability and the criminal justice system

DADHC is the lead agency for a cross agency Senior Officers' Group (SOG) responsible for improving support for people with an intellectual disability who are in, or at risk of, contact with the criminal justice system.

We have monitored the work of the SOG since 2004, and this year have produced a report on its work over the past three years. This report details relevant developments in the disability services sector and discusses actions taken to improve the operation and accountability of senior officer groups.

Our report highlighted the slow progress of the SOG, and outlined our concern that, while a number of significant initiatives have commenced, key areas of work have yet to be finalised or progressed to a point at which they can be evaluated. Through our recommendation to DADHC, we will continue to closely monitor the progress of the SOG.

DADHC's Aboriginal policy framework

Last year we reported on our consultations with peak Aboriginal disability bodies about their awareness of DADHC's *Aboriginal Policy Framework* and *Aboriginal Consultation Strategy.* These policies are aimed at ensuring that Aboriginal people with a disability and their carers have:

- equity of access and outcomes to DADHC programs and services
- equity of participation in DADHC planning and decision-making.

In June this year we started a review of how DADHC is implementing these policies 'on the ground'. The review will explore the adequacy of consultation mechanisms in place between DADHC, relevant service providers and Aboriginal communities at a local, regional and state level. We will also look at whether these mechanisms are providing Aboriginal people with better access to DADHC's services and the services they fund.

For more details about this review, see page 50 in Chapter 1: Community engagement.

Social housing tenants with mental health issues

This year we started an investigation into the implementation of the Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing (JGoS). We are examining the steps taken by the Department of Housing and NSW Health to meet the objectives of the JGoS. These are to:

- better assist and enhance the wellbeing of existing social housing tenants whose tenancy may be otherwise at risk
- help housing applicants who may be homeless or at risk of homelessness to successfully establish a tenancy.

For more details about this investigation, see page 31 in 'Our organisation'.

Reviewing complaint-handling

This year we started a review of complaint-handling in agencies providing services under the DADHC funded community participation program. Our aim is to increase awareness across the sector of the complaints framework established under CS-CRAMA, and help service providers better understand and fulfil their responsibilities under the Act.

Community participation services aim to help young people with a disability to develop the skills they need to work towards their goals, increase their independence, and participate as valued and active members of the community. Many of the young people are from vulnerable groups with culturally and linguistically diverse backgrounds.

We will review 20 services from all DADHC regions plus one statewide service. Many of the services are funded by large organisations, so the review provides an opportunity to implement changes that could have an impact on a large number of service users.

We hope to report on the results of our review by the end of 2008.

Reviewing deaths of people with disabilities

The Ombudsman's statutory responsibilities include reviewing the deaths of people with a disability living in care and people living in licensed boarding houses.

Our goal is to identify shortcomings in agency policy, systems and practice and make recommendations to prevent and reduce the risk of deaths in future. An advisory committee contributes to our review function. In 2007–2008 the committee met twice. There is a list of the committee members in Appendix M.

Our annual report

In November 2007 we released the fourth annual report about our work in this area, *Report of Reviewable Deaths in 2006 Volume 1: Deaths of people with disabilities in care.* The report is available on our website.

Between 1 January and 31 December 2006, we reviewed the deaths of 98 people with a disability. Our report highlighted issues such as:

- insufficient management of dementia and risks such as falls and swallowing problems
- inadequate or ineffective first aid responses to critical incidents, and the need for mandatory first aid requirements in all services accommodating people with disabilities
- the need for improved discharge planning by hospitals, including assessing whether the person's health needs can be adequately met in their home environment
- the need for improved service provision for people living in large residential centres — including identifying the needs of individual residents, providing adequate access to the broader community, and ensuring meaningful involvement in decisions about their lives.

We made a total of eight recommendations to DADHC and NSW Health and we are actively monitoring their implementation.

The deaths we reviewed in 2007

This year we reviewed the deaths of 98 people who died in 2007, including 15 people who lived in licensed boarding houses and 83 people who lived in group homes or residential centres.

We took action in relation to 11 of these deaths, including two matters that we investigated. In eight cases, we prepared a report for the service provider about the issues we identified.

This year's annual report on reviewable deaths of people with a disability in care will be tabled and publicly available later in 2008. It has a particular focus on the deaths of people with Down Syndrome who also had dementia.

In May 2008, we engaged the National Centre for Classification in Health (NCCH) to analyse both the underlying and contributory causes of 466 reviewable disability deaths between 2003 and 2007. The results of this work will be covered in our annual report on reviewable deaths of people with a disability in care.

Policing 5

We have a long-term commitment to working with the NSW Police Force (NSWPF) to improve the police complaints system. Although overseeing individual matters is a large part of our role, so is monitoring the general effectiveness of the police complaints system. We protect the public interest by making sure individual complaints are effectively handled and by proactively reviewing general complaint-handling procedures and overall system performance.

Highlights

- Cut red tape in police complaint-handling by introducing electronic delivery of complaint notifications and final investigation reports.
- Evaluated the streamlined complaint-handling trial in 13 NSW Police Force commands and supported its general roll out to all commands, simplifying the management of less serious complaints.
- Identified 328 investigations where there were defects in the investigation or proposed management outcomes. Over three quarters of the identified deficiencies were remedied following our advice to the NSW Police Force.
- Our review of the use of emergency powers to prevent or control disorder, enacted in response to mob violence at Cronulla, was tabled in Parliament.
- Conducted a major survey of defendants in local courts to assess their experience of police searches conducted under the *Law Enforcement (Powers & Responsibilities) Act 2002*.

The police complaints system

Like other public and private sector organisations, the NSWPF needs to quickly and informally resolve complaints about minor unprofessional conduct by their officers. At the same time, complaints about more serious professional misconduct and corrupt behaviour need to be vigorously investigated — and decisive action taken if they are sustained. This is essential to maintain high professional standards and the reputation of the force.

Figure 28 — The police complaints system

Category of complaint	Description	How the complaint is handled
Notifiable complaints Police must notify the Ombudsman about these matters.	More serious complaints, such as complaints involving allegations of criminal, corrupt or unreasonable conduct. This includes conduct that may result in serious management action — e.g. reduction in rank/ salary or dismissal — or conduct indicating a lack of integrity. Some examples of serious complaints include allegations of perjury, involvement in the manufacture or supply of illegal drugs, or police action or inaction resulting in death, injury or significant financial loss.	Police investigate the majority of these complaints and the Ombudsman oversees the investigation. PIC may investigate or oversee any complaint. In practice, the PIC only does this in a small number of cases.
Non-notifiable complaints Police must record these matters on their complaints information system but need not notify the Ombudsman.	Less serious complaints, such as complaints about poor customer service, rudeness or minor workplace conduct issues.	Dealt with by local commanders without any direct Ombudsman oversight. We use methods such as audits to examine the way some of these complaints are handled.

New South Wales has a mature and sophisticated police complaints system that caters well for these dual requirements. It has changed considerably over the past three decades since we have had an oversight role and continues to evolve. Currently, the statutory framework in the *Police Act 1990* provides for the majority of complaints to be dealt with directly by police. The more serious complaints are notified to the Ombudsman and we review the adequacy, timeliness and fairness of their investigation and the action taken. We have the discretion to monitor police investigations, seek further information, or ask the Commissioner to review any action taken if we believe it is inadequate. We can also take over a police investigation, initiate 'own motion' investigations, and make reports about police investigations we consider deficient.

We have a class or kind agreement with the Police Integrity Commission (PIC) that specifies the types of less serious complaints that can be handled directly by police, without our direct case by case oversight. Police can decide if these complaints need an evidence-based investigation or can be informally resolved, or if no action needs to be taken. We conduct regular audits to ensure these matters are handled appropriately.

In the past year, we implemented a new class or kind agreement and oversighted the trial and implementation of a new streamlined complaint-handling process. Both initiatives were aimed at making the complaints system more efficient and effective, but still preserving the critical independent oversight role of the Ombudsman. These new procedures have significantly cut 'red tape'. They have also provided a more flexible and responsive system for citizens, internal police complainants and the NSWPF. Figure 28 shows how the agreement works.

Streamlining the complaints process

Since 2004, we have been encouraging the NSWPF to manage complaints more quickly and informally, without always using their resource-intensive complaint management teams (CMTs).

This year we worked closely with the Professional Standards Command (PSC) to develop and implement a complaints streamlining project. The project was launched in July 2007 by the Ombudsman and Mr Ken Moroney, the former

NSW Police Commissioner. New guidelines were developed for handling less serious complaints and then trialled over a six month period at nine local area commands and four specialist commands across the state.

The trial was monitored by a Complaints Advisory Group (CAG) convened by the Ministry for Police. This group included representatives of the Ministry for Police, the Professional Standards Command, PIC, the Police Association of NSW and the NSW Ombudsman.

Our evaluation of the trial included a comprehensive review of 223 finalised complaints as well as discussions with professional standards officers, executive officers and commanders at participating commands. The guidelines achieved their goals — complaints were resolved more quickly, less resources were used, and appropriate action was taken to address the concerns of complainants.

Importantly, surveys conducted by the PSC of complainants and subject officers revealed increased levels of satisfaction. Commanders and professional standards officers also strongly supported the new procedures.

"The introduction of the streamlining strategy has proven to be an efficient and timely method of dealing with complaints."

"The feedback I have received indicates the new process is not only a great improvement on the previous process, but it is also seen as being a lot fairer by subject officers."

Complaints streamlining has "taken a lot of pressure off the Exec Officers and CMT."

"The process has reduced the time for complaints making it a better/fairer process for both — the subject officer and complainant."

"Great improvement in time and satisfaction with the process."

The NSWPF introduced the new streamlined complaint process across the organisation in May 2008. It includes:

- a triage procedure to provide a more timely and effective assessment of complaints at the outset
- a 45 day timeliness standard for completing less serious complaints — the previous NSWPF standard for complaints managed by CMTs was 90 days
- decreased workloads for CMTs
- reduced administrative procedures for less serious complaints.

After the trial, the CAG supported an amendment to s.141 of the Police Act to allow commanders to consider additional information from complainants and any existing relevant records to determine whether complaints should be investigated or not. This supported the new assessment procedure developed during the trial.

Maintaining effective relationships with police

The Ombudsman and the police have complementary roles in ensuring that the police complaints system works effectively. To achieve this, we need to build and maintain constructive and professional working relationships. Staff from both our organisations meet regularly to discuss issues ranging from major developments and points of contention to individual complaints.

We also share information about how we do our work. For example, we use our intelligence holdings to provide information to commanders about officers who have complaint histories of concern. This helps commanders to manage those officers more effectively. We also discuss any issues that may have arisen as a result of our consultations with community groups.

This year we visited 11 commands — Coffs/Clarence, Cootamundra, Wagga Wagga, Flemington, The Rocks, Rosehill, St Marys, Lake Illawarra, Brisbane Water, Macquarie Fields and Barwon. We also regularly talk to student police officers at the Police Academy about the features and ethical underpinnings of the complaints system.

Police complaints this year

During 2007–2008 there were over 15,000 police officers in the NSWPF. They attracted approximately 5,000 complaints from the public and their own colleagues. The most serious complaints were investigated and directly oversighted by the Ombudsman, while the police directly handled the remaining complaints as local management issues using more informal methods.

Figure 29 — Formal complaints about police received and finalised — five year comparison

	03/04	04/05	05/06	06/07	07/08
Received	3,565	4,179	3,753	3,466	2,969
Finalised	3,316	4,367	3,833	3,555	3,254

This year we received 2,969 formal or written complaints. These came either directly from the public or as notifications from police or referrals from the PIC. We also received 2,994 informal complaints by telephone or in person. We dealt with these by providing advice and referral information.

We finalised 3,254 formal complaints. The drop in notifiable complaints reflected in figure 29 is a direct result of changes to the class or kind agreement. This raised the threshold of seriousness and diverted more complaints to police for handling as local management issues.

We declined to investigate a percentage of the complaints we received for various reasons. For example, there could have been an alternative and satisfactory means of redress — such as raising allegations in court if they were directly related to charges. We reviewed 2,082 individual complaints that were fully investigated or conciliated by police. Of these 1,752 or 84% were considered to be satisfactory. However in 328 matters (16% of all investigated or conciliated matters), we found that the investigation itself — including its timeliness or the management action taken in response to the findings of the investigation — was deficient. Following our advice, the NSWPF remedied over three quarters of the identified investigation deficiencies and proposed management outcomes.

Figure 30 — What people complained about

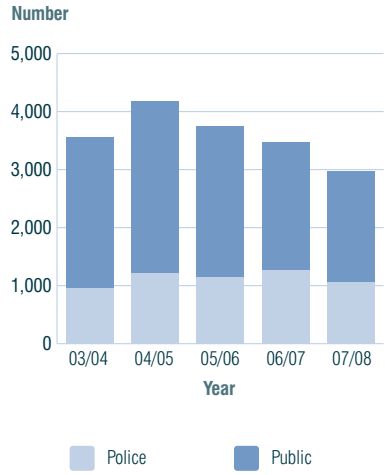
Subject matter of allegations	No of allegations
Arrest	223
Complaint-handling	213
Corruption/misuse of office	473
Custody/detention	225
Driving related offences/misconduct	150
Drug related offences/misconduct	225
Excessive use of force	1,115
Information	913
Inadequate/improper investigation	1,232
Misconduct	1,616
Other criminal conduct	461
Property/exhibits/theft	373
Prosecution related inadequacies/misconduct	321
Public justice offences	286
Public servants	31
Search/entry	179
Service delivery	1,586
Total	**9,622**

Overall, 72% of complainants who police contacted at the end of investigations reported they were satisfied with the action police took about their complaint. However this figure may not be reliable, as in 22% of applicable cases the police were unable to contact the complainant or they failed to advise their level of satisfaction.

Figure 30 shows the type of issues raised in the complaints finalised this year. Appendix A breaks down each issue into the specific allegations made and the action taken.

Figure 31 — Who complained about the police?

This figure shows the proportion of formal complaints about police officers made this year by fellow police officers and from members of the general public, compared to the previous four years.



Of the serious complaints we directly oversighted this year, 1,913 were made by members of the public and 1,056 (or 36%) were made by other police officers — either internally or directly to us. Compared to the previous year, the percentage of complaints made by police decreased marginally by 1% (see figure 31). The fact that such a high percentage of complaints against police are generated by their colleagues indicates a healthy professionalism and intolerance for misconduct by serving police and is a very positive reflection on the health of the complaints system.

Outcomes

Figure 32 shows the type of action we took in response to complaints finalised during the year. There were 1,983 complaints investigated by police and reviewed by us. We also reviewed the informal resolution of 99 additional matters. We decided that 490 of the complaints we received were local management issues and referred them back to police to be resolved at a local level.

We decided 682 complaints did not require any action at all. Some of the incidents were too remote in time, in others the conduct complained about would be dealt with in upcoming court proceedings, or sometimes there were other alternative and satisfactory ways to resolve the grievance.

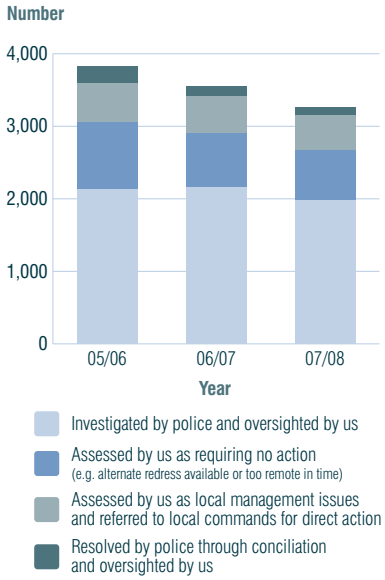
This year more than half of the 2,082 police investigations and conciliations we reviewed resulted in some form of management action. The most common action taken was formal counselling, followed by official reprimands or commander's warning notices (see figures 33 and 34).

In some cases, a police officer is charged with a criminal offence during or at the end of an investigation. This year 49 officers were charged with a total of 136 offences. There was a 26% decrease in the number of charges laid against serving officers in comparison to the previous year. See figure 35 for a five year comparison of charges against police arising from complaints. Figure 36 lists the type of charges laid against police. Compared to the previous year, there was a noticeable decrease in the number of charges relating to domestic violence and sexual assault matters.

In addition, as a result of complaints, the appointment of one probationary constable was terminated and 23 police were dismissed from the force during the year. See case study 38 for an example of a serious complaint that resulted in an officer being removed from the force.

Much of the more serious management action resulted from internal police complaints. Sixty five per cent of the officers charged with criminal offences as a result of complaint investigations involved complaints made by other police officers. Similarly, more than 75% of the referrals of officers to the Internal Review Panel for reviewable management action resulted from officers' complaints.

Figure 32 — Action taken in response to formal complaints about police that have been finalised — three year comparison



Performance indicator

Percentage of our reports about police complaints that made recommendations relating to law, policy or procedures

Target	2007–2008
70%	75%

Performance indicator

Percentage of our recommendations in formal reports implemented by the NSW Police Force

Target	2007–2008
80%	91%

Figure 33 — Action taken by the NSW Police Force following complaint investigation — five year comparison

	03/04	04/05	05/06	06/07	07/08
No management action taken	1,072	1,480	895	936	837
Management action taken	606	960	1,236	1,221	1,146
Total investigations completed	**1,678**	**2,440**	**2,131**	**2,157**	**1,983**

Contributing to the quality of complaint investigations and outcomes

Under the current statutory framework, the police are responsible for investigating and dealing with the vast majority of complaints about their officers. Our role is to make sure the whole complaints system works well and to review the more serious complaints on a case by case basis.

If we identify deficiencies, we send detailed advice to the NSWPF outlining our concerns. This year, in response to such advice, the NSWPF remedied 76% of the identified investigation deficiencies and 83% of the proposed management actions identified as deficient.

Case study 38

In the early hours of a Sunday morning, two male police officers pulled over a woman for a random breath test. The woman took the test and was over the 0.05 limit. It was alleged that one of the officers told the woman that if she performed a sexual act on his colleague, she would not be charged. The other officer then got in the car with the woman and there was apparently some interaction between them. The woman was then allowed to leave the scene without being charged. As a result of the police complaint investigation, the officers were charged for attempting to pervert the course of justice and making a collusive agreement with a member of the NSWPF. One of the officers has resigned and the other was dismissed.

Figure 34 — Common NSW Police Force management outcomes to complaints about police

Type of management action taken against police officers as a result of investigation of complaints 2007–2008	Percentage
Management counselling	36%
Official reprimand/warning notice	15%
Additional training	10%
Performance agreement	7%
Coaching/mentoring/referral to specialist services	6%
Change in policy/procedure	5%
Increased or change in supervision	4%
Transfers	4%
Removal under s.181D	3%
Reduction in rank/seniority	3%
Restricted duties	3%
Formal apology	2%
Deferral of salary increment	1%
Compensation paid	1%
Total	**100%**

Case study 39

A supervisor became aware that a five page fax had been inappropriately sent to an external address. The fax contained confidential information from the COPS system about the registration details of a vehicle. The officer who sent the fax was spoken to and could not adequately explain why it had been sent.

Later the same day, the officer created a false intelligence report stating that the owner of the vehicle in question was involved in car rebirthing.

The officer then sought advice from a colleague who advised her, if questioned to lie about the circumstances of the matter. This second officer was also involved in the matter and had accessed the COPS details in relation to the same vehicle.

Both officers were untruthful when subsequently interviewed. The second officer later admitted that he had colluded with the first officer in supplying a false account of the circumstances surrounding the access and dissemination of the information.

Both officers eventually admitted that the information from the COPS system had been supplied to a friend who was interested in purchasing a vehicle.

The first officer was removed from the NSWPF due to the integrity issues that the investigation had identified. Police proposed that the second officer be transferred to another command.

We raised concerns about the adequacy of the management action in relation to the second officer. The NSWPF subsequently agreed to take further action and the officer's pay increments were reduced a number of levels.

This is a very positive response rate, given that a number of matters may not be capable of direct remediation due to time and other reasons.

Case studies 39 to 43 provide examples of deficient investigations or outcomes that were remedied after our advice.

Monitoring investigations

We usually do an initial assessment of a complaint and then check the quality of the investigation once it has been completed. In some cases, we also monitor investigations while they are being conducted. For example, we observe interviews with complainants, witnesses and officers or review investigation records progressively during the course of the investigation. In both cases, we liaise with the police investigators to make sure all relevant lines of inquiry are fully considered.

This year we used our monitoring powers to closely scrutinise 17 investigations while they were in progress.

Monitoring investigations is one of the ways we keep the standards of the complaints system under scrutiny. Often, the complaints we choose to monitor involve complainants from vulnerable groups who have communication difficulties or are fearful of police. Sometimes there are other public interest reasons for closer scrutiny of the police investigation. For example, this year we closely monitored an internal police complaint about a critical incident in which a suspect was shot while being apprehended.

Improving the police complaint-handling system

We are committed to working with police to improve the efficiency of the complaint-handling system. Apart from the major streamlining trial, this year we implemented a number of other reforms to achieve this.

Class or kind agreement

On 1 June 2007 we finalised a new class or kind agreement under s.122(2) of the Police Act. It was aimed to achieve two key outcomes. Firstly, to ensure that allegations of criminal and other types of police misconduct raising integrity issues continue to be notified to us and subjected to rigorous oversight. Secondly, to allow police commanders to manage a wider range of less serious matters more informally — without our direct oversight.

During its first year of operation, the agreement resulted in a drop of over five hundred complaint notifications from the previous year.

Preliminary assessments by the PIC, our office and Professional Standards Command all indicate that the agreement has been operating effectively.

Identifying deficiencies in police investigations

This year we audited a sample of 157 police investigations that we had assessed as being deficient. We wanted to identify any common features and find out if the outcomes changed as a result of our feedback.

The most common deficiency was the failure to pursue relevant lines of inquiry — such as interviewing key witnesses, reviewing COPS accesses or entries, reviewing CCTV material and following up information to check statements made in directed memoranda or interviews. Failing to identify key issues in the complaint — as well as policy or procedural issues that need to be addressed as a result of an investigation — were the next most common deficiencies we identified.

The NSWPF remedied a high percentage of the deficiencies we identified in individual cases. We will be preparing a report about these common deficiencies to help educate investigators.

Detrimental action complaints

Historically, police in most jurisdictions have been reluctant to report misconduct by their colleagues. In recent years this has changed significantly for the better in NSW. However, there remains a constant challenge to provide a supportive ethical environment — backed by strong policies and procedures — in which officers can have the confidence to make a complaint without the fear of retribution.

It is an offence to take detrimental action against an officer because they made a protected allegation under the Police Act or a protected disclosure under the *Protected Disclosures Act 1994.* These are important whistleblower protections. This year we conducted a review of cases involving detrimental action to assess how well these protections are operating.

Our review showed that much of the detriment suffered by internal police complainants and witnesses is caused by their work colleagues. Detrimental action was generally taken in response to allegations of serious misconduct being made. It included bullying, harassment, verbal abuse (direct and to other officers), undermining of the officer to their staff and others, ostracism at the workplace, 'pay-back' complaints or a combination of these. A common and disturbing feature of the cases was the significant stress suffered by the officers victimised.

Figure 35 — Police officers criminally charged — five year comparison

	03/04	04/05	05/06	06/07	07/08
No. of complaints leading to charges	54	78	65	63	50
No. of officers charged	52	81	64	60	49
Total charges laid	**95**	**155**	**101**	**184**	**136**
Officers charged following complaints by other officers	40	63	51	48	32
% of no. of officers charged	77%	78%	79%	80%	65%

Figure 36 — Types of charges

Type of charge	Number of charges	Proportion of total
PCA and other driving related offences	14	10%
Assault	16	12%
Criminal conduct — other	79	58%
Sexual assault	4	3%
Fraud	2	1%
Public justice offences	11	8%
Drug offences	1	1%
Domestic violence related	1	1%
Dangerous/culpable driving	8	6%
Total	**136**	**100%**

Case study 40

Police were called to an 18th birthday party that had got out of hand. There were a few hundred young people in attendance, some heavily intoxicated. As the police were in the process of closing down the party, the complainant and some friends arrived and were told to leave. As they were walking to their cars, some police called them names and started jostling them to hurry up. The complainant became concerned when police pushed one of his friends. He took a photo on his mobile phone and when the police spotted this, they tackled him to the ground and demanded the phone. The complainant claimed he was kneed in the back and an officer stood on his ankle, resulting in injuries. The police let him go when they confirmed the photo had not been saved.

The police admitted they detained the youth because they thought he was committing a criminal offence by photographing them. They claimed the ankle injury was accidental as they had all fallen down during the incident.

We identified deficiencies in the investigation of the complaint and an error of law. As a result, a memo was distributed throughout the command involved reminding police that it is not an offence to take photographs of police in the execution of their duties.

Case study 41

A young person was involved in a police pursuit. After the car crashed and he absconded on foot, police eventually arrested him. When the young person did not comply with police directions, a degree of force was used to restrain him. The young person had minor injuries and was taken to the police station where he was strip searched. When he later arrived at a detention facility, he complained that police had assaulted him.

Police investigated the allegation and made no adverse findings. We were concerned that the youth may have been strip searched unlawfully. Police must have reasonable grounds to conduct a strip search. However, an internal custody document that was regularly used at the station concerned appeared to specify that strip searches should be routinely conducted in all circumstances. We raised our concerns about this document with the commander and he agreed with our view. The commander advised that the document would be amended to ensure that strip searches are not considered a routine practice for people in custody.

Case study 42

Police had been involved in a car pursuit when they momentarily lost sight of the vehicle. They later spotted what they thought to be the same car. Two men were ordered out of the car by the police, who had their guns drawn. The men were handcuffed and made to lie on the ground until the officers realised that this was not the car they had been following. The officers immediately apologised to the men and explained their mistake.

A solicitor complained about the way the men had been treated by police and asked for them to be financially compensated for the trauma they had suffered.

Police investigated the complaint and we asked them to provide further information about the incident. We noted that a number of standard operating procedures had not been followed. As a result of this additional information, we accepted the police had made an honest mistake when arresting the men. We felt a written apology was appropriate in the circumstances. Police agreed and provided one to both men.

Case study 43

A complaint was made that an officer was acting as his fiancé's 'pimp' and that she was working as a prostitute at a brothel. It was also alleged the officer had a second job as a panel beater for which he did not have approval.

Police investigated and found that the officer was doing unauthorised work as a panel beater. They also found he had failed to declare a conflict of interest in relation to his fiancé's employment. The officer was counselled about this and given advice and guidance about not associating with people in his private life that may subject him to a professional risk. The officer advised his commander that he no longer lived with his fiancé.

The officer had a significant complaint history and, when we made some further checks, we found that he and his fiancé had registered a business with a suggestive name that was described as an 'automotive consultancy'. However, we also identified a website that advertised the business as a male and female escort service catering for couples. Both escorts had 'working names' and the female's name was the same as the officer's fiancé. The site included suggestive photos of the male escort with his face partially obscured.

We asked the police to make further inquiries about this new information. One of our concerns was that the officer may have been untruthful during the investigation. We also asked police to consider if the officer was the male escort in the photos. The investigator then advised that the sex industry is not defined as a 'high risk' industry in the NSW Police Force's secondary employment policy, and thus was not a matter for Professional Standards Command to investigate. Because of our concerns about the obvious risks associated with this matter, we then met with the investigator. When he was shown the photos, the investigator immediately identified the officer as being the male escort.

Police made further inquiries and found that the officer had signed the business registration document and was a co-proprietor. The officer claimed he did not know his photos were being used on the website, although his mobile phone number was listed on it. He also told police that he was no longer in a relationship with his fiancé. He was living with her in a one bedroom flat, but paying her rent to sleep in the sunroom. Police found that the officer was untruthful in his original interview and that his engagement in the sex industry was unauthorised secondary employment.

Although the investigator felt that the officer's untruthfulness was 'at the lighter end of the scale considering the nature of this investigation', we felt significant management action should be considered. We contacted the officer's commander who shared our concerns. The matter was sent to the Internal Review Panel (IRP) and a reviewable order under s.173(2) was recently served on the officer advising him that his conduct and integrity was unsatisfactory and improper. Police also reduced him to a lower pay level.

Of the 26 cases we reviewed, 29% were considered to have been unsatisfactorily investigated — a deficiency rate more than three times higher than the general pool of police investigations. Problems included confusion about legislative requirements and difficulties proving that detrimental action had actually occurred or was 'substantially in reprisal' for making a protected allegation or disclosure. Cases involving detrimental action generally took substantially longer to investigate than other internal police complaints. A troubling finding was that none of the cases reviewed led to a charge being laid under either the Police Act or the Protected Disclosures Act, or made a clear finding that detrimental action had occurred. In most matters, no management action was taken in relation to the behaviour suspected of being detrimental action.

There are significant problems with the interpretation and practical application of the legislative protections for whistleblowers. There are also no protections for people who forward on a complaint, act on behalf of a complainant, or are mistakenly identified as having made a protected disclosure or allegation.

There is a need to create a simpler and more effective legislative framework and have clear and practical police procedures to better deal with 'pay-back' complaints and detrimental action. We are in the process of refining a discussion paper on detrimental action with suggestions for reform.

Recording false or vexatious complaints

The Police Act allows the Ombudsman, the Police Integrity Commissioner and the Commissioner of Police to develop protocols about the information recorded on the police complaints information system, c@tsi.

This year a new memorandum of understanding was introduced about complaints considered to be frivolous, vexatious or not made in good faith. With the agreement of the Assistant Commissioner Professional Standards and the Assistant Ombudsman, specific complaints like this can be registered on c@tsi without the name of the police officer who is the subject of the complaint.

False and vexatious complaints can harm the complaints system by causing unnecessary investigations and unfairly bringing the work of honest officers under suspicion and causing them stress. In appropriate cases, we support police in taking appropriate action against people who make false complaints. Case study 44 describes one of the cases this year where a complainant was successfully prosecuted for making a false accusation.

Case study 44

A woman was arrested and charged with a number of offences after a violent altercation. She was convicted and sentenced to a term of imprisonment. She appealed the severity of her sentence and lodged a complaint alleging criminal conduct on the part of the police during the incident.

The allegations included a number of physical assaults on the woman, and the capsicum spraying of herself and her nine year old daughter in the eyes during the incident. She further alleged that police assaulted her six year old son with batons before arresting her and another 14 year old son. The woman claimed that police refused to provide her and her son with refreshments, blankets or phone calls after they were taken into custody, her son was interviewed without her consent, and police failed to contact a legal representative on her behalf. It was alleged that both the woman and her son had physical injuries as a result of the incidents that took place.

The investigator found no evidence to support any of the woman's allegations. The woman was given eight opportunities to provide more details to the police investigator, including giving a statement in the company of her solicitor, but she did not cooperate on any of these occasions. Custody records showed she ate meals and a number of phone calls were made on her behalf, including to a local solicitor. The woman was also visited by a close relative. An ambulance officer who de-contaminated the woman and her son from the capsicum spray at the station did not find, or hear them complain of, any injuries. A friend who stayed in the woman's house and looked after the other children — including the six and nine year old who police had allegedly assaulted — confirmed she did not witness anyone being assaulted and the children had no injuries. A probation and parole officer, who interviewed the woman on two occasions after she pleaded guilty to the original charges, confirmed she raised no issues about police assaulting her or her children or having any injuries as a result of the altercation and arrest.

As a result, the woman was charged with making a false accusation. A two day hearing involving evidence from police and civilian witnesses resulted in her being convicted and sentenced to a 12 month bond. Police are appealing that conviction on the grounds that it is an inadequate sentence.

Evaluating the effectiveness of the CARA protocol

The Complaint Allocation Risk Appraisal (CARA) process helps police to decide if complaints should be managed locally or transferred to another location for investigation. It involves assessing risk factors — such as whether the command or the investigator has any conflict of interest that may affect the fairness or effectiveness of the complaint investigation. Police began using CARA in March 2007.

This year, together with the PIC and the NSWPF Professional Standards Command, we reviewed 100 investigations to check compliance with the CARA process and see if the process would benefit from any changes.

Overall, we found that most commands were using CARA appropriately. However, all three agencies agreed that changes could be made to the process to improve accountability and transparency. These changes relate to the requirement for commands and investigators to document how an identified conflict of interest will be managed.

As a result of the audit, a tri-agency report with a number of recommendations to improve the effectiveness of CARA is currently being prepared.

Delivering reports electronically

In July 2007, we successfully developed and deployed a new system for the electronic delivery of police complaint notifications in cooperation with the NSWPF. The electronic system operates on a secure network and means that police no longer have to send us new complaints in hard copy. This saves police resources and means we receive new notifications more promptly.

In 2008, we extended the system to include the electronic delivery of complaint investigation reports. Again, this provides the NSWPF with substantial resource savings. We have made further improvements to the system by allowing additional documents to be sent without the need to resend the original report.

Maintaining the integrity of the police complaints system

As well as overseeing individual investigations, we regularly review the overall effectiveness of the complaints system by conducting regular compliance audits.

Auditing local management issues

The class or kind agreement under the Police Act allows police to deal with less serious complaints directly, without the involvement of the Ombudsman. These matters are recorded on the police complaints system as local management issues. We regularly inspect police records to ensure the complaint provisions of the Act are being followed. One aim of our audits is to ensure only less serious matters are being treated as local management issues and that the issues raised are being appropriately addressed.

A particular focus of our 2007 audit was to examine whether the new class or kind agreement — which started in June 2007 — was working successfully. We examined more than 1,400 matters and found a high level of compliance with the notification requirements. We raised only 13 matters with police that we considered should have been notified, but hadn't been. The police agreed to notify all of these after we asked them to reconsider their original assessment decisions.

Monitoring delayed investigations

Undue delay in investigations can result in complainant dissatisfaction and added stress for police officers. We have a long standing policy of systematically identifying untimely investigations and raising them with police through meetings between the Assistant Ombudsman and Commander of the Professional Standards Command. As a result, the number of delayed matters has steadily declined. This year we are satisfied that the overall numbers of delayed matters has reduced to such a level that we have agreed — with Professional Standards Command — to trial having identified delays dealt with directly by middle managers.

Case study 45

A man was searched by police during a drug detection dog operation at a nightclub, but no drugs were found. The man complained about police infringing his privacy by recording his personal details from his driver's licence without consent. The man was also concerned about the impact of being publicly searched by police in front of work colleagues.

As a result of a previous complaint, and our review of the *Police Powers (Drug Detection Trial) Act 2003,* the NSWPF had already acknowledged that they did not have the power to obtain personal details from belongings during a search in which no offence was detected.

We reminded police of this and they apologised to the man and removed his details from the incident record in COPS. In addition, they amended policies and procedures to ensure that officers are aware that there is no power to obtain or compel a person to provide details when no offence has been detected.

Monitoring reviewable actions and observing panels

Some complaints result in serious management sanctions such as removal from the police force or reductions in rank or seniority. These matters are managed by employee management and are referred to a police internal review panel for consideration. The panels provide expert advice to commanders and the Commissioner on appropriate sanctions to ensure they are fair and proportionate.

We began regular audits of the timeliness of these matters in 2007. Since then police have introduced a number of changes aimed at reducing delay. This has included outsourcing some of the work involved to a private law firm.

We continue to closely monitor the process and outcomes. Our staff regularly observe the work of the internal review panels so they have a full appreciation of the involved decision-making that occurs. We will also be participating in a review by the Complaints Advisory Group of Part 9 of the Police Act, which deals with the management of misconduct and unsatisfactory performance.

Improving our internal procedures

We regularly review the quality of our own complaint-handling and oversight work.

Checking our monitoring process

The Ombudsman has the power to monitor a complaint investigation if we think it is in the public interest. In 2007 we negotiated a new agreement with police setting out a protocol for how we will arrange and conduct these monitored investigations.

We conducted an audit of monitored investigation files to see if the new arrangements were working successfully. The audit found that we were complying with the terms of the agreement and that, in most cases, our monitoring was positively contributing to the overall quality of the investigation.

External quality review of a random sample of files

Over the last two years we have engaged external consultants to closely examine a random sample of completed complaint investigation files that involve allegations of serious police misconduct. The purpose of the reviews was to find out if:

- We made appropriate assessments of the adequacy of complaint investigations and the management actions taken by the NSWPF.
- We took appropriate action in matters where the actions taken by the NSWPF were identified as deficient.

The previous review was done by a barrister with significant experience in police misconduct matters. This year the review was conducted by a retired NSW Police Chief Superintendent. It concluded that:

> *The overall quality of the Ombudsman's oversight of these matters displayed a great attention to detail and a very thorough analysis of the material provided by NSW Police. Indeed the case officers showed the consistent ability to detect deficiencies in investigations which needed to be readdressed by the investigators. The deficient investigations reviewed were very good examples of the ability of the case officers to analyse and correct shortcomings and also to praise competent investigators who have carried out a thorough investigation.*

Research and projects

Examining the use of Tasers

Use of force by police regularly generates complaints. It also places police and the public at risk and is often the cause of injuries and police sick leave. Getting operational procedures for the use of force right therefore benefits both the police and the community. In the past, we have examined the police use of capsicum spray. This year we undertook a major project that examined the police use of conducted energy devices, commonly known as Tasers. Although in use by the NSWPF since 2002, there was a significant spike in their use in 2007. Our decision to review the use of Tasers was also driven by an emerging public concern about their use and increasing demands from police to equip all officers with Tasers.

We did an international literature review and closely examined all incidents where police had used Tasers between May 2002 and February 2008. We tracked the medical treatment given to people who had been 'Tasered' in these incidents. We also examined the standard operating procedures and training given to officers and interviewed officers who used the Tasers.

During our investigation, the Minister for Police announced the roll out of a further 229 Tasers to duty officers and supervisors and the training of a further 2000 officers in their use.

We found the police use of Tasers in NSW had been responsible to date, because they were used by specialist and well trained officers. Even so, Tasers were ineffective in more than a quarter of the incidents in which they were used. In the report, we identified improvements that need to be made to police standard operating procedures and training and outlined the risks involved in their use. We also called for further monitoring, especially given the plan to roll Tasers out to some general duty officers. Once our report is tabled in Parliament it will be available on our website.

Working with Aboriginal communities

Our work with police and Aboriginal communities across the state continues to focus on trying to resolve issues at a local level — improving Aboriginal access to quality policing services and helping police implement effective initiatives and reforms.

An important part of our role is to identify and support local police efforts to create and strengthen genuine partnerships with Aboriginal people and organisations. With the help of our Aboriginal Unit, we also work with the Commissioner of Police and the NSWPF Aboriginal coordination team to ensure that local initiatives receive the support they need.

Increasingly, crime prevention partnerships and other local initiatives involve police working closely with agencies such as community services, probation and parole, health and education. Together, they plan and implement coordinated strategies to address child abuse and sexual assault, domestic and family violence, substance abuse and other issues that impact on community life. Community organisations and other non-government agencies with responsibilities for providing outreach services, emergency accommodation and other essential services are also an important part of developing local solutions.

Aboriginal Strategic Direction audits

Last year we finalised our four year program of audits of 36 local area commands to assess the implementation of the NSWPF's *Aboriginal Strategic Direction 2003–2006.* At the end of 2008 we will start monitoring implementation of the new *Aboriginal Strategic Direction 2007–2011.* The new policy includes specific objectives requiring police to focus more closely on developing effective strategies to deal with sexual assault and Aboriginal substance abuse. Both require police to foster closer links with agencies that can help them address these issues. Our audits will focus specifically on progress in improving outcomes in relation to these two new objectives.

Child sexual assault

To help us develop our audit strategy, we met with the Department of Aboriginal Affairs to gain an understanding of their coordinating role for the *NSW Interagency Plan to tackle child sexual assault in Aboriginal communities*. Given the sensitive and complex nature of the subject matter, we also consulted with 233 people from communities in 30 towns across NSW to seek their input about our proposed audits. We gathered information about the impact of child sexual assault on the community, and discussed current and proposed strategies and support services.

Our consultations highlighted some key challenges, including the need:

- for police and the community to work in a more unified way to address child sexual assault and substance abuse in their local communities
- to encourage Aboriginal communities to talk about child sexual assault — the issue is overwhelmingly still not being discussed
- for awareness/education programs and empowering community members to make a stand and speak out against child sexual assault
- to increase the knowledge of community members about available services and programs, and make these services more culturally appropriate or accessible.

Although the NSWPF has a clearly defined role, they are only a small part of the overall picture. Our future audits may need to include the many mainstream organisations that provide services to Aboriginal people.

Police Aboriginal Strategic Advisory Committee

The Police Aboriginal Strategic Advisory Committee (PASAC) is the main forum for showcasing good practice police work with Aboriginal partners at a local and corporate level, and for raising and addressing any impediments to improving police work in Aboriginal communities. It has also proved an effective avenue for tracking progress on other police work — such as the long-awaited *Aboriginal Employment Strategy 2008–2011* that brings together a number of police initiatives to promote Aboriginal school retention and employment opportunities. Our 2005 report to Parliament, *Working with local Aboriginal communities*, highlighted the value of linking Aboriginal employment and training programs with targeted crime prevention strategies and other police priorities. Our participation in PASAC helps us track progress on various youth diversion, school retention and youth mentoring programs, models for coordinating domestic and family violence investigation and prevention initiatives, and other police work with Aboriginal people.

Special Commission of Inquiry into Child Protection Services in NSW

Our submissions to the Special Commission detailed a number of important opportunities for police and other agencies to play a more active role in linking Aboriginal communities with the programs and services needed to address long-standing issues and improve outcomes for Aboriginal children. These are set out in our submissions on interagency cooperation and Aboriginal communities. For more details about these submissions, see Chapter 3: Children and young people.

For more details about our work with Aboriginal communities, see Chapter 1: Community engagement.

Policing domestic violence

This year we continued to closely monitor the implementation of the recommendations in our 2006 special report to Parliament, *Domestic violence: improving police practice.* In mid 2007, the NSWPF established a steering committee to oversee the implementation of the recommendations. It included separate working parties focusing on human resources, standard operating procedures, legal issues, and education and training. We attend regular meetings of the committee and provide detailed advice and feedback where appropriate. For example, we have commented on new draft standard operating procedures, revised domestic violence liaison officer position descriptions, and reviewed proposals for locating 35 new positions targeting domestic violence.

How our recommendations have been implemented

In December 2007, we wrote to the Commissioner of Police to commend the progress police had made in implementing our recommendations. This progress includes:

- A significantly expanded domestic and family violence team within the NSWPF to better develop and monitor the capacity of police to respond to domestic violence. The team became operational in April this year and will have a particular focus on responding to repeat offenders.
- A comprehensive review of all domestic violence training for police. New courses have been developed for general duties officers and domestic violence liaison officers and these have begun to be delivered. A new course for supervisors and another focusing on Aboriginal family violence are being developed. Police in 'high risk' commands will be required to undertake annual domestic violence training.

- The introduction of and recruitment for a new domestic violence prosecutions coordinator position. This position is responsible for developing, trialling and monitoring good prosecution practices, providing expert legal advice to prosecutors, monitoring the overall quality of briefs and reasons for failed prosecutions, and providing training to prosecutors.
- The progressive rollout of domestic violence evidence kits, and associated standard operating procedures, to all commands to help police investigate and prosecute domestic violence.
- The development of new and comprehensive domestic violence standard operating procedures (SOPS). The SOPS were due for release earlier this year but were delayed following the announcement of the Wood Inquiry into Child Protection Services in NSW. The inquiry is likely to impact on police procedures in relation to child protection — a key aspect that police must consider when responding to domestic violence — but we have encouraged the NSWPF to consider releasing the new SOPS in electronic form as soon as possible, with a temporary caveat on those sections addressing child protection issues.

Since the tabling of our report in Parliament, new domestic violence legislation has also been introduced. Among other things, the *Crimes (Domestic and Personal Violence Act) 2007* includes provisions to better protect children affected by domestic violence. Part 9 of the Act requires the court to include any child in a domestic relationship with the adult as a protected person under any apprehended domestic violence order (ADVO) taken out on behalf of that adult, unless there are good reasons for not doing so. The Act also includes measures to protect children during ADVO court proceedings.

Our ongoing role

Half of the recommendations in our report have now been implemented by the NSWPF. We are closely monitoring their progress in implementing the remainder. Of particular importance are our recommendations that they develop a good practice framework for commanders and a publicly available code of practice. We have had a number of detailed discussions with police about the basis for these recommendations and have communicated our views about what the framework and code should include. We have also participated in several meetings with the NSWPF and other relevant agencies about developing a cross agency domestic violence risk assessment tool.

In March 2007, the Premier announced funding for 35 new police officers to target domestic violence in 'high risk' areas. The positions will become operational in 2009–2010. In feedback to the NSWPF about their proposed locations for these officers, we have emphasised the need to take a range of factors into account. These factors include the particular needs of regional and remote locations, per capita rates of domestic violence, communities in which domestic violence is known to be highly under-reported, and the needs of communities with significant Aboriginal populations.

In September this year we addressed a domestic violence stakeholder forum convened by the NSWPF to explain our ongoing role in monitoring the implementation of our recommendations. At this meeting, NSWPF sought the views of stakeholders about the development of a domestic violence code of practice. They also provided information about how they are ensuring that police officers respond appropriately to domestic violence situations when there is a need to correctly identify the 'primary aggressor'. We have had a number of discussions with the NSWPF about this issue, based on information and concerns communicated to us by stakeholders, and have emphasised the need for police to be provided with advice and training that adequately addresses it.

Domestic homicide review process

We support the establishment of a domestic homicide review process in NSW. We believe that such a process has the potential to improve the collective understanding and knowledge of agencies, including the NSWPF, about how domestic homicides come to occur and what strategies and practices may reduce the risk of them happening. There have been a number of domestic homicides this year and renewed calls for a review process to be introduced. We have recently written to the Premier to reiterate our support for a domestic homicide review process and ask for information about the progress of the government's consideration of such a process. We will continue to monitor developments in this area.

Reviewing legislation

Current legislative reviews

Since 1998, Parliament has asked the Ombudsman to review the implementation of more than 20 new laws. Our review function requires us to look closely at the agencies and people affected by certain new laws to check that the powers are being exercised in a proper, fair and effective manner. If we identify any problems or inconsistencies with the use of the powers, we make recommendations to the appropriate minister. See Appendix B for a list of our legislative review activities in 2007–2008.

During the year, we worked on six legislative reviews of laws conferring new police powers.

Review of emergency powers to prevent or control disorder

In September 2007, we provided the Attorney General and the Minister for Police with a report on our 18 month review of the exercise of powers conferred on police officers under the Part 6A emergency powers inserted into the *Law Enforcement (Powers and Responsibilities) Act 2002.*

Part 6A gives police emergency powers to deal with actual or threatened large-scale public disorder. These powers were enacted in direct response to violence that occurred at Cronulla, Sydney on 11 December 2005 and the reprisal attacks in the southern and eastern suburbs of Sydney in the days that followed.

Since then, the Part 6A powers have been used on just four occasions. Our review found that police acted in a responsible and appropriate manner on these occasions. However as some powers are yet to be used at all, the operational value of all the provisions and their possible shortcomings could not be fully evaluated. We concluded that certain changes should be considered if Parliament decides to retain the powers.

The 14 recommendations in our report aimed to improve fairness to the community and the effectiveness of police. They included proposals to:

- Strengthen safeguards, especially for when and in what circumstances the powers could be used.
- Provide much clearer direction on when — and for how long — police can shut down liquor outlets, allow people to enter or leave a lockdown area and seize vehicles, mobile phones and other items.
- Clarify police authority to seize items such as sporting equipment and other everyday items that could be used as weapons during a riot.
- Provide police with clearer direction on seizing and returning vehicles and mobile phones.
- Simplify the recording requirements.

We also recommended the ongoing review of future uses of these 'extraordinary' powers.

The NSW Government supported almost all of our recommendations. The only one not supported was a proposal for police to apply a 'reasonable suspicion' test in determining who should be searched in a lockdown area. The government reasoned that the powers would rarely be used and that other safeguards, including ongoing Ombudsman oversight of the powers, would be sufficient to address the concerns raised.

Updated Part 6A legislation was introduced in Parliament in December 2007. It included a requirement that the Ombudsman 'keep under scrutiny' any exercise of powers and report annually on this work.

Immediately after the introduction of the legislation, we implemented interim reporting arrangements in which police agreed to advise us of any uses of the powers. In January 2008, we proposed arrangements to facilitate the provision of information about uses of Part 6A powers. By the end of June 2008, the NSWPF had not yet provided us with a formal response to this proposal.

There have been no further uses of the power up to the end of the reporting year.

Terrorism reviews

In 2005, Parliament added two new parts to the *Terrorism (Police Powers) Act 2002* providing for preventative detention orders and covert search warrants. Under Part 2A, a person can be detained by court order for up to 14 days to prevent — or preserve evidence of — a terrorist act. Part 3 allows the NSWPF and the Crime Commission to carry out covert search warrants to prevent or respond to a terrorist act.

We consulted widely with the agencies directly involved in these changes — including the police, the Department of Corrective Services, the Department of Juvenile Justice and the Crime Commission. We negotiated information exchange agreements, monitored police implementation, attended relevant meetings, inspected records and observed detention facilities. In April 2007 we published an issues paper and received 34 submissions from government agencies, interested organisations and individuals.

To ensure procedural fairness and accuracy, we sent a consultation draft of our report on the exercise of covert search warrant powers and our interim report on preventative detention orders to the relevant agencies in February 2008. Final comments were not received till July. We issued our report to the Attorney General and Minister for Police in September 2008.

Drug detection trial

This year we finalised our review of the *Police Powers (Drug Detection Trial) Act 2003.* This Act gives police the power to set up roadside check points in outer metropolitan areas of NSW and randomly stop and screen vehicles with drug detection dogs. A senior police officer may authorise a drug detection operation if there are reasonable grounds to suspect that an area is being regularly used to supply prohibited drugs and there is suspected criminal activity.

We monitored the use of the legislation for the first 12 months of operation and provided our report detailing research activities, findings and recommendations to the Attorney General, Minister for Police and the Commissioner of Police in June 2008. It was tabled in Parliament on 21 August 2008.

CINs review

This year we started a review of the penalty notice provisions of the *Criminal Procedure Act 1986*. These provisions extend the criminal infringement notices (CINs) scheme that was previously trialled (and reviewed by the Ombudsman) in 12 local area commands. The scheme gives police the option of issuing an on-the-spot penalty notice to adults for certain minor offences such as offensive language, offensive conduct and some stealing related offences.

This review requires us to scrutinise the impact of the CINs scheme on Aboriginal and Torres Strait Islander communities.

We are in the process of analysing CINs data from the NSWPF, and have begun conducting consultations on the impact of CINs with a range of key stakeholders — including police and Aboriginal and Torres Strait Islander community workers in regional and metropolitan areas. Submissions from the public will also be invited. For more details about this review, see Chapter 1: Community engagement.

LEPRA

Between 1 December 2005 and 30 November 2007, we reviewed the implementation of certain parts of the *Law Enforcement (Powers and Responsibilities) Act 2002*. The police powers under review were those relating to personal searches on arrest or while in police custody, the establishment of crime scenes, and the provisions regarding notices to deposit-taking institutions to produce documents.

During the review period, we conducted focus groups with a wide range of police in the 13 local area commands we visited — and interviewed, surveyed and met with various stakeholders, interest groups and specialist policing units. We also observed police doing their work to gain valuable insight into the practical operation of the legislative provisions under review.

We anticipate that our final report on the exercise of these powers will be delivered to the Minister for Police and the Attorney General in the latter part of 2008.

Survey of people facing charges

As part of the LEPRA review, we also undertook some important research which involved surveying people facing charges in the local and Children's Courts. We wanted to find out about police searching practices from the perspective of those who had experienced them first hand. A team of 18 Ombudsman staff conducted 463 surveys at 12 local and two Children's Courts between September and December 2007. The survey contributed to our review of the LEPRA powers, but also raised many issues beyond the scope of the review which provided us with other areas for possible investigation in the future.

Achieving positive results

In 2005, we began to systematically monitor the implementation of the recommendations in our legislative review reports. This year, we examined the implementation of 119 recommendations made to the NSWPF since we began the monitoring project. We found that police have either implemented, partially implemented, or are in the process of implementing 80% of these recommendations.

A further 62 recommendations — involving operational policing practice made in our reviews of the *Crimes (Forensic Procedures) Act 2000* and the *Law Enforcement Legislation Amendment (Public Safety) Act 2005* — are to be addressed by whole-of-government responses that are in the process of being finalised.

The provisions in relation to internally concealed drugs were repealed, effective from December 2007. This was the main recommendation of our legislative review of the *Police Powers (Internally Concealed Drugs) Act 2001*, tabled in Parliament in November 2005.

We have also been monitoring the implementation of recommendations made to other NSW government agencies. Since 2005, we have made 43 recommendations to the Department of Corrective Services — 77% (33 of 43) of these have been implemented, partially implemented, or are in the process of being implemented. The Department of Juvenile Justice has implemented, or is in the process of implementing, 79% (11 of 14) of our recommendations to them.

Witness protection

The witness protection program was established under the *Witness Protection Act 1995* to protect the safety and welfare of Crown witnesses and others who have given information to police about criminal activities. The Ombudsman is responsible for hearing appeals about the exercise of certain powers and handling complaints from people participating in the program.

Appeals

The NSW Commissioner of Police has the power to refuse someone entry to the witness protection program or remove them from the program. A person directly affected by such a decision can appeal to the Ombudsman. The Ombudsman must determine an appeal within seven days of receiving it and our decision overrides the Commissioner's decision. This year we received no appeals under the Act.

Complaints

Every person taken on to the witness protection program has to sign a memorandum of understanding with the Commissioner of Police. This memorandum sets out the basic obligations of the participant and includes provisions such as:

- prohibitions from engaging in specified activities
- arrangements for family maintenance, taxation, welfare or other social and domestic obligations or relationships
- matters relating to their identity
- the consequences of failing to comply with the provisions of the memorandum.

The Witness Protection Act states that witnesses must be informed they have a right to complain to the Ombudsman about the conduct of police in relation to any matters covered in the memorandum.

Historically, we have received only a few complaints from participants in the witness protection program. When complaints have raised systemic issues, the police have responded positively and resolved those issues. This has contributed to the noticeable improvement in the management of the program and a related decrease in the number of complaints we receive. This year we dealt with only two complaints related to the program.

Juvenile justice 6

We recognise the particular difficulties young people — and especially those in detention have in making complaints. We therefore do our work concerning juvenile justice a little differently. Young people in detention do not need to write to us to complain. We can take an oral complaint from them over the telephone or in person. We regularly visit all juvenile justice centres, taking complaints and talking to detainees about what we do. We also talk regularly to senior staff at the Department of Juvenile Justice to make sure we are aware of any particular problems or significant changes that are planned. Letters between our office and a young person in detention attract professional privilege which means they cannot be opened or read by anyone else.

Highlights

- Made 17 visits to juvenile justice centres in NSW, visiting each of the eight full-time centres twice and the part-time centre once.
- Consulted with police, juvenile justice staff, solicitors, magistrates and the Children's Court about overcrowding issues in centres and changes to the *Bail Act 1978*.
- Produced a fact sheet for Department of Juvenile Justice staff explaining the type of complaints we handle and how we deal with them, and the important role staff can play in resolving complaints at a local level.

Complaint trends and outcomes

This year there was an increase in both formal and informal complaints (see figure 38). While the majority of complaints from detainees continue to be received on visits or over the phone, there has been a 50% increase in the number of formal complaints we have taken this year. This is largely due to our increased focus on improved service delivery to young complainants. Rather than requiring a young person to write to us, we will now take an oral complaint over the telephone. We conducted 99 preliminary investigations this year as a result of formal complaints received, up from 49 last year.

Figure 37 — What people complained about

This figure shows the complaints we received in 2007–2008 about juvenile justice centres, broken down by the primary issue that complainants complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Probation/parole	0	1	1
Mail	0	3	3
Community programs	0	1	1
Child abuse related	0	0	0
Case management	3	5	8
Transfers	1	12	13
Enforcement	0	0	0
Records/administration	2	2	4
Fail to ensure safety	4	1	5
Daily routine	22	73	95
Food and diet	4	19	23
Visits	13	10	23
Issue outside our jurisdiction	0	5	5
Unfair discipline	14	21	35
Day/other leave/works release	1	5	6
Object to decision	2	0	2
Legal problems	0	2	2
Segregation	1	4	5
Security	0	3	3
Other administrative issue	7	23	30
Information	3	3	6
Officer misconduct	9	25	34
Customer service	0	0	0
Buy-ups	0	1	1
Work and education	2	8	10
Property	5	8	13
Medical	6	8	14
Total	**99**	**243**	**342**

Figure 38 — Five year comparison of matters received and finalised

Matters	03/04	04/05	05/06	06/07	07/08
Formal received	25	19	41	49	99
Formal finalised	25	21	44	47	98
Informal dealt with	318	216	257	219	243

Figure 37 gives a breakdown of the issues complained about. The majority of complaints were about daily routines in centres, food and diet, visits and discipline. Problems are likely to have arisen more often this year due to the overcrowding experienced in juvenile justice centres. While department and centre staff have worked hard to manage the increased numbers, it is not surprising that this situation has resulted in more complaints (see 'Numbers in custody' for more detail).

A typical visit

There are nine juvenile justice centres in NSW. Eight are full-time and one operates on a needs basis. This year we made 17 visits, going to each of the full-time centres twice and the part-time centre once.

We arrange a visit a few weeks ahead with the manager of the centre. We send posters advertising our visit for display around the centre and detainees are told they can put their names down to see us or approach us on the day. Generally two staff go on each visit and this often includes an officer from our Aboriginal Unit. Sometimes someone from our workplace child protection area also attends.

When we arrive at the centre we talk to the centre manager and other senior staff about how the centre is going, any particular problems or challenges they are dealing with, and any issues that might be raised with us during the day. We interview the detainees who have put their names down to see us in a private interview room so they can speak freely.

We also inspect the centre's accommodation units, common areas, holding rooms, rooms used for strip searches, and program and activity areas as well as the gym and sports facilities. While we are inspecting the centre, we talk to any detainees who want to chat to us and can arrange to talk with them privately if appropriate. Sometimes we also talk to the Justice Health nurse or visit the school.

The operation of centres is tightly regulated and staff are required to document many of the tasks and procedures that occur every day. For example, if a young person misbehaves staff must complete a report detailing the nature of the misbehaviour and who was involved — and recommend a punishment from among those set down in legislation. This is then considered by a more senior officer and a final decision made. Similarly if a young person is

placed in segregation or force is used, a report must be completed. We inspect a random sample of these records during our visit to gain additional information about how the centre is operating on a day-to-day basis and to check that staff are being appropriately supervised.

Before we leave, we meet with the centre manager again to go through the complaints raised by detainees as well as broader systemic issues we have identified during our day at the centre. We confirm these issues in writing and ask the centre manager to report back to us on action taken. Often complaints are about issues common to all institutions such as food, clothes and visits. Other issues raised with us this year include young people requesting transfers to a centre nearer their family, delays in gaining a place in a centre school, and complaints about unfair punishments.

Case study 46

Following a phone call from our office, centre staff arranged for a young detainee to be placed under close supervision for his own safety. The young man had telephoned us about being bashed by other detainees and was scared. He said he had not told anyone about what was happening because he did not want to be a 'snitch'. We explained the centre could not help him unless he told them what was happening. He agreed we should call the centre and ask a member of staff to see him. The centre called us back to confirm they had done this. They had not been aware the young person had been having any problems. As well as talking to the detainee, they had looked at the CCTV footage in the unit. While the footage did not show him being hit, staff were satisfied he was genuinely fearful and arranged for him to be closely supervised.

Fact sheet for juvenile justice staff

During visits to juvenile justice centres, we often talk to youth officers and a number of times this year we have been invited to speak with groups of new staff about our work. As a result of these discussions, we realised that few centre staff knew about the broad range of functions we have. Indeed, many thought that detainees could only talk to us about complaints concerning juvenile justice. To address this we have produced a new fact sheet for staff who work for the Department of Juvenile Justice explaining the type of complaints we deal with, how we deal with them, and how they can support young people to make complaints. The fact sheet emphasises our focus on resolving matters as informally as possible at a local level, as well as the important role staff can play in resolving complaints (see case studies 46, 47 and 48).

Numbers in custody

Over the last two years there has been an increase in the number of young people in custody. We have reported on this trend in our last two annual reports. This year the problem of overcrowding has become acute.

Although it is a court that decides a young person should be placed in custody, the Department of Juvenile Justice is responsible for accommodating them. Each juvenile justice centre is designed to accommodate a particular number of detainees. When there are more than this, young people may have to sleep on mattresses on the floors of other detainees' rooms or in holding, admissions and interview rooms. Accommodating additional detainees in this way has a range of possible consequences including:

- an increase in minor misbehaviour and an increase in the seriousness of punishments being given
- an inability to accommodate detainees near their families
- delays in starting new unit based programs
- delays in getting places in school, including for young people of compulsory school age
- a shortage of escort staff to take detainees to medical appointments
- lack of holding room space for detainees who need to be confined or segregated
- increased pressure on resources, including bedding and clothes
- a significant use of overtime, leading to staff tiredness and irritability.

Case study 47

This year we received a call from a detainee in a juvenile justice centre to complain that he could not make any legal calls as the detainee automatic phone system was blocking him. He told us he spoke with unit staff and nothing had happened. We immediately telephoned the centre manager who found a problem with the system affecting all detainees at that centre. The manager resolved the problem by providing detainees with alternative phone access to make legal calls while the technical problem was fixed.

Case study 48

Instead of wasting more time looking for paperwork he realised had been lost, a youth officer acted promptly to resolve a detainee's complaint that he had heard nothing about his request for his cousin to be approved as a visitor.

The young person told us he had asked about his application a number of times but staff had told him he would just have to wait. The detainee had done the right thing in trying to resolve the problem with the centre first. As this had not worked, we called the centre and asked what was happening with his application. The officer who looked into it could trace the paperwork up to a certain point, but then it seemed to have been lost. To solve the problem he got the detainee to complete a new application, emailed the form to his juvenile justice officer for approval, and hand delivered the request to the centre manager for sign off. This was all done within 24 hours and arrangements were then made for the cousin to visit at the weekend.

Overcrowding increases the risk of serious incidents occurring. There are particular risks associated with detainees sharing rooms, especially when they have been recently admitted to a centre and their behaviour is not well known.

Juvenile justice has a focus on programs and meaningful activities. The ability of centres to provide these is severely tested by the extra numbers in spaces not designed to hold so many people.

In the course of our work we have consulted with police, juvenile justice staff, children's solicitors, Children's Court magistrates and officers of the Children's Court to better understand the reasons for the increased numbers in custody. There is general agreement that the increase has been caused by a number of factors, particularly changes to the *Bail Act 1978* which make it more difficult for some young people to get bail and the proactive policing of compliance with bail conditions.

Although measures are now being put in place — somewhat belatedly — to provide additional beds, we remain concerned at the adequacy and appropriateness of some of the arrangements. We will be closely monitoring what happens in the centres.

Transfers to an adult correctional centre

Recent amendments to the legislation concerning children in detention mean that certain categories of detainees over the age of 18 may be transferred to an adult correctional centre. The existing legislation permitted some over 18 year olds to be moved from a juvenile justice centre to the adult corrections system. The changes have added some new grounds — and therefore potentially increased the number of young people aged between 18 and 21 who will be accommodated in an adult prison. We will be closely monitoring the implementation and impact of these changes.

Changes to the incentive scheme

This year the Department of Juvenile Justice has started to roll out a new incentive scheme. Incentive schemes are based on the idea of a token economy and used as a means of behaviour management. Previously each centre had its own scheme with differing ways of calculating rewards. The new system means common terms will apply in all centres, making it much easier for detainees who move between centres. It also places much more emphasis on improving behaviour. Weekly meetings must be held with each detainee to discuss their behaviour and to set targets for the coming week. In the past, we have been critical of a sometimes blurred line between incentive schemes and the disciplinary system. Although the new scheme is in its infancy, early reports seem positive. We will continue to monitor the new scheme through our visits to centres and general complaint-handling work.

Corrections 7

In an environment of ever increasing prison populations and the resulting impact on the resources and the staff of the Department of Corrective Services (DCS), the role of the Ombudsman as an independent oversight body is critical to ensuring that inmates, their families and friends have an avenue through which to raise issues and make complaints. Sometimes people think our role is to advocate for inmates, but that is not the case. As with our work across all NSW government agencies, we are an advocate for good public administration. In the context of the corrections system, this means administrative practices that result in a fair, reasonable and humane correctional system.

Highlights

- After our inquiries, the Department of Corrective Services reviewed their compassionate leave policy and procedures to include the involvement of the Aboriginal Planning and Support Unit and allow for the approval of compassionate leave at a regional level.
- Made suggestions to devise and adopt appropriate timeframes for responding to inmate applications for classification reviews, and these were accepted and implemented by the Commissioner of Corrective Services.
- Spent 167 days visiting 28 different correctional centres around NSW, meeting with inmates and staff.
- Visited the High Risk Management Unit every six months and raised concerns about the management of inmates with mental health issues.
- Worked with Justice Health to address issues such as behaviour management and poor access to dental services.

The Ombudsman Act makes provision for people who are detained by a public authority to have direct access to the Ombudsman to make a complaint. It specifies that contact between a person in custody and the Ombudsman must be outside the ordinary security restrictions that cover inmate contact with other people. This is a clear indication from the lawmakers of our state of the importance of an independent, external complaints system for inmates — one that ensures that any complaint they make, regardless of its seriousness, will be independently and effectively considered and appropriate action taken. A correctional centre is a very closed environment and it can be a difficult decision for an inmate to make a complaint about the actions of people who control every aspect of their daily life. This makes our role as an independent oversight agency especially important.

To provide independent and effective action on complaints, we have a team of staff who deal only with complaints and issues relating to the correctional system. As the number of people who spend some time in custody in NSW continues to grow — in June 2008 there were approximately 9,800 people being held in correctional centres and court cells across the state — a specialised team has proved to be the most efficient way to manage the many thousands of contacts we have from inmates, their families and friends. Most of these contacts relate to the conduct of the Department of Corrective Services (DCS), the GEO Group (that operates Junee Correctional Centre) and Justice Health. We also receive complaints from many of the 18,000 or so people who come under the Community Offender Services arm of DCS. This covers parole supervision, periodic detention, home detention and community service orders.

Our staff understand the complex environment of correctional facilities and spend significant amounts of time inside the centres speaking with inmates and staff to resolve issues and improve processes and procedures. Their familiarity with relevant legislation, policies and procedures means they can often provide immediate advice and clarification on issues brought to them. Many times this means that a formal complaint is not made, as the inquiry can be resolved right away.

In the past year, changes have been made to the way we work with the official visitors who are appointed by the minister to go to correctional centres and interview staff and inmates about complaints. We have always regarded our contact with official visitors as fundamental to ensuring that the complaints of inmates are monitored. Although official visitors have no capacity to investigate complaints as we do, they are a vital resource for both inmates and our office. Our reduced access to official visitors has the capacity to diminish the system of oversight in the NSW correctional system.

Complaint trends and outcomes

The complaints and inquiries we receive in the corrections area range from complaints about food and access to treatment programs to serious allegations of criminal or other misconduct. Our objective is to resolve each complaint cooperatively, in consultation with the department and the inmate.

More serious allegations however may be investigated in a number of ways, and we can use our own motion investigative powers if we become aware of an issue that causes us significant concern.

This year we made a series of inquiries with DCS using our own motion powers, after identifying trends in a number of contacts and complaints we were receiving. Often, the complaints or inquiries we received were relatively minor when taken on their own. However once the contacts were analysed, certain common issues were identified and we needed to make further inquiries. The following sections show the range and complexity of the issues and complaints we deal with in the corrections area.

Despite a continuing increase in the number of people in custody, overall complaint numbers remained relatively stable when compared to 2006–2007.

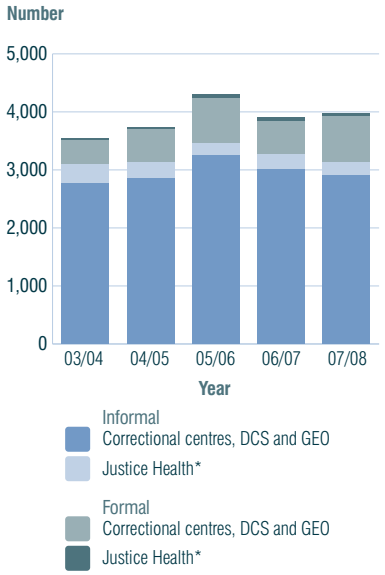
However, the proportion of matters we received as formal complaints increased by 38% (see figure 39). A significant number of these formal complaints were made to us by phone.

As can be seen in figure 41 (see over page), the main areas of complaint involve the daily routine in correctional centres as well as property, visits and transfers. There has been a considerable increase in complaints received about work, education and 'buy-ups', along with a noticeable increase in informal complaints about periodic and home detention. On a positive note, the number of complaints alleging officer misconduct, as well as those about segregation, has dropped.

We finalised preliminary or informal investigations of 692 complaints, an increase of approximately 31% from last year (see figure 40). We achieved a positive outcome in 440 of these matters, including having errors acknowledged and corrected, apologies given, the payment of compensation, and reasons for decisions being provided. In many cases we were able to provide further information to the complainant that helped them to better understand a decision or the reason why certain things had happened.

The number of complaints received about individual correctional centres is set out in Appendix I. In the ten months after it opened in August 2007, we received 229 complaints about Wellington Correctional Centre — the major issues of complaint are covered elsewhere in this chapter. The number of complaints we received about the Metropolitan Special Programs Centre (MSPC) were much higher this year than previously, as were those about Broken Hill Correctional Centre. Reasons for such variations are not always easy to detect but they are taken into consideration when we prepare our schedule of visits to centres.

Figure 39 — Formal and informal matters received about correctional centres and Justice Health — five year comparison



* Justice Health provides services in both Correctional Centres and juvenile justice centres. For simplicity, all Justice Health matters are reported in this figure.

Compassionate leave

We were contacted by many inmates who had not been given compassionate leave by the department to attend the funeral of a family member. In one case, the inmate was not told about his mother's death until the following day. This meant that the paperwork was not done in time for a decision to be made before her funeral. Another inmate was refused permission to go to his grandmother's funeral because staff did not believe they had a sufficiently close relationship.

Our inquiries involved looking at the department's policy and the timeliness of the procedures used to make decisions about who should go to funerals and in what circumstances permission was granted. The department's response revealed that the majority of applications were not approved because the deceased was not an immediate family member, or because there was too great a security threat if the inmate was allowed to attend. After our inquiries, DCS reviewed their compassionate leave policy and procedures and we were pleased by a number of changes — including involving the Aboriginal Planning and Support Unit to help staff to determine kin relationships within Aboriginal communities.

The revised policy also allows for compassionate leave to be approved at a regional level, rather than by a centralised officer as was previously the case. A local delegation to make a decision about leave, along with the ability to email applications, will result in a faster approval process. For cases where inmates are not granted permission to attend a funeral, the new policy also guides staff on other ways the inmate can be helped to honour the occasion.

Figure 40 — Formal complaints about corrections finalised in 2007–2008

Access to education

This year we received an increasing number of complaints from inmates about education related issues. Some complained about being unable to access any education programs and others complained that they were enrolled in education in one centre and then transferred to another where there was little or no ability for them to continue with their studies.

Figure 41 — What people complained about

This figure shows the complaints we received in 2007–2008 about correctional centre concerns, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Probation/parole	24	84	108
Court cells	1	2	3
Mail	18	74	92
Community programs	1	4	5
Child abuse related	0	0	0
Case management	46	102	148
Transfers	48	182	230
Records/administration	54	80	134
Fail to ensure safety	16	42	58
Daily routine	118	437	555
Food and diet	16	57	73
Visits	52	208	260
Issue outside our jurisdiction	12	30	42
Unfair discipline	20	98	118
Day/other leave/works release	16	21	37
Legal problems	11	46	57
Periodic home detention	4	19	23
Segregation	19	44	63
Security	5	39	44
Other administrative issue	19	229	248
Complaint-handling	1	0	1
Information	20	66	86
Classification	32	178	210
Officer misconduct	49	149	198
Buy-ups	45	153	198
Work and education	23	98	121
Property	77	286	363
Medical	32	174	206
Total	**779**	**2,902**	**3,681**

When we made inquiries, we were invited to a meeting with departmental staff to see and hear first hand the measures being introduced to track each inmate's progress through education and therapeutic programs. A new database is accessed by offender services and programs staff at the end of each day to record when an inmate has attended an education or program session, as well as when they have completed a module. This data will be of great assistance to both program and parole staff in monitoring and reporting on inmates and assessing the availability of programs if a prisoner is transferred.

There are many educational services and programs available in the correctional system and the new database is an improvement on the haphazard way information was previously collected. DCS advised us that most inmates who want to attend education will be given access. However there remains a significant number who will not have access, particularly at centres that find it difficult to attract and retain sufficient staff to provide the services identified for that centre. This is especially the case at the newer regional centres.

Inmate classification appeals

Several inmates from the Dawn De Loas Centre had appealed against decisions made about their classification. The inmates had followed the standard procedure for lodging their appeals, but after many weeks they had not heard anything more. Staff at the centre were unable to find out anything further about their appeals and, as the time approached for their next classification, the inmates were worried their original appeals had not yet been decided. We made some inquiries with centre staff and found that the appeal documents had to be sent out of the centre to a number of other areas of the department for approval — and there were no specific timeframes for processing the documentation.

As the Dawn De Loas Centre is relatively small, it does not have a designated Classification and Case Management Review Coordinator who would monitor these applications. We wrote to the Commissioner and were sent the information about the appeals process and the outcomes for inmates. In spite of this, we remained concerned about the procedures generally so we suggested to the Commissioner that he devise and adopt appropriate timeframes for responding to applications for classification reviews. The Commissioner accepted our suggestion and has implemented timeframes. These timeframes will also be supported by the roll out of the department's electronic document management.

Weekly 'buy-ups'

Several inmates from a remand unit at Parklea Correctional Centre called when they did not receive their weekly buy-up. They had put in their order forms but when the buy-up providers arrived there were no parcels for them. Buy-up is an important part of the inmate week because it is when they receive the toiletries, tobacco and other goods they have purchased. The inmates had tried to resolve the problem and been told that the buy-up provider did not receive any of their purchase forms. No reason could be

found for this, but staff in the unit did not have the authority to make any further decisions to help resolve their problem. We contacted the General Manager who agreed to issue these inmates with new forms and authorise the provider to supply their buy-ups within the next few days.

Wellington Correctional Centre

When Wellington Correctional Centre opened in August 2007, we were contacted by many of the inmates transferred there. Most of the issues raised related to 'teething problems' that can be expected when a new building opens, housing hundreds of people and staffed by many new employees. By November 2007, however, Wellington inmates began to complain about being placed into segregation, without knowing why or for how long and without any segregation order. Also, several inmates in the mainstream accommodation units complained about the size of the cells and especially the inclusion of a second bunk in a cell that was clearly built for only one person.

Our initial inquiries with the centre found the inmates were being put into a behaviour management program run in a separate pod from the mainstream accommodation, not the identified segregation unit. They were not placed on a segregation direction while in the program unit, but in the behaviour management unit (BMU). We visited Wellington Correctional Centre in February and observed the BMU as well as the mainstream cells where the inmates had complained about the second bunk.

We were particularly concerned the BMU was similar to other short term management programs the department had operated several years earlier. As a result of previous investigations conducted by the Ombudsman, it was determined that participants housed in these units had been illegally segregated.

After our visit to Wellington Correctional Centre, we wrote to the Commissioner using our own motion powers. Shortly after our approach to the Commissioner we were told by inmates that the BMU had been closed. In responding to our inquiries, DCS said the BMU draft program had been discontinued and no inmate would be placed in the BMU until there was a further review of the program. Also, if and when the BMU program is approved, it will only be used to manage inmates on a valid segregation direction back to a normal institutional routine.

We also asked the Commissioner for information about the second bunk in the main accommodation cells that were originally designed to accommodate one person. Our staff who visited the centre noted that a person sitting on the bottom bunk hit their head on the top bunk, there was only space in the cell for the property tubs for one inmate, and there was only one fixed concrete stool in the cell. This meant that only one person could sit at the fixed concrete bench to eat or write.

The Commissioner responded with advice that although the cells did not meet the terms of either the Development Consent from Wellington Council, or clause 22 of the Public Health (General) Regulation 2002, the department had submitted an amended development application to council which was approved. In addition, the Minister for Health issued an order exempting them from the provisions of clause 22 of the Public Health (General) Regulation "subject to the condition that at all times the Department of Corrective Services shall be satisfied that this exemption will not result in adverse effect on the health of persons sleeping in any room or cubicle which is the subject of this exemption". Clause 22 provides that a room or cubicle that is to be occupied for more than 28 days by any person must have a floor area of 5.5 square metres for each person. We had been advised by the department that the standard for single cells (i.e. the original design of these cells) is between 7.5 and 9 square metres. The exempted cells will now potentially house two inmates. We remain concerned about aspects of this issue and we are continuing our inquiries.

Case study 49

An inmate's partner had been banned from visiting all correctional centres and wrote to us questioning the ability of DCS to stop her from visiting him in a public hospital.

The inmate had been transferred to a public hospital and his partner decided to visit because she believed that her visiting 'ban' applied only to correctional centres. DCS became aware of the partner's intention to visit the hospital and allegedly threatened the inmate with removal from the hospital if the visit occurred.

We made inquiries with DCS about the allegations and their authority to stop anyone, including those banned from DCS centres, from visiting public places such as a hospital. The department denied any threat had been made to the inmate. They acknowledged that he had been told that such a visit might cause them to review his situation and location, but that his medical condition would not be compromised.

When inmates need to go to hospital they spend the minimum possible amount of time there. Inmates who are in hospital are not normally entitled to visits, unless for compassionate reasons when their next of kin may be called.

In this case, the inmate had been told to warn his partner not to visit him — especially given her status as a 'banned visitor'. DCS agreed that they did not have any legal authority to stop a person who has had their visiting privileges removed from attending anywhere other than a correctional facility. Given that DCS 'bans' visitors on the basis of their potential or actual risk to the good order and security of a correctional centre, we suggested they look at the relevant provisions of the legislation to see whether any amendments are justified to provide clarification in other circumstances.

Visits to correctional centres

Each year we run a program of visits to correctional centres. This year we spent 167 days visiting 28 different centres. Our visit program puts us in the unique position of visiting nearly every correctional centre at least once every couple of years — with some centres visited much more regularly. As a result, we have developed some very effective professional relationships with many senior managers and staff in these centres which assist in the local and timely resolution of inmate grievances. The visits we make have also given us a first hand appreciation of the culture and environment of most centres, something rarely experienced by those who do not live or work within the correctional system. It can also mean that we look at what happens in the centres with experienced but 'fresh eyes'.

For example, when we visited Kariong Juvenile Correctional Centre we received a complaint from a young man about the conditions in the 'observation' cell in which he had been housed for several days as part of his initial assessment. When our staff inspected the cell, they agreed with the young man that it was unreasonably dirty and that he should have been given more adequate bedding and other facilities.

Over the past year there have been some occasions where many more inmates than we can see have asked for an interview with our staff during a visit. Sometimes when this happens we first meet with the elected inmate delegates to determine if there are any general or 'systemic' issues in that centre. We took this approach when we made our first visit to the newly opened Wellington Correctional Centre, where we had received a large number of inquiries.

Of course we are not the only people who visit correctional centres. Apart from many other authorised or official visitors, each week many thousands of people go to correctional centres across the state to visit their families and friends who are serving time. Inevitably, incidents occur and sometimes visitors have their visiting privilege removed by DCS. This is commonly referred to as a 'visit ban'. One complaint we received this year raised a slightly different implication of a visit ban (see case study 49).

Sex offenders

In 2005–2006 we reported that the length of the waiting list for inmates to take part in sex offender treatment programs was an issue of some concern. The *Crimes (Serious Sex Offenders) Act 2006* had been introduced and it was becoming increasingly apparent that inmates assessed as being 'high risk' would not be released from custody unless they completed the custody based intensive treatment (CUBIT) program. However, the CUBIT program is currently only run at the Metropolitan Special Programs Centre (MSPC) at Long Bay.

Shortly after his appointment, we met with the department's coordinator of sex offender programs. He outlined several changes to be made to the treatment programs to increase the number of participants in any one year. It is now more than a year since the program was changed from a 'closed' group format to one in which inmates can start the program at any stage — as soon as a vacancy arises — and progress at their own speed. The number of inmates completing the program has increased by 30%, but the total number of offenders estimated to complete it each year is still only between 50 and 60.

Case study 50

A man alleged he had been assaulted by DCS officers when force was used on him at a court cell complex. We referred the allegations to DCS for investigation and asked for a copy of their final report. It appeared that DCS had already started investigations into the use of force generally at this court cell complex, and this complaint became part of that broader investigation.

The department's investigation was lengthy and resulted in three recommendations. These were that the two officers involved should be subject to formal disciplinary investigations and processes, and DCS procedures for questioning inmates after a use of force and collecting relevant cell complex camera or video footage should be examined.

We are awaiting confirmation from the department that they have implemented the recommendations made by the investigators.

The waiting list for the CUBIT is over 100 inmates at any given time. Priorities are set based on an inmate's earliest release date, not when they accept referral to the program. As a result, we are now receiving complaints from inmates who applied to take part in the program (some as long as three years ago) in plenty of time to complete it before their earliest release date. These inmates are now being pushed further down the waiting list, causing them justifiable concern as their parole dates approach. We understand it is unlikely that any of the inmates currently in the program will complete it in time to be given favourable consideration for parole at their earliest opportunity.

During the past year, the senior psychologist responsible for the CUBIT program left the department, as did the psychologist running the lower risk CORE program at Kirkconnell Correctional Centre. The MSPC has also introduced a series of regular 'lock-in' days, meaning inmates are locked in their cells and unable to attend the program. Many inmates complained to us that the lock-in days could add as much as three months to the length of time it will take them to complete the program. When we raised the issue of the lock-in days with the coordinator, he agreed they were interfering with the program and had instructed psychology staff to restructure the program to avoid the lock-ins where possible.

The sex offender treatment programs offered in NSW are currently considered to be the most effective way of reducing the risk of serious sex offenders re-offending. While the state is now able to apply to the courts to extend the custodial detention of any 'high risk' sex offender inmate who has not attended a treatment program, it is concerning that the daily routine at the main therapeutic correctional centre cannot be structured to ensure the best opportunity for treating as many inmates, as quickly as possible. We will continue monitoring this important issue.

Court cells

The court cell complexes operated by DCS are considered the 'pointy end' of the correctional system. This is where most people have their first experience of being in custody, and they are often under significant stress. In these circumstances it is imperative that court cell staff have clear guidance from legislation, policy and procedures about how they should do their job — for their own safety and that of the offenders. DCS court cell staff also need regular review by their managers and support from the various specialist units within the department. As the numbers coming into custody continue to increase, people are frequently spending up to the maximum allowable time of seven days in these cell complexes which are, in reality, ill equipped to cater for the needs of inmates.

Case study 51

An offender who had a physical disability affecting his walking alleged he had been assaulted at a court cell complex. He said he was told by officers to walk to a cell and when he refused, because he did not have his usual walking aids available, he was dragged to the cell and forcibly strip searched. We asked DCS to investigate the matter and report back to us. When we received the report several months later, we assessed it as being inadequate and asked DCS to reinvestigate the complaint.

Ultimately, a more thorough report was prepared into the incident. Although the allegation of assault could not be substantiated as there was insufficient evidence available, it was found that court cell staff had failed to identify the incident involving the man as a use of force, and so had not complied with the relevant procedures for reporting. If those procedures had been followed, there may have been sufficient evidence to conclusively determine whether or not an assault had occurred.

It was clear from the investigation that court cell staff could have been more proactive in managing the inmate's stay in the cell. We suggested to the department that they should require their Disability Support Unit to liaise with court cell staff on an ongoing basis about the services they can offer.

High Risk Management Unit

The High Risk Management Unit (HRMU) is the most secure unit within the NSW correctional system and the inmates housed there are subject to very strict daily regimes and intense scrutiny by staff. It is therefore important that we record in this report our contact with them and the corrections staff that work there. Our staff visit the HRMU every six months. This year, the Ombudsman also visited the HRMU. He went to each of the units and met with several inmates who valued the opportunity of explaining to him about their issues and concerns.

We have spoken with HRMU management about the number of inmates in the unit who seem to suffer from mental health issues, including those who occasionally receive assessment and treatment at the forensic hospital. It is sometimes difficult to determine whether these inmates only intermittently need the ongoing psychiatric care and treatment available in the hospital, have been identified as too high a risk in terms of the challenge of managing them, or simply pose too great a risk to security to stay in a hospital environment. There is no doubt, however, that the HRMU does not provide a therapeutic environment for these inmates.

Equally concerning is the number of fires lit in recent years by inmates in the HRMU, potentially causing danger to inmates and staff alike. Some of the fires have been started by inmates suffering from a mental illness. Other fires have been lit by inmates who described it as the only method available to them to express their frustration and exasperation at their life in the HRMU.

Junee Correctional Centre

In recent years we have reported that the number of complaints received from Junee Correctional Centre, the only privately operated centre in NSW, was significantly higher than from other similar sized centres. We have met with staff from GEO, the company that runs Junee, on several occasions to try to find out the reasons for this. One possible cause identified was the physical separation of the inmates from the staff in their office in the accommodation units. When the inmates were in their pods they could see staff in the office, but could not readily contact them. They did, however, have easy access to their phone to call our office and would therefore contact us directly. Junee management suggested they would trial having staff spend a fixed period of time in the pods each day when the inmates were there, specifically to deal with inmate requests and inquiries. The number of calls to our office has since decreased slightly.

Case study 52

When an inmate called from Junee to complain that their toilet roll ration had been reduced, we made immediate inquiries with the centre. Reducing or removing basic necessities such as toilet paper can spark an easily preventable incident in a correctional centre. We were told that each inmate usually received two rolls per week, but if they ran out they could get more from the sweepers (inmate domestic workers) in their pod. The sweepers, however, no longer had a supply and — in the absence of sufficient toilet rolls — they had become gaol currency and were being stolen from cells. When we called the centre they were not aware of any change to the ration of toilet paper and undertook to investigate and rectify the situation immediately.

Justice Health

Medical services in the NSW correctional system (except for Junee) are provided by Justice Health. We do not examine clinical or professional matters, but we do receive complaints from inmates about access to health services. The inmate population is generally highly compromised healthwise and the demand for health services sometimes exceeds the available resources. Justice Health aims to provide a service to the standard equal to that in the community public health system. Sometimes this means a lengthy waiting list to see a doctor, particularly for specialist services, and to attend appointments at hospitals and clinics. As well as contending with waiting lists, inmates and Justice Health staff are reliant on DCS officers to provide escorts to hospital and for appointments, and to ensure that inmates are out of their cells and able to move around their centre to access medical services. This does not always happen and generally causes the inmates who miss out to complain to us.

Case study 53

One inmate complained by phone that he had not received his heart medication as the nurses had refused to give anyone their pills until 'whoever made a rude comment to staff owned up'. We were told about 20 inmates had missed out on their pills. We contacted the clinic and were told the nurses had decided not to hand out medication in the wing where the comment was made until after they had given all other wings their medication. They intended to return to the wing, but had told the inmates they would not get any medication that night. All medication was eventually given to those inmates who needed it.

We were concerned the nurses appeared to have administered collective punishment, and that inmate disciplinary issues should be managed by custodial rather than clinic staff. We wrote to the CEO of Justice Health and were advised that they do not have a policy authorising the refusal of prescribed medication to patients. It was also noted that inmate discipline is the responsibility of DCS. The appropriate way for clinic staff to manage incidents is to log them in the incident information management system and ask DCS officers to control any unruly behaviour by inmates. Justice Health advised they would try to ensure this approach is adopted in future.

Many complaints we receive relate to poor access to dental services. Inmates wanting to see a dentist, either for a check up or because they are in pain, must call a central hotline number and describe their needs. The person on the hotline then 'triages' the inmate and they are given an appropriate place on the dentist's list for their centre. In some centres this can be a very long wait. An inmate who is in pain can visit the clinic for general pain relief, but the nurses are not usually able to give them any more assistance. Significantly, nurses cannot assess an inmate's dental needs and make an appropriate recommendation to the dental hotline staff about priorities. If they could this might improve the service for inmates with serious dental problems. Inmates regularly tell us that they call the dental hotline over and over in an attempt to have their call answered. More often than not the call rings out. Sometimes an inmate's dental problem can deteriorate significantly before they see the dentist and those who seek preventative care will usually be continually reprioritised on the waiting list, unless they are in a smaller centre.

Endnote

Figure 39 — Number of formal and informal matters received about correctional centres and Justice Health — five year comparison

	03/04	04/05	05/06	06/07	07/08
Formal					
Correctional centres, DCS and GEO	412	561	772	566	779
Justice Health*	30	41	80	69	61
Sub total	**442**	**602**	**852**	**635**	**840**
Informal					
Correctional centres, DCS and GEO	2,773	2,852	3,242	3,010	2,902
Justice Health*	327	283	218	266	241
Sub total	**3,100**	**3,135**	**3,460**	**3,276**	**3,143**
Total	**3,542**	**3,737**	**4,312**	**3,911**	**3,983**

* Justice Health provides services in both correctional centres and juvenile justice centres. For simplicity, all Justice Health matters are reported in this table.

Departments and authorities 8

The NSW Ombudsman has jurisdiction over a wide range of NSW public sector agencies — including large agencies such as the Roads and Traffic Authority, the State Debt Recovery Office and WorkCover, and smaller agencies such as the Nurses and Midwives Registration Board and the Public Trustee. This chapter outlines the breadth and scope of the work we do across the NSW public sector to ensure high standards of administrative practice.

Highlights

- Held a complaint-handling forum for all NSW universities to discuss the implementation of our guidelines on complaint-handling in universities, and a number of universities have now implemented these guidelines.
- Completed an investigation into the implementation of the Department of Education and Training's policy and procedure for long suspensions, and made recommendations across four main areas.
- Conducted a survey of complaint-handling systems across all NSW government departments and authorities, and analysed similarities and differences between different size agencies.
- Achieved a broad range of positive outcomes for complainants, as well as improvements to the policies and procedures of the agencies involved.

Our specific work in relation to the Department of Corrections, Juvenile Justice, freedom of information and local government is reported throughout other chapters.

One of the areas we have focused on this year is education, both school and higher education. In addition to dealing with individual complaints about universities and the Department of Education and Training (DET), we have undertaken a number of projects on issues that have the potential to affect a large number of people. Our work on university complaint-handling, international students and the suspension of students from public schools is discussed below.

Complaints trends and outcomes

This year we received 1,348 formal complaints about departments and authorities, a significant upward trend from last year and a number more consistent with the number of complaints we received in 2004–2005 (see figure 42).

Figure 42 — Five year comparison of matters received and finalised

This figure does not include complaints about public sector agencies that fall into the categories of police, community services, local government, corrections or FOI.

Matters	03/04	04/05	05/06	06/07	07/08
Formal received	1,390	1,355	1,329	1,158	1,348
Formal finalised	1,390	1,386	1,317	1,167	1,354
Informal dealt with	4,161	4,414	3,625	3,465	3,962

Figure 43 — Formal and informal complaints received

- Aboriginal Land Councils and services **0.4%**
- Culture and recreation **0.4%**
- Emergency services **1%**
- Environment and natural resources **3.4%**
- Health **6.8%**
- Education **11.2%**
- Transport and utilities **16.8%**
- Law and justice **17.8%**
- Business regulation and revenue **17.9%**
- Planning, property and housing **24.3%**

Planning, property and housing issues were the subject of 24% of complaints (see figure 43). Complaints about business regulation and professional disciplinary bodies were also high. As in previous years, the two largest categories of complaints continue to be about poor customer service and poor complaint-handling practices, with a significant increase in the latter category (see figure 44).

This year we finalised over 800 formal complaints following preliminary investigations and 12 formal complaints through an investigation that involved the use of our coercive powers (see figure 45). As a result of our involvement in these matters we achieved 772 positive outcomes including the department or authority providing reasons for its decision, reviewing its decision, changing its policies and procedures, correcting an error or apologising to the complainant. (Please see Appendix G for a full list of agencies we received complaints about this year and how we dealt with these complaints.)

Performance indicator

Average time taken to assess complaints

Target	2007–2008
90% within 48 hours	94%

Performance indicator

Average time taken to finalise complaints

Target	2007–2008
7 weeks	5.2 weeks

Performance indicator

Complaints resolved through the provision of advice or constructive action by public sector agency

Target	2007–2008
65%	70%

Performance indicator

Percentage of our formal investigation reports recommending changes to law, policy or procedures

Target	2007–2008
90%	50%

This outcome includes suggestions made on three formal investigations that were discontinued. Another three cases were FOI matters where the focus is on release of documents rather than changes to law, policy or procedures.

Performance indicator

Percentage of recommendations made in investigation reports that were implemented by public sector agency/authorities

Target	2007–2008
80%	80%

This outcome includes suggestions made on 3 formal investigations that were discontinued.

Focus on education

Universities

Forum for university complaint-handlers

Our *Complaint-Handling Guidelines for Universities* was released in December 2006, and in November 2007 we hosted a forum for university complaint-handlers to obtain feedback on the implementation of the guidelines. Twenty four complaint staff representing all NSW public universities attended.

Many participants advised that the forum was the first opportunity they had had to discuss how they were dealing with complaints. The first part of the forum was spent identifying key issues arising from our guidelines and exploring how each university currently handles complaints from students and staff. The afternoon sessions dealt with more practical issues facing complaint-handlers — such as complaints that involve multiple parties and unreasonable complainant conduct. We received overwhelmingly positive feedback about the forum and, as a result, a further forum is planned for late 2008.

International students

This year we have received an increased number of complaints from international students studying at NSW universities. The introduction in 2007 of a new *National Code of Practice* under the Commonwealth *Education Services for Overseas Students Act 2000* appears to have contributed to this increase, with more students contacting us to request a review of a university's decision to exclude them from studying at the university. We have been proactive in contacting universities about a number of procedural issues to do with the 'external review' mechanism outlined in the code and our ordinary complaint processes. We have also established a communication protocol with each university for international student complaints and developed an information sheet for universities to give to students at the conclusion of their internal appeal. The information sheet advises students of their rights, the role of the Ombudsman in conducting an external review, and what complaints can be made to us.

Figure 44 — What people complained about

This figure shows the complaints we received in 2007–2008 about NSW public sector agencies other than those complaints concerning police, community services, councils, corrections and freedom of information, broken down by the primary issue that each complainant complained about. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Charges/fees	158	558	716
Contractual issues	81	321	402
Child abuse related	0	3	3
Misconduct	38	59	97
Enforcement	123	173	296
Management	13	61	74
Policy/law	41	179	220
Child protection	0	2	2
Natural justice	15	28	43
Issue outside our jurisdiction	86	267	353
Object to decision	120	554	674
Other administrative issue	4	137	141
Complaint-handling	244	476	720
Information	83	251	334
Approvals	102	302	404
Customer service	240	591	831
Total	**1,348**	**3,962**	**5,310**

Figure 45 — Formal complaints finalised

- Formal investigation **12**
- Conduct outside our jurisdiction **107**
- Agencies outside jurisdiction **364**
- Assessment only **419**
- Preliminary or informal investigation **816**

Current investigations (at 30 June)	
Under preliminary or informal investigation	46
Under formal investigation	5
Total	**51**

Case study 54

We received a complaint from a student who had been excluded from her university for poor academic performance. She believed this was strongly connected with the fragile state of her mental health after aggressive conduct towards her by a teacher. In addition, certain key documents about the student's performance appeared to be missing from the university's records. Following our inquiries, the university redoubled their efforts and located the documents. They then proceeded to deal with the student's situation appropriately, structuring a return to studies program designed to maximise her chances for success.

This case highlights the difficulties that can arise if students suffer from depression or other mental illnesses. Although many students may be more reluctant to give universities information about mental health issues than about other health issues that may affect their study, it is also clear that universities cannot take into account circumstances they do not know about. Universities need to carefully consider how these issues can be treated with appropriate sensitivity and confidentiality.

We have also given feedback to a number of universities on their handling of specific internal appeals. In particular, we identified the need for university staff to keep better records of internal appeal decisions and to give students written and sufficiently detailed reasons for their appeal being rejected.

School education

Investigating long suspensions

This year we completed an own motion investigation into the Department of Education and Training's policy and procedure for long suspensions. Students can be given a short or long suspension for poor behaviour. A short suspension is for up to and including four school days. A long suspension is for up to and including 20 school days. We focused on long suspensions as they have a significant impact on both students and their parents or carers. There is an obvious impact on students' access to learning when they are out of the classroom, and practical implications for working parents or carers who have to make alternative arrangements for their child's supervision. There is also concern that if parents or carers can't or won't arrange supervision, the student may be on the street while out of school. The home environment itself may not be ideal and being in school may be providing the student with some degree of respite from difficulties at home. A long suspension may also exacerbate a student's disengagement from school.

Case study 55

A student with a disability complained that his university had twice failed to provide him with the appropriately formatted exam for one of his units. On the first occasion, the exam papers had not been enlarged as required under his disability access plan. On the second occasion, the examination and the answers sheet were numbered differently which created some confusion in completing the exam. To resolve the matter, and because there was no further formal examination time available, the university proposed to give the student a final grade based on the average of his assignment marks. The student complained this was unreasonable, as it would mean his entire grade would be based on one assignment.

As a result of our inquiries, the university contacted the student to seek a more appropriate solution. They ultimately agreed to a further special examination and issued a written apology to the student. The university also assessed how disability access plan examination requirements are handled more generally, and took action to avoid a situation such as this occurring again. We were pleased with how the university finally handled this complaint.

We identified the mandatory elements of the procedure and audited for compliance a random sample of several hundred long suspension files from schools across the state. We also interviewed a range of departmental staff — including primary and high school principals and deputies, school education directors and student welfare staff.

It was evident from our work that schools are dealing with significant instances of poor behaviour on a regular basis, often in very challenging and difficult circumstances. Lack of engagement by parents or carers is unfortunately all too common. This is sometimes because parents themselves have had a poor experience of school or because the nature of their lives is

such that they are unable to engage. We found that the procedure on suspensions provides a framework for schools to manage poor behaviour, but there are significant areas where the requirements of the procedure are not being adequately implemented. We identified examples of good practice which the department could use in improving action taken by schools in relation to suspensions.

We have made a number of recommendations across four main areas:

- Operational and administrative issues — including the development of a checklist of the essential requirements of the long suspensions procedure for use by schools, training in the procedure for deputy principals, and guidance to schools about what work should be given to a student on suspension.
- Measures to help the department better understand the characteristics of students who are being suspended — including a review of the range and adequacy of the data currently captured about long suspensions.
- The adequacy of support services and assistance — including a review of how effective the early intervention approach is in identifying and managing poor behaviour, and the availability of school counsellors and support for students identified as having behavioural and emotional problems.
- The use of in-school suspensions and time out rooms.

The department worked constructively with us throughout the investigation and welcomed our recommendations. We have asked them to report to us on the implementation of the recommendations.

Case study 56

In late 2007, we met with the Wildlife Licensing and Management Section of the Department of Environment and Climate Change (DECC). We receive complaints from time to time about the granting of licences to care for native wildlife. We took the opportunity presented by a particular complaint to gain a better understanding of the department's role in overseeing community wildlife care bodies and the process for determining licence applications. We were also aware that this is a difficult area of work for DECC. It is not uncommon for difficulties to arise in licensed groups and for disputes to have long term and significant consequences for both the individuals involved and the department.

DECC staff told us a new Wildlife Council has been formed to coordinate the work of the sector and improve standards across licensed groups. We raised the issue of complaint-handling within groups, as poor complaint-handling has created difficult situations involving many hours of staff time. DECC advised that they and the council are actively pursuing this issue, and we were pleased to subsequently learn that the council has developed their own complaint-handling policy. We told DECC staff about some useful resources — including our new training courses on managing unreasonable complainant conduct which staff from the unit later attended.

We also discussed the procedures for issuing general licences to care for sick and injured wildlife. As a result of our involvement, DECC agreed to clarify certain provisions in their procedures to ensure transparency in their decision-making.

Restricting access to school grounds

We received two complaints about DET's decision to restrict access to school grounds under the *Inclosed Lands Protection Act 1901*. Concerns raised included the Act being used instead of alternative dispute resolution techniques to resolve complaints. We also had concerns about DET's failure to review the restrictions periodically and provide reasons — both for imposing restrictions in the first place or for extending the restrictions. Although the department had produced guidelines to assist principals in imposing restrictions, they do not appear to be official departmental policy and it is not clear how accessible the guidelines are to school staff and the wider community. We have suggested that DET provide advice to school principals about the need to give clearer reasons for decisions to restrict access and make the guidelines more widely available. DET has agreed to implement these changes.

Case study 57

A doctor working in rural NSW as a GP had worked in several 'area of need' positions for over three years. Areas of need have a shortage of doctors and these positions can be filled by overseas trained doctors. When the doctor started applying for other 'area of need' positions in 2006, he found that the NSW Medical Board required him to pass the English proficiency test for new entrants into the system. This meant that he was unable to practice for two years because he could not pass the test.

In July 2005, a national agreement had been reached between state medical boards that all overseas trained doctors would be required to meet a defined minimum standard of English language proficiency. The policy allowed for exemptions in certain circumstances. The Medical Board decided it would not require currently registered overseas doctors to comply with the national policy, but all applicants for new registrations would need to comply with the new English language standard.

The doctor applied to the Medical Board for an exemption from the English language policy. His request was rejected because each area of need application was considered to be a new registration. The doctor felt this was unfair as it failed to take into account the fact that he had been registered for over three years. He also believed a policy should not apply retrospectively and consequently complained to us.

Our review of the doctor's file showed that the Medical Board made a policy decision that no discretion would be applied to area of need applications in relation to the English language requirements. It seemed to us that by having a policy that is indiscriminately applied in every case — without being able to consider the individual merits of a particular case — the Medical Board was unreasonably fettering the discretion given to it by the *Medical Practice Act 1992*.

After we had made extensive inquiries, the Medical Board agreed to review the doctor's application. They decided to waive the English language requirements in his case, having taken into account the merits of his individual circumstances. The board also agreed to consider our suggestions for improving their processes. These suggestions included reviewing how they give advice to applicants about their appeal rights, reviewing the processes used to ensure procedural fairness is afforded to all applicants, and considering making passing the English language requirements a prerequisite to registration — to avoid unnecessary delays in filling 'area of need' positions.

Good complaint-handling

An important part of our work is to encourage good complaint-handling by agencies themselves. Our work on individual complaints often allows us to identify areas for improvement in an agency's own complaint-handling processes. Our complaint-handler's toolkit, now in its second edition, gives advice to agencies about setting up a complaint-handling system and includes practical information and guidance on handling complaints. This year we also conducted a survey of complaint-handling systems across all NSW government departments and authorities. The survey allowed us to paint a high level picture of the current 'complaint-handling' situation and analyse the similarities and differences between different size agencies. For further details see page 8 in 'Our year in review'.

Apologising for mistakes

One element of good complaint-handling is a willingness to apologise for mistakes. Nobody is perfect and neither is any organisation — we all make mistakes. We encourage agencies who have made an error in judgement to consider giving an apology as a way to help resolve the matter. Last year we published guidelines for public authorities to help them to give appropriate and effective apologies. An appropriate apology is often seen by complainants as an essential prerequisite for resolving their complaint. In our experience, it is often the main thing they really want. However, a poorly crafted apology can be just as damaging as one that is not delivered at all.

Our experience this year suggests that saying sorry is still sometimes a challenging process. We saw an example of a very poor apology by the Office of Fair Trading (OFT). Although there had been clear customer service problems in handling the complainant's application for a licence, the apology from OFT was vaguely worded and did not acknowledge

the concerns raised. It is unlikely this apology went any way towards resolving the complainant's concerns.

Delay in giving an apology can also diminish its worth. The Legal Aid Commission of NSW issued an apology to a complainant for failing to respond to a complaint he lodged with them and for using an old address in relation to his application. On this occasion, the form of the apology was appropriate. However the agency failed to send it until a month after we had told the complainant they would be issuing it. The apology did not arrive until after the complainant contacted our office a second time, advising it had not arrived. Given the poor customer service experienced by this complainant originally, the delay in issuing the apology would have diminished its effect and sincerity.

In contrast, a fulsome and timely apology can be very powerful. We suggested to RailCorp that they apologise to a complainant about a number of customer service issues, including staff rudeness and a lack of response to inquiries. RailCorp agreed to this suggestion and the apology made to the complainant was an outstanding example of a successful apology. Despite the substantive issues involved in the complaint showing no evidence of wrong conduct on the part of their staff, RailCorp took the opportunity to try and repair their relationship with this person. It was clear from their unreserved and sincere letter of apology that RailCorp staff appreciated the complainant's concerns about how she had been treated.

Good results

We achieve a broad range of outcomes in relation to the complaints we handle. In many matters we dealt with this year, our intervention led to an improvement in an agency's policies or procedures as well as a good outcome for the person who complained to us. Case studies 56 to 59 illustrate some of those outcomes.

Case study 58

We received a complaint that some wheelchair accessible taxis licensed by the Ministry of Transport did not comply with the Commonwealth's Disability Standards for Accessible Public Transport in terms of the space allocated for wheelchairs. Licences for wheelchair accessible taxis are subsidised and cost considerably less than licences for standard taxis. The concern was that wheelchairs could not fit into the accessible taxis and so taxis licensed to transport wheelchairs were not able to do so.

When we raised this with the Ministry of Transport, they asked the Roads and Traffic Authority to measure the wheelchair accessible taxis in question. The RTA concluded they did not comply with the Commonwealth standards. The Ministry then employed an independent engineer to check the taxis again. The engineer concluded the taxis did comply, but found there was a lack of guidance provided to companies that convert taxis and to engineering signatories who certify them. As a result of our investigation, the Ministry drafted a protocol that clearly explains the allocated space required for wheelchair accessible taxis to comply with the Commonwealth standards. This protocol will help taxi operators, conversion companies and engineering signatories understand what is required.

Case study 59

A Department of Housing tenant called us to advise she had received a notice of termination. She had deliberately not paid rent for the last three weeks because of a leaking roof that had not been properly repaired. After making inquiries, the department realised the workmen who were supposed to repair the roof a few months earlier had not done so. They acknowledged they did not have a mechanism in place to follow up repairs not actioned. The tenant had continued to ring her local office and was referred each time to the maintenance line, who advised that nothing could be done until the weather cleared up. The department apologised to the tenant for not following up and the roof was repaired.

Case study 60

We received a complaint about delays by the Office of Fair Trading (OFT) in issuing a contractor's licence. The OFT's guarantee of service states that applicants can expect their application to be processed within six weeks. We made inquiries with the agency who told us there had been a spike of 16,000 applications for electrical qualified supervisors during February 2008. However, as these licences are renewed at the same time every three years, the agency had anticipated this and appropriately resourced the sections responsible for processing them. Our complainant had his contractor's licence issued seven weeks after he submitted his application. Although this was outside the guarantee of service, this case is an example of an agency taking proactive steps to manage its resources in difficult circumstances so that delays are minimised.

Case study 61

The Nurses and Midwives Registration Board had an unusually high workload due to changes to the vetting of qualifications. An employment agency sent two applications to the board in August 2007 on behalf of two overseas nurses. These applications had not been assessed by March 2008. We found that the board did not have a formal complaint-handling policy and had no system for recording what applications had or had not been assessed. We advised that as well as providing a transparent process for dealing with complaints, a complaint-handling policy would help the board identify systemic problems — such as those with managing applications. This would enable them to address such problems proactively. The board agreed to our suggestion and have developed and implemented a formal complaint-handling policy.

State Plan

The State Plan is a blueprint for agencies to deliver better results for the community. It sets priorities for government with challenging targets for improvement.

We provide advice and support to agencies around implementing State Plan strategies, particularly relating to complaint-handling, customer service and improving service delivery. In November 2007 the Premier issued a memorandum to all agencies promoting our *Complaint-Handling Guidelines* as the standard to be used when reviewing and improving their complaint-handling systems as required by the State Plan's customer service priority. We made our guidelines and other information available through our website.

We have continued to promote effective internal complaint-handling through our representation on the Senior Officers Working Group for this initiative. We also conducted a major survey of the existing complaint systems of public authorities to gain a compliance snapshot which will guide our future work.

Managing delays

From time to time agencies may experience a significant increase in workload or a reduction in resources, leading to delays in the provision of services. This may be due to circumstances beyond the direct control of an agency, but it is important that they nevertheless actively manage the situation. Good administrative practice to deal with delays can include providing information to the public about the challenges being faced, establishing additional communication strategies to manage expectations, and adopting procedures to expedite genuinely urgent matters.

Last year we reported our concern that a restructure at the Office of the Protective Commissioner (OPC) had resulted in significant problems. These problems included delays in callers getting through to customer liaison staff, delays in decisions being made, and a lack of coordination between new specialist units. As the Protective Commissioner administers the financial affairs of people with a disability who are unable to do this for themselves, any delays in making decisions is of considerable concern. We have been impressed by the frank and cooperative approach of the OPC in response to our inquiries. They provide us with regular briefings about the difficulties they are facing and the progress of the change program they are undertaking to address these. We will continue to monitor the situation closely.

Local government 9

Customer service issues make up 25% of the complaints that we receive about councils. The NSW Government's priority in the State Plan is to increase customer satisfaction with government services. Our experience, confirmed by our recent mystery shopper audit of 30 councils, suggests that the quality of customer service can vary widely within and across various councils. We promote customer friendly service delivery through our advice and our *Good Conduct and Administrative Practice Guidelines*. We also promote customer satisfaction through our work with councils to improve their complaint-handling systems and processes.

Highlights

- We achieved 367 positive outcomes for complainants in relation to 442 complaints investigated.
- After we met with senior management, Wollongong City Council properly investigated allegations of illegal work, set up a regulation and enforcement division within their organisational structure, and started to develop a compliance policy.
- After our investigation, Bathurst Regional Council agreed to improve their insurance and sewer asset management processes and paid compensation for possessions damaged after a sewer overflow.
- Several councils, including Woollahra and Albury City Council, apologised for delays or not responding to customer correspondence.
- We conducted mystery shopper audits of 30 councils to assess their customer service standards and received positive feedback from the councils audited, many of whom have made improvements to their systems and processes.

Complaint trends and outcomes

This year we received fewer overall complaints about corporate and customer service, development, misconduct, management and community service matters and people objecting to council decisions. The largest number of complaints this year related to corporate and customer service issues. Routine customer service issues such as inaction, failing to reply to correspondence, delays in taking action, providing incorrect advice, lack of notification and consultation, and poor complaint-handling continued to be matters of concern.

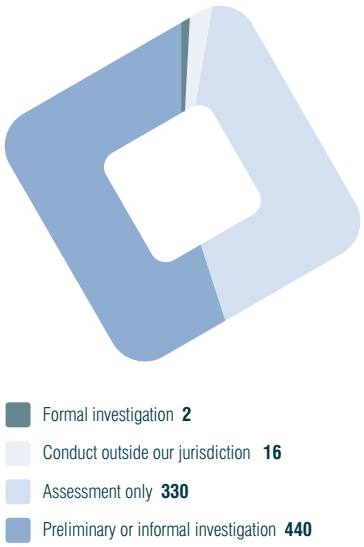
There was an increase in the number of formal complaints about strategic planning (100%), rates and fees (91%), engineering (28%), environmental enforcement (15.6%) and environmental services (3%). See figure 48 for the issues people complained about.

We achieved 367 positive outcomes for complainants as a result of 440 preliminary investigations and 2 formal investigations. This was a 10.8% increase from last year (see figure 47). Some of the outcomes we achieved included payment of compensation, apologies, admission and correction of errors, reviews of cases and changed decisions, mitigation of the consequences of decisions, changes to procedures, the implementation of policies and staff training. Over a third of the outcomes involved providing further information and/or reasons for decisions that helped complainants to understand the basis for the council's action.

Figure 46 — Five year comparison of matters received and finalised

Matters	03/04	04/05	05/06	06/07	07/08
Formal received	840	814	744	841	768
Formal finalised	865	833	720	837	788
Informal dealt with	2,194	2,138	1,891	1,992	1,965

Figure 47 — Formal complaints finalised



Customer service and complaint-handling

This year, complaints involving poor service and complaint-handling included incorrect advice (see case study 63), delays (see case studies 64 and 68), inaction on complaints (see case studies 65 and 66), poor communication (see case studies 62 and 67) and failing to reply (see case studies 69 and 70). We received 3.5% less complaints about councils than last year. There were 8.7% less formal written complaints and 1% less informal complaints received by telephone or in person at our office (see figure 46).

Figure 48 — What people complained about

Issue	Formal	Informal	Total
Corporate/customer service	312	376	688
Uncategorised	0	109	109
Development	102	337	439
Misconduct	38	83	121
Enforcement	118	183	301
Management	0	18	18
Engineering services	45	190	235
Strategic planning	12	32	44
Issue outside our jurisdiction	6	57	63
Object to decision	24	170	194
Community services	9	27	36
Environmental services	32	189	221
Rates charges and fees	70	194	264
Total	**768**	**1,965**	**2,733**

Case study 62

After paying a levy for a new sewerage system to Cabonne Shire Council for 10 years, a number of ratepayers were concerned about how much longer they would have to pay but not be told about progress. Initially the council had kept the ratepayers informed but, as the years went by and various obstacles to completion surfaced, communication with the community dropped away. After our intervention, council reinvigorated their consultation processes and appointed the project manager as the designated person for communications with ratepayers. The ratepayers were pleased with this outcome while council told us they had learned an important lesson.

Case study 63

A landowner complained that Eurobodalla Shire Council had not taken action when her neighbour illegally cut down trees on their boundary. At first the council allowed the neighbour to apply to surrender the consent. They then determined that consent was no longer required for tree removal in rural areas, even though this was contrary to their own local environment plan (LEP). The council had also published a fact sheet incorrectly advising the community that consent was no longer required for tree removal in rural areas. We found the surrender of consent was not in accordance with the law, even though the application had not been finalised, and consent to remove the tree was still required as the LEP had not been changed. We recommended council consider issuing a fine for the illegal tree removal, apologise for the way the complaint was handled, provide the complainant with trees to replace those cut down, and re-issue their fact sheet with correct advice. Council has complied with our recommendations.

Case study 64

A man complained that Bathurst Regional Council took a long time to refuse two small insurance claims following damage to his relatives' possessions from a sewer overflow — caused by poor maintenance of a section of sewer main near the property. Our investigation found a lack of procedures, poor record-keeping, inadequate communication between sections of councils and council and their insurance company, and inadequate sewer asset management. Council agreed to improve their insurance and sewer asset management processes and compensated the claimants more than $4,000.

Case study 65

A family's access to their home was severely restricted for a long period because of delays with footpath works by Ryde City Council. The family's communications went unanswered while their frustrations mounted as cars and bins had to be left in the street. After our inquiries, council organised a temporary access, had the family's damaged gateway repaired and undertook to complete the footpath work as a priority.

Case study 66

A resident complained that Wollongong City Council took a long time to deal with their application to close an unformed road and did not act on their complaints about another resident doing illegal work on the road reserve. Our inquiries revealed inadequate investigations and record-keeping, poor communication between sections of council, failure to progress a development application that had to be determined before other decisions could be made, and failure to advise the complainant. After we met with senior management, council properly investigated the allegations of illegal work, determined the development application, progressed the road closure application, wrote to the complainant, set up a regulation and enforcement division within their organisational structure, and started to develop a compliance policy to guide the work of that division.

Case study 67

Shellharbour City Council conducted a public consultation for a controversial new cycleway. Although council conducted a survey on different route options, they promoted a particular option. We received a number of complaints from residents concerned that council had treated their 49 form-letter submissions as only one submission. Our inquiries showed that council was not clear why they had conducted the survey, what would happen with the data once it was obtained, and how it would be analysed and weighted. Council seemed to have given more weight to the survey results than to submissions. We advised council that the methodology for assessing public submissions and surveys should be made public at the start of consultation to ensure transparency and accountability. We also discovered council had prepared a flow chart explaining the consultation process but had not published it, despite the clear public interest in doing so. At our suggestion, council placed this document on their website and reviewed their processes for analysing public submissions.

Case study 68

Woollahra Council carried out extensive work on a heritage wall that damaged a home owner's sewer pipes. Council told the home owner to repair the pipes and apply for reimbursement. However, the refund was delayed by conflicting opinions at council about their liability. After our intervention, council reviewed the case, reimbursed the $6,000 repair bill and apologised for the delay.

Case study 69

A legal firm contacted us when Sutherland Shire Council failed to respond to their correspondence for a second time on the same matter. We made inquiries and council admitted the error, rectified the circumstances through improved resourcing of the section of council involved, and provided the outstanding response.

Case study 70

A community activist complained that Albury City Council did not reply to his correspondence about a controversial development of a child care centre at a popular local park. When we made inquiries, the council said the officer has assumed answers to the questions raised in the letter would be well known to the community so he did not provide a response. A response and apology were provided to the complainant.

Council customer service audits

The NSW Ombudsman *Customer Service Audit — Multiple Local Councils* report is one of a series of reports on mystery shopper audits of customer service standards in the NSW public sector.

In 2007–2008 we conducted mystery shopper audits of 30 NSW councils.

The following councils were part of this year's audit:

Albury City Council
Ballina Shire Council
Blacktown City Council
Blue Mountains City Council
Camden Council
City of Botany Bay Council
City of Sydney Council
Clarence Valley Council
Coffs Harbour City Council
Cowra Shire Council
Gilgandra Shire Council
Glen Innes Severn Council
Great Lakes Council
Greater Taree City Council
Greater Hume Shire Council
Hurstville City Council
Kogarah Municipal Council
Ku-ring-gai Council
Lachlan Shire Council
Liverpool City Council
Liverpool Plains Shire Council
Mid-Western Regional Council
Orange City Council
Queanbeyan City Council
Ryde City Council
Shoalhaven City Council
Strathfield Municipal Council
Tamworth Regional Council
Waverley Council
Yass Valley Council

Between 19 February and 20 May 2008, 30 identical inquiries were made with each of these councils — with equal numbers made via a phone call, letter or email. All tasks were conducted by and assessed by our staff.

Telephone contact

The advice provided by council staff in response to telephone inquiries was of a higher quality than advice provided in response to letters or emails. The advice given was generally accurate, but in only 75% of cases was the information provided considered to be a complete response.

The vast majority of calls we made to councils were answered by a person (80%) rather than interactive call systems or recorded messages (20%). Calls were answered promptly and very few callers experienced technical difficulties, such as being disconnected. There were also very few occasions where mystery shoppers were placed on hold for extended periods.

Council staff were generally considered to be courteous and appropriately business-like when handling inquiries. Very few staff were discourteous or uninterested in our callers' inquiry.

Letters to councils

The average turnaround time for a response to a letter was only 10 days, which is an extremely good result. The advice in the response letters was generally accurate, clear and understandable.

However, only 78% of letters sent were responded to by councils. Of these responses, only 72% were assessed as providing complete information.

In total, only 57% of letters (170 of 300) received an appropriate response. This result is very disappointing.

Emailed requests

The response rate to email inquiries was also disappointing, and considerably worse than the response rate to the letters we sent. Over 30% of emails sent were not responded to within 17 business days, with only 202 responses received to 300 emails sent.

However, response times were prompt when the council did reply to emails. The most common response time to emails was one business day (29% of all responses) and many responses arrived in under half a day (20% of all responses).

There were significant problems with the completeness of the responses provided by councils to emails. Only 67% of responses were judged to be complete. Overall, only 44% of emails received an adequate response.

The feedback received from the councils audited has been overwhelmingly positive and many have indicated how valuable the results have been in understanding the quality of their customer service and developing improvements to their systems and processes.

Feedback from councils

Many councils have contacted our office and expressed their appreciation at being included in the audit. They have also noted particular changes they have implemented in light of the results. A number of councils will be providing further training for staff about access to council documents and privacy. Other changes implemented as a result of the audit are automatic acknowledgement of emails, training in writing business letters and, in the case of one council, the development of an integrated customer service centre.

Freedom of information 10

On 22 April 2008, the Ombudsman announced that he would conduct an independent and comprehensive review of how the *Freedom of Information Act 1989* (FOI Act) is implemented in NSW. The Premier has given his support for the review.

Freedom of information legislation is one of the cornerstones of good governance. It ensures that government decision-making is open and transparent and decision-makers are held accountable for their actions.

Highlights

- Started an independent and comprehensive review of the implementation of the *Freedom of Information Act 1989* (FOI Act) in 18 agencies, and released a public discussion paper to provide all interested parties with an opportunity to contribute to the review.
- Clarified the use of clause 13(a) of the FOI Act to exempt documents, such as employment contracts, from being released due to a breach of confidence.
- After a journalist applied unsuccessfully under FOI to eight area health services in NSW and The Children's Hospital for access to clinical indicator reports, we intervened and NSW Health directed all the area health services and The Children's Hospital to release the reports in the public interest.
- Worked with agencies on a range of FOI issues including advance deposits, applications for electronic documents, and the need for good communication with applicants.

Review of the Freedom of Information Act

Since the FOI Act came into force nearly 20 years ago, the way government departments operate and do business has altered dramatically. The Act has been the subject of more than 60 amendments in that time which have only served to make it more complex and difficult to navigate. We are aware from our work dealing with FOI complaints that both applicants and agencies find the Act frustrating to use and work with. For nearly 14 years we have been calling for an independent and comprehensive review of the FOI Act.

Eighteen agencies have been selected for specific investigation as part of the review. We have deliberately selected a mix of agencies including:

- government departments, local councils, universities and area health services
- agencies of varying sizes, to reflect the different resources available to handle FOI matters
- agencies with different functions such as regulatory, service delivery or policy coordination
- agencies that receive varying numbers of FOI applications, from large numbers to more limited applications.

Each agency has been asked to provide specific documents and information. We are conducting audits of a sample of their FOI files and interviewing agency staff who deal with FOI applications.

We have requested information from the Administrative Decisions Tribunal about the external review applications they deal with, as well as information from all NSW local councils about requests they deal with under s.12(6) of the *Local Government Act 1993*, the FOI Act, the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*.

As part of the investigation process, we have released a public discussion paper to provide all interested parties with an opportunity to contribute to the review. This is a detailed document reflecting our experience in dealing with a wide range of challenges and difficulties related to FOI in NSW. The discussion paper was distributed widely and is available on our website.

The findings from our investigation will inform our final report and recommendations to Parliament. Updates and announcements about our review will be posted on our website.

The decisions agencies make on FOI applications

As in previous years, we reviewed the reporting of FOI statistics in the annual reports of over 100 agencies.

The review indicated that the number of FOI applications reported to have been made to those agencies decreased by 9.5% between 2005–2006 and 2006–2007. This continues the downward trend that was first noticed in the 2005–2006 reporting period. Overall there has been a decrease of close to 20% in the number of FOI applications reported to have been made to reviewed agencies since 2004–2005 (a decrease of 3,280 applications — down from 15,958 to 12,678). The primary cause of this decrease has been the significant reduction in the number of FOI applications made to the NSW Police Force (NSWPF), down from a peak of 8,505 in 2003–2004 to 5,780 in 2006–2007 (a decrease of 32%). However, applications to other audited agencies have also decreased by 690 per year, down from 7,587 to 6,898 (a decrease of 9%) over the past three reporting periods, primarily between 2005–2006 and 2006–2007.

Of the 103 agencies whose annual report FOI statistics were reviewed, the 20 agencies that received the most FOI applications in 2006–2007 between them received 91.5% of all reported FOI applications (11,576 out of a total of 12,678). This is largely similar to the percentage of total applications received by those

same 20 agencies in the two preceding reporting years. Excluding the figures for the NSWPF, the remaining 19 agencies between them received 84% of all non-police applications (5,796 out of 6,898). This is an increase of 4% over the figure for 2004–2005.

Since 2002–2003, the percentage of FOI applications reported to have been approved in full in all annual reports (the subject of our review) has decreased by approximately 18% in total and by 10.5% to non-police agencies. This means that total refusals increased by 18% and 10.5% respectively.

As part of this latest review, we analysed in more detail the reporting history of the seven agencies that received more than 300 applications per year (a total of 9,916 out of 12,678 applications reported to have been made in all reviewed annual reports). While the nature of the reported statistics had not changed significantly for six of those agencies, there has been a significant change in the nature of the determinations made by the NSWPF over the past four reporting periods. Over that time, the total number of applications refused by the NSWPF based on exemption clauses has increased by 43% (from 12% of refusals to 55%).While this was almost completely related to partial refusals, the total number of applications refused in full based on exemption clauses has increased by 6% (from nil to 6% over the period). Over the past three years the determinations made by the NSWPF have significantly impacted on the overall statistics from all reviewed annual reports. With the police figures removed from the calculation, over the past three reporting periods there was still an approximate 10.5% increase in refusals by agencies, including an approximate 6% increase in partial refusals and an approximate 5% increase in full refusals.

Figure 49 — Five year comparison of matters received and finalised

Matters	03/04	04/05	05/06	06/07	07/08
Formal received	139	189	188	208	225
Formal finalised	129	182	198	205	197
Informal dealt with	309	345	294	316	422

FOI complaints

This year we received over 220 formal complaints about FOI applications (see figure 49). As was the case last year, most complaints involved agencies refusing access to documents requested (see figure 50). This reflects an overall trend we have observed of a significant decline in the number of applications resulting in the release of all documents.

In many of the complaints, the agency had not made an actual determination to refuse to release the documents, rather, it had made a 'deemed refusal'. A deemed refusal occurs when an agency does not determine the FOI application within the statutory time frame and does not seek an extension of time to process the application, as provided for by the FOI Act. We found that as a result of poor FOI application management or a lack of resources, a number of agencies simply let the statutory time frame elapse without determining the FOI application. The use of the wrong procedure by an agency in determining an FOI application was also the subject of a large number of complaints.

In 2007–2008 we finalised over 190 FOI complaints and achieved 171 positive outcomes in these matters (see figure 51 over page). Many of these matters were resolved by the agency agreeing to re-determine the FOI application and release the documents. We also resolved a number of matters where the agency had been unable to locate the documents at the time of the original determination, but subsequently located and released them to the applicant at our suggestion. See Appendix J for a full list of actions we took for each complaint finalised this year.

Figure 50 — What people complained about

This figure shows the complaints we received in 2007–2008 about freedom of information, broken down by the primary issue for each complaint. Please note that each complaint may contain more than one issue, but this table only shows the primary issue.

Issue	Formal	Informal	Total
Third party objection	7	10	17
Agency enquiry	0	54	54
Pre-application enquiry	0	75	75
Documents not held	8	7	15
Issue outside our jurisdiction	1	3	4
General FOI enquiry	1	104	105
Documents destroyed	0	2	2
Documents lost	1	5	6
Pre-internal review enquiry	0	32	32
Documents concealed	0	8	8
Charges	8	21	29
Access refused	126	63	189
Information	0	2	2
Wrong procedure	67	32	99
Amendments	6	4	10
Total	**225**	**422**	**647**

We continue to receive complaints about agencies requesting advance monetary deposits. We encourage these agencies to explain to applicants in detail how the advance deposit charge was calculated. This information can assist applicants to negotiate a more restricted FOI application so as to reduce the cost incurred.

Figure 51 — Significant outcomes achieved in relation to complaints about freedom of information finalised in 2007–2008

Outcome	No.
Policy/procedure change	5
Authority pays compensation	1
Authority makes apology	4
Other remedy	5
Authority reviews case	12
No significant outcome	37
Further information provided	58
Authority admitted and corrected errors	5
Authority reviewed and changed decision	15
Authority provides reasons	14
Agreement reached through informal means	3
FOI documents released	38
FOI refund/remission of fees	7
FOI search made and documents made	4
Total	**208**

Confidentiality clauses in employment contracts

In 2007, the Sydney Morning Herald made FOI applications to each of the NSW public universities for the Vice Chancellors' (VC) employment contracts. Macquarie University, the University of Technology, Sydney and the University of Newcastle released the contracts fully, and two universities released them partially. However, the five remaining universities exempted them in full, relying largely on clause 13(a) of Schedule 1 of the FOI Act. This provides for an exemption if disclosure of information would be a breach of confidence for which legal action could be taken.

We made own motion inquiries into how the universities made their decisions. We learned that a number of them exempted the contracts on the basis of a confidentiality clause within the contract.

We were concerned that the approach taken to clause 13(a) effectively amounted to 'contracting out' of FOI by expressly creating a contractual obligation of confidentiality — and therefore predetermining the exemption of documents under FOI. We considered this to be contrary to the public interest. We believe that the terms and conditions of employment contracts of public sector staff should be transparent and open to public scrutiny, except in exceptional circumstances.

At the time of our inquiries, the Administrative Decisions Tribunal (ADT) also addressed the issue of whether the inclusion of a confidentiality clause could predetermine that a document would be exempt under FOI in *Watt v Forests NSW* [2007] NSWADT 197. This decision contrasted with a previous ADT decision in *Fomiatti v University of Western Sydney* (No 2) [2006] NSWADT 210.

In light of the conflicting case law, we asked the NSW Solicitor General for advice about the appropriate interpretation of clause 13(a) of the FOI Act. The Solicitor General's advice was that "clause 13(a) is principally directed to cases in which a person has provided confidential information to a government agency and another person seeks to obtain access to that information by lodging a request under the Act". A right of action arising under a confidentiality clause of a contract would be for a breach of the agreement, not for a breach of confidence.

Case study 71

Miners are required to submit reports to the Department of Primary Industries about their mining exploration activities. The department received an FOI application for such reports and, as required by the FOI Act, consulted the miners about the release of the documents. Two miners objected to the release. The objection was based on the fact the department had previously advised them that the information in the reports would be kept confidential while their licences were in force. The miners were also concerned about an unreasonable adverse effect on their business affairs as information about specific exploration locations is valuable to competitors. They also claimed that when site locations had been released in the past, competitors had carried out unauthorised work.

We wrote to the department and suggested they delete those parts of the reports that referred to specific exploration locations. We also suggested they amend their Exploration Reporting Guidelines to indicate that confidentiality of the reports cannot be guaranteed. They have complied with this advice.

The relevant issue for clause 13(a) is whether the disclosure of the material would satisfy the elements of an equitable action of breach of confidence. According to the Solicitor General, these elements are:

- the information is confidential
- the information was originally imparted in circumstances importing an obligation of confidence
- there was, or is threatened, an unauthorised use of the information to the detriment of the party communicating it — where embarrassment, for example, has constituted sufficient detriment in the case of a private individual, although damage to the public interest must be demonstrated by a government agency.

The Solicitor General did not consider the disclosure of Vice Chancellors' employment contracts would meet these criteria because the contracts would be unlikely to contain confidential information imparted by the VC to the university or vice versa.

We have shared the Solicitor General's advice with the universities and they have all indicated they would consider it in any future applications of clause 13(a).

Case studies 71 and 72 demonstrate how an undertaking of confidentiality can also create unrealistic expectations in people that their information will not be released under FOI.

Case study 72

A journalist applied under FOI to eight area health services in NSW and The Children's Hospital for access to clinical indicator reports compiled by the Australian Council on Health Care Standards (ACHS), a non-profit organisation. ACHS compiles these reports from clinical information given to it by private and public hospitals and health care institutions. They provide the reports to the institutions themselves, not to any of the area health services or NSW Health.

All but one of the area health services and The Children's Hospital exempted all the reports under clauses 7 and 13(b) of Schedule 1. They argued that release of the reports would unfairly disadvantage ACHS's business affairs as its competitors would be able to copy their procedures. They also claimed that professional and medical staff would stop providing the information for the reports. One area health service only claimed exemption under clause 7.

After obtaining all the clinical indicator reports from all the institutions, we met with ACHS to find out about their role and procedures. We then met with ACHS and the journalist to try to resolve the complaint. ACHS advised us they effectively had no competitors and would welcome a mandatory reporting scheme implemented by the NSW Minister for Health.

Following our consideration of the complaint, we wrote to NSW Health and presented our view that the release of information and statistics about the performance of hospitals and other health institutions would be in the public interest. To try to resolve the complaint, we asked whether NSW Health would consider directing or suggesting to the various area health services and The Children's Hospital that they release the clinical indicator reports they had determined as exempt.

NSW Health advised us that they agreed with our view and directed the chief executives of all the relevant area health services and The Children's Hospital to release the reports to the journalist. NSW Health also advised that release of the reports would be subject to any contractual arrangements of the area health services and The Children's Hospital with ACHS.

NSW Police Force — determining FOI applications

In 2005, we completed an investigation into the failure of the NSW Police Force (NSWPF) to comply with timeframes in the FOI Act. The NSWPF responded by allocating nine additional staff to their FOI Unit to help deal with the significant volume of 8,000 applications they receive every year.

Since our investigation, the FOI Unit has reduced the back-log of unprocessed applications by approximately half. They have made significant improvements in the volume of applications they process each month. However, we continue to receive complaints about ongoing and sometimes significant delays in determining FOI applications.

We have had a number of meetings with the FOI Unit to discuss how they manage their workload. We will continue to monitor the way the NSWPF addresses delays in processing times. We are also keen to see them consider ways of releasing certain types of information outside of FOI, particularly in response to requests from complainants (both police and public) for information about the outcome of their complaint.

Case study 73

A journalist made an FOI application to the NSWPF for documents concerning the number of times police had been called out to private schools and the reasons for those call-outs. The police exempted the material claiming that its release could reasonably be expected to have an unreasonable adverse effect on the business, professional, commercial or financial affairs of the schools.

We wrote to the NSWPF suggesting the information sought by the journalist be released. We did not consider that the information in the documents concerned the business, professional, commercial or financial affairs of the schools — as the business of private schools is providing education to children.

The NSWPF argued that the schools' reputation and standing in the community had a direct influence on their ability to attract students and staff. The disclosure of the information, they argued, might attract unwarranted discrimination — resulting in the schools becoming less competitive and unable to attract students and staff. In addition, prospective parents may be influenced by negative newspaper articles in their choice of schools and this would diminish the competitiveness of individual schools.

Our view was that a school's reputation is made up of many individual factors and there are a multitude of reasons that may affect or influence a parent's choice of school. Given this, the release of information about police call-outs could not be reasonably expected to affect the competitiveness of the schools. While there was a risk that the release might have this effect, this was not enough to meet the test in the business affairs exemption in the FOI Act — this requires there to be a reasonable expectation of an unreasonable adverse effect.

The NSWPF agreed to release the documents. One of the schools challenged that decision in the Administrative Decisions Tribunal.

Case study 74

We received a complaint from a young man that there were two identical records about him in the police database. The young man had previously advised us he often found it very difficult to resolve problems with government agencies because of his mental illness. He also said he had attempted to alert the NSWPF to the error but with no success. While the complainant had previously made a number of FOI requests to the police about this information, it was unclear whether he had formally requested the information be amended.

Regardless of this, given the complainant's personal circumstances and his lack of success in complaining to the police, we asked the NSWPF FOI Unit to assess his concern about the extra record and make necessary amendments if an error was identified. The police reviewed the matter and amended the record.

In this case, the complainant spent many months attempting to resolve a concern that was ultimately fixed quickly once our office became involved.

Case study 73 provides an example of a matter where the NSWPF exempted material sought by a journalist because of concerns they held that the release of the information would damage the reputation of certain schools.

Mental health issues can often be a barrier in successfully negotiating FOI outcomes. If a complainant has a mental illness, or their ability to resolve a matter is in some way limited, government agencies must be proactive in reviewing and resolving matters promptly. Case study 74 illustrates this.

Open disclosure and FOI

The Department of Health's open disclosure policy and related guidelines applies to all area health services. It sets out how healthcare staff should communicate with patients and their support persons after adverse incidents. One of the requirements is the provision of an apology in appropriate circumstances.

We consider that full and frank disclosure can go a long way towards helping patients come to terms with an adverse situation. It can also prevent matters from developing into drawn out complaints or multiple FOI applications. Adherence to the open disclosure policy also means that patients and their families don't need to resort to FOI to find out what happened. Case study 75 illustrates this issue.

Case study 75

A complainant sought an external review of the determination the North Coast Area Health Service made on her FOI application. She wanted documents that would explain the treatment her elderly father had received in hospital, as he came home with bruises. Although the hospital initially gave some information, the complainant was not satisfied and sought additional details. In response to her FOI application, the hospital released incident reports and medical records — but declined to give documents about their investigation of the complaint about the treatment the father received.

We suggested the documents about the investigation be released. As it appeared the open disclosure policy was not followed in this case, we also suggested the area health service apologise to the complainant for both the shortfalls in the treatment her father had received and the way they had responded to her complaint. The area health service gave the complainant a written apology and an opportunity to meet with the chief executive so he could apologise in person.

While we consider the apology and the release of the documents resolved the issues raised by the complainant, we have continued to monitor the way area health services comply with the open disclosure policy.

Food hygiene matters

Food hygiene related issues continued to receive media interest this year with journalists lodging FOI applications to obtain information from councils about breaches of the *Food Act 2003*. Last year we reported that, in our view, there are good reasons for introducing a system that alerts the public to health and hygiene issues in all food businesses. We did not think the FOI Act was a suitable vehicle to achieve this outcome, but developing an appropriate system was an important issue for policy-makers to consider.

Since then, there has been further debate about whether information on food hygiene standards should be disclosed by the government outside of the FOI Act. In response to this debate, the NSW Food Authority started publishing the results of successful prosecutions on their website. On 14 April 2008 the Food Amendment (Public Information on Offences) Bill 2008 was assented to, providing for the publication of information about infringements by the NSW Food Authority. This practice has already started with the authority naming establishments on their website that have been prosecuted for infringements.

Legal professional privilege

Last year, we suggested the Department of Education and Training (DET) consider redrafting their reporting school accidents policy in regard to the application of legal professional privilege. DET's policy stated that legal professional privilege will apply to all school accident reports, thus pre-determining a blanket exemption for such documents requested under FOI. Our view, supported by the Solicitor General, is that this approach is wrong. DET has advised us that they have now amended the policy to state that legal privilege 'may apply'.

Sometimes our review of how an agency handled an FOI application reveals problems in the agency's systems or processes that need to be rectified.

Case study 76

An inmate from the High Risk Management Unit (HRMU) lodged an FOI application for a large number of documents held on his case management file. When he received the documents, he was concerned that documents about regular case reviews appeared to be missing and pages were missing from other documents.

In addition to finding that some documents had been omitted and some had been incorrectly copied by the HRMU, we also found that the HRMU had been using outdated forms to record inmate case reviews. Our inquiries drew attention to the need for the HRMU to review their document management practices. We will continue to monitor this matter.

Case study 77

The Combined Pensioners and Superannuants Association applied for access to all documents about a Roads and Traffic Authority (RTA) review of pensioner concessions for driving licences and car registrations. The review sought to introduce charges for pensioners that conflicted with the Minister's earlier advice to the association that there would be no changes to pensioner concessions. The RTA refused access to many documents under the internal working document exemption.

When we first made inquiries with the RTA about whether the documents were of any ongoing relevance, they advised us there was no current review of pensioner concession charges. We therefore suggested the documents should be released. In response, the RTA advised us they were conducting a review. At our suggestion, the RTA advised the association of the review. The RTA's letter contained contradictory remarks about how much information they would provide to the association about the review and the extent of any consultation.

Following two media articles about the review, a senior RTA manager contacted the association to advise them the RTA was not carrying out a review of pensioner concessions. As a result, the RTA agreed with our suggestion and released the documents.

Case studies 76 and 77 demonstrate our work in FOI sometimes highlights underlying issues with agencies' administrative processes which we can give agencies feedback about.

Investigations

This last year has been a particularly busy year for investigations into how agencies handle FOI applications. We have some investigations underway that we cannot report on due to their confidential nature, but a number of completed investigations — some of which are detailed below — demonstrate the issues confronted by the community in relation to accessing information under the current FOI legislation.

Investigation 1

The Sydney Morning Herald applied to the RTA for access to documents relating to a payment in 2006 of $25 million to Connector Motorways, the company that built and operates the Lane Cove Tunnel. The payment was made to allow for a delay to changes in traffic direction in roads close to the Lane Cove Tunnel. The RTA refused access to all 59 documents under clauses 1, 7, 9 and 10 of Schedule 1 to the FOI Act.

We conducted a formal investigation into the RTA's conduct. In accordance with normal procedure, the RTA obtained certificates from the Department of Premier and Cabinet to support their determination that the documents were Cabinet documents. The RTA obtained certificates for 39 documents and continued to maintain other documents not covered by the certificates were also Cabinet documents. After considering our preliminary report, the RTA agreed that many documents they initially considered exempt could be provided to the newspaper. However they continued to maintain exemptions for a second category of documents, including the ones they had no Cabinet certificates for.

In our final report we recommended the release of most of the second category of documents, as we considered there was a strong public interest in knowing the details of the $25 million payment of public money to Connector Motorways. The RTA refused to comply.

We also had concerns about the way the RTA consulted with Connector Motorways. They consulted with them a second time after the company had initially advised the RTA they had no concerns about the release of documents concerning their affairs.

Investigation 2

We conducted two investigations into how the NSW Rail Corporation (RailCorp) handled applications by the Sydney Morning Herald for documents involving a public private partnership for the purchase of new railway carriages, as well as documents about the risk assessment of major infrastructure above rail tracks. After lengthy negotiations, RailCorp released a number of documents about the rail carriages previously considered to be exempt. However they refused to fully comply with our recommendations about the documents on the risk assessments of infrastructure — stating concerns that the information in the documents could be used for possible terrorist attacks.

We were concerned that these two cases may indicate a systemic problem in the way RailCorp handles applications by the media. We suggested consideration be given to a more proactive disclosure of information, particularly in situations where there is an already known or perceived risk to public safety. This would allow RailCorp to demonstrate that they had been diligent in mitigating risks, as we were satisfied they did in this case.

Advance deposits

Many agencies receive FOI applications that request access to a large number of documents, sometimes involving hundreds or thousands of pages. Such applications clearly mean a lot of work for an agency's FOI staff.

Although agencies can request an advance monetary deposit from an applicant, they should take care to ensure any advance deposits and FOI charges are reasonable and appropriate. Two cases we dealt with highlight this issue:

- We received a complaint from an employee of Sydney South West Area Health Service (SSWAHS) who became involved in an industrial dispute with SSWAHS. He applied under FOI for all documents about his employment and the industrial dispute. Hundreds of documents were involved and the applicant was asked to pay over $1300 in processing fees. The majority of documents were about the applicant — such as his timesheets and other personnel documents. Access to these should have been available to him without recourse to FOI. We suggested to SSWAHS that they negotiate with the applicant to reduce the fee. They waived the entire fee and released nearly all the documents.
- An application was made to the Department of Education and Training for two different categories of documents. One category related to the applicant's personal affairs and included thousands of documents, while the other category did not concern her personal affairs. The department asked the applicant for an advance deposit for the part of her application that did not concern her personal affairs, but did not commence processing the applicant's personal affairs application until we became involved.

  When we received her complaint we were quickly able to resolve that part of her application that did not concern her personal affairs. However, there were long delays by the department in processing the documents about the applicant's personal affairs. We negotiated with the department over many months. While we do understand there could be legitimate delays when an agency has to deal with such a large application, we considered it was inappropriate for the department to request any advance deposit for the documents not concerning the applicant's personal affairs due to the extensive delay. The department agreed.

We believe it is good practice for agencies to consider the types of documents being requested and any potential for delay when calculating advance deposits and processing charges. Agencies should consider refunding fees where delays have been experienced.

Applications for electronic documents

With continuing advances in technology, we see an increasing number of FOI applications for documents that are held in electronic format.

The FOI Act, which was written before the advent of email and the widespread use of the computer, provides no clear guidance for dealing with requests for electronic documents — except that such documents are subject to FOI applications. There can sometimes be a fine line between a legitimate application for 'existing' documents held on a database, and a request for information that requires complex research or the manipulation of information technology. Our review of the Act will address some of these important issues.

In dealing with complaints involving electronic documents, we would generally examine whether the agency has tried to properly satisfy the applicant and provide access to the documents. This may include the agency seeking information technology advice about whether documents can be located, downloaded or easily retrieved. We would also look to see whether an agency may be using the difficulties in retrieving a document to simply avoid releasing it.

Searching for documents

We are seeing a rise in the number of complaints claiming an agency has failed to carry out a proper search for documents. On 19 June 2008, in the case of the *Administrative Decisions Tribunal Appeal Panel v Director-General, Department of Commerce & Ors* [2008] NSWCA 140, the Court of Appeal determined that the jurisdiction of the ADT does not extend to reviewing the adequacy of searches undertaken by the agency in response to an FOI application. We expect a further rise in insufficient search complaints to us as a consequence of this decision.

These complaints mostly arise in large decentralised agencies where FOI staff cannot carry out searches themselves and have to rely on other staff, often located away from the head office, to supply them with documents.

We expect FOI staff to carry out sufficient and appropriate searches for documents in every case, even if that means contacting the local office several times. It is important however that agencies ensure all staff fully cooperate with FOI managers and provide all assistance needed in locating documents.

The importance of communicating with applicants

In our experience, many problems that emerge from an agency's handling of FOI applications arise through poor communication with the applicant. Problems can include a failure to identify all relevant documents, insufficient searches, excessive FOI charges and unnecessary work carried out to determine particular documents are exempt — as it sometimes turns out the applicant is not really interested in these.

It is not uncommon for FOI applications to be very broad and for an agency to have difficulty identifying all the relevant documents. It is appropriate for agencies to consult with applicants if they have any difficulty in dealing with the application, wish to clarify parts of it, or discuss why the applicant wants the documents. If an agency knows the reasons behind an application, there may be an opportunity to resolve either the FOI application or a related issue. Although it may not always be appropriate to contact an applicant, communication about any possible delays in dealing with an application is always good practice.

Protected disclosures 11

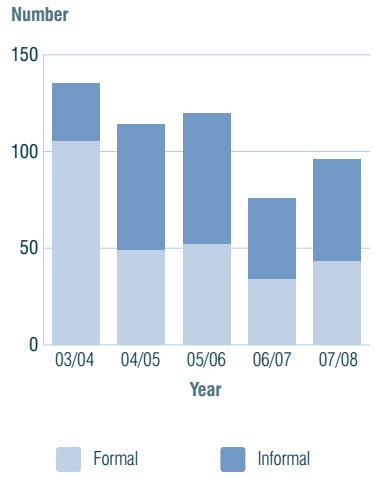
In November 2006, the Parliamentary Joint Committee (PJC) on the Independent Commission Against Corruption made 17 recommendations for amending the *Protected Disclosures Act 1994* (the PD Act) and improving how protected disclosures are handled.

Highlights

This year we have:

- Continued our contribution to the Whistling While They Work research project.
- Started a review of our *Protected Disclosure Guidelines*.
- Promoted the implementation of the recommendations of the 2006 Parliamentary review of the *Protected Disclosures Act 1994*.
- Produced a guideline for agencies on *Reporting of Progress and Results of Investigations*.
- Conducted eight training workshops on the better management of protected disclosures.

Figure 52 — Protected disclosures received — five year comparison



Progress on amending the legislation

In March 2008, the Protected Disclosures Act Implementation Steering Committee wrote to the Premier encouraging the government to implement the Parliamentary Joint Committee on the Independent Commission Against Corruption's (ICAC Committee) recommendations. The Steering Committee is yet to receive a response from the Premier.

In June 2008, the Protected Disclosures Amendment (Supporting Whistleblowers) Bill 2008 was introduced in Parliament by the Leader of the Opposition. The Bill covers the main recommendations of the PJC's review of the PD Act and seeks to establish a Public Interest Disclosures Unit within the Ombudsman's Office.

On 11 July 2008, the ICAC Committee announced the start of a further inquiry into the effectiveness of current laws, practices and procedures in protecting public sector whistleblowers.

Whistling while they work project

Over the past four years, we have been involved in a collaborative national research project on the management and protection of internal witnesses — including whistleblowers — in the Australian public sector. The Deputy Ombudsman has provided considerable input into this project and is the co-author of two chapters in the project's final report.

The first report of the project, called *Whistleblowing in the Australian Public Sector,* was published in draft form in October 2007. The final version was published in September 2008, entitled: *Whistling While They Work: Enhancing the theory and practice of internal witness management in public sector organisations.* It is proposed that a draft of a second report — on internal witness management systems — will be released at the National Investigation Symposium to be held in Sydney in November 2008.

The first report of the Whistling While They Work project focuses on such important issues as:

- the incidence and significance of whistleblowing — identifying that disclosures of wrongdoing by staff are far more common than was expected
- who blows the whistle, who doesn't, and why — finding that just about anybody could blow the whistle, depending on circumstances such as the seriousness of the issue and whether they thought anything would be done about it
- whether reports are made internally or externally — finding that the vast majority of reports are made internal to the organisation, and usually to a supervisor
- the outcomes of whistleblowing — finding that while a majority of whistleblowers reported there was no change or they were better off following the making of a report, a significant number reported that they suffered reprisals
- identifying the risks of mistreatment — identifying a number of common risk factors (which interestingly did not include confidentiality).

Other issues addressed in the report include:

- improving investigation practices and capacity
- internal witness support
- comprehensiveness and effectiveness of agency procedures
- key principles for whistleblower legislation
- project findings, including an agenda for action.

We have started reviewing our own *Protected Disclosures Guidelines* in the light of the findings of the research and plan to publish a new version (the 6th edition) later in 2008.

Providing information to interested parties

This year we received a number of inquiries from agencies about what information can be given to interested parties about the progress and results of investigations into complaints or protected disclosures. Although it is not possible to give a definitive answer to this question that applies in all circumstances, we issued some general advice to agencies in a guideline called *Reporting of Progress and Results of Investigations*. These can be downloaded from our website.

Information given to interested parties — such as complainants/whistleblowers, subjects of complaints/disclosures and witnesses — should:

- meet the legitimate expectations of those involved
- respect the rights and interests of those involved
- improve how complainants/whistleblowers and subjects of complaints/disclosures are managed
- provide procedural fairness to subjects of complaints/disclosures.

The actual information provided and how it is provided will depend on:

- the nature of the investigation — 'evidence focused' or 'outcome focused'
- who the information is given to — e.g. complainant, whistleblower, witness or subject of the investigation
- the particular stage of the investigation — e.g. at the outset, after a decision is made, during the course of the investigation, before completion or at the end of the investigation.

Complainants and whistleblowers should be given at least enough information to show that their complaint was properly investigated.

Timely assessment of protected disclosures

We received a complaint this year alleging that detrimental action was taken against the complainant as a result of making a protected disclosure to an agency. It highlighted the importance of agencies assessing internal disclosures and complaints from their staff to determine, at the outset, if they are protected disclosures. This allows agencies to appropriately manage confidentiality issues, the complainant's expectations about the actions to be taken, and the level of information provided to them. It also enables agencies to assess the risk of any potential for detrimental action.

Developing a protected disclosure assessment tool, with a checklist based on the eligibility criteria in the PD Act, will assist agencies with this task. Our fact sheet on Protected Disclosures provides useful guidance for doing this.

Providing training workshops

Providing regular training to the nominated disclosure officers in an agency is vitally important to ensure internal reporting procedures are working properly. This is especially the case in large organisations that have many decentralised units. Staff sometimes temporarily act in positions that are nominated to take protected disclosures, but don't understand what they are required to do when they receive one. This can cause problems for both the agency and the whistleblower.

During 2007–2008, the Deputy Ombudsman and a representative of the ICAC conducted eight Better Management of Protected Disclosures workshops in Sydney, Albury, the Hunter, Newcastle and Wagga Wagga. About 20 people attended each workshop, and over 90% of participants provided feedback that the workshops were very useful and relevant to their work.

In addition, the Deputy Ombudsman:

- conducted several in-house training sessions for staff of a number of agencies on the management of whistleblowers
- presented a workshop on managing public interest disclosures with Dr A.J. Brown of Griffith University, as part of the APSAC Conference in Sydney in October 2007
- co-delivered a presentation on whistleblowing at an Australian and New Zealand School of Government (ANZSOG) training course in Melbourne in May 2008.

Pay-back complaints

Several years ago, a number of whistleblowers made a series of protected disclosures that led to a major investigation by the Ombudsman. This year we received a new complaint from one of those whistleblowers. Several people within her organisation had made complaints about her. She believed these complaints were malicious, and had been made by friends of the person who had been investigated after the earlier disclosure — as a 'tit for tat' response for her having come forward.

We organised a meeting between the chief executive officer of the organisation and the complainant. We discussed the fact that if a person makes a disclosure and seeks the protections of the Protected Disclosures Act, it is important to not — at the outset — dismiss the idea that a matter may be genuine, even if some 'tit for tat' considerations may be involved. Every complaint needs to be examined on its merits.

However, we also pointed out that the Act provides that principal officers of an authority may decline to investigate a matter if they believe that the disclosure was made frivolously or vexatiously. In this case, a person who makes such a complaint could be penalised under the organisation's code of conduct. The chief executive officer agreed to communicate these considerations in a memo to all staff to prevent any further pay-back disclosures being made against the complainant. The complaints already made were found to be groundless.

Covert operations 12

The NSW Police Force, the Crime Commission, the Independent Commission Against Corruption and the Police Integrity Commission have the power to do a range of things — as part of a covert operation — that would otherwise be illegal.

Highlights

- During the year, we inspected the records of 364 controlled operations, an increase of 59 over the previous year.
- Conducted 19 separate on-site inspections of the telecommunication interception and controlled operations records of the relevant law enforcement agencies.
- Complied with our external reporting obligations.

Under the *Listening Devices Act 1984* (recently replaced by the *Surveillance Devices Act 2007)*, the Commonwealth *Telecommunications (Interception and Access) Act 1979* and the *Law Enforcement (Controlled Operations) Act 1997*, the relevant law enforcement agencies can intercept telephone conversations and plant devices to listen to and video conversations and track positions of objects. They can also carry out controlled or 'undercover' operations that may involve committing breaches of the law, such as being in possession of illicit drugs.

Because these kinds of operations involve significant intrusions into people's private lives, the agencies may only use these powers if they follow the approval procedures and accountability provisions set out in the relevant legislation. An important function of the Ombudsman is to review the compliance of agencies with these requirements.

The Ombudsman has always been involved in monitoring compliance with the legislation for telecommunications interception and controlled operations. However, up to this year, there was no external oversight of listening devices by an independent agency. The *Surveillance Devices Act 2007* was assented to on 23 November 2007, but was not yet in force during this reporting year. Under this new legislation, we will also have the role of inspecting the surveillance device records of NSW law enforcement agencies to determine the extent of compliance with the Act — both by the agency and their law enforcement officers. We will also have reporting obligations to the Attorney General and Parliament.

These monitoring and inspection functions are carried out by specialist, security cleared staff in our secure monitoring unit who report directly to an Assistant Ombudsman. During 2007–2008, staff from the unit conducted 19 separate on-site inspections of the telecommunication interception and controlled operations records of the relevant law enforcement agencies to make sure they were complying with their legislative obligations. For controlled operations, this monitoring role extended to three Commonwealth law enforcement agencies that are eligible to conduct operations under the NSW Act. These are the Australian Federal Police, the Australian Customs Service and the Australian Crime Commission. To date, only the Australian Crime Commission has conducted controlled operations using their powers under the NSW Act.

Controlled operations

Controlled operations are an important investigation tool. They allow law enforcement agencies to infiltrate criminal groups — particularly those engaged in drug trafficking and organised crime — to obtain evidence to prosecute perpetrators of criminal offences or expose corrupt conduct.

The chief executive officer of the law enforcement agency gives approval for controlled operations without reference to any external authority. To ensure accountability, the Ombudsman has a significant role in monitoring the actual approval process for these undercover operations.

Agencies must notify us within 21 days if an authority to conduct an operation has been granted or varied, or if a report has been received by the agency's chief executive officer on the completion of the operation.

We are required to inspect the records of each agency at least once every 12 months to ensure they are complying with the requirements of the Act. We also have the power to inspect agencies' records at any time — and make a special report to Parliament if we have concerns that should be brought to the attention of the public.

During 2007–2008, we inspected the records of 364 controlled operations.

We report in detail on our monitoring work under the Law Enforcement (Controlled Operations) Act in a separate annual report that is available on our website or from our office. As well as reporting on compliance with the Act, the report includes details about the type of criminal conduct targeted in the operations and the number of people who were authorised to undertake controlled activities. It also provides some basic information about the results of those operations.

Telecommunication interceptions

A judicial officer or member of the Administrative Appeals Tribunal grants a warrant for a telephone interception, so — unlike controlled operations — our role does not include scrutinising compliance with the actual approval process.

We make sure that the agency carrying out the telecommunication interception complies with all the necessary record-keeping requirements. These records must document the issue of warrants and how the information gathered was used. Some records have to be given to the Attorney General and all intercepted material must be destroyed once specified conditions no longer apply. All telephone intercept records have to be kept under secure conditions by the agency.

We are required to inspect each agency's records at least twice a year, and also have discretionary power to inspect their records for compliance at any time. We report the results of our inspections to the Attorney General. The *Telecommunications (Interception and Access) (New South Wales) Act 1987* prevents us from providing any information about what we do under that Act in our annual report — or in any other public report we prepare.

In 2006, the Commonwealth *Telecommunications (Interception and Access) Act 1979* was amended to allow the interception of communications of an innocent third party known to communicate with a person of interest. These amendments also provided for stored communications warrants. These warrants are obtained by law enforcement agencies to lawfully access — by covert means — emails, SMS and voicemail messages that are stored on telecommunications service providers' equipment. NSW law enforcement agencies can already use these additional powers. However, as we reported last year, the failure over recent years to amend the NSW Telecommunications (Interception and Access) Act to keep it up-to-date and compatible with the Commonwealth legislation means that we do not monitor how agencies use these powers.

Financials

The following information including the audited financial statements, provide an overview of the financial activities of our office during 2007–2008. The financial statements, our supporting documentation and our systems and processes have all been reviewed by our own auditors and the NSW Audit Office. We have received an unqualified audit report.

Our accounts section has the day-to-day responsibility for managing and reporting on our finances, including liaising with NSW Treasury and the Audit Office. This year, we continued our ongoing review of the roles and responsibilities of the accounts section so that we could better focus on internal budgeting and reporting and improve our financial management. Although some changes are still to be implemented, we have seen significant improvements — particularly with expenditure reporting and forecasting.

Highlights

- Received an unqualified audit report.
- 28% reduction in workers compensation expenses.
- Paid 98.44% of accounts on time.
- Generated $263,000 in revenue.
- Improved internal financial reporting.
- Updated our accounting policies and manual.

Financial summary

Balancing our books

The Ombudsman receives funding from the government. Although we account for these funds on an office-wide basis — as reflected in our financials — internally we allocate them between our four business programs and our corporate and cross agency teams. However our 'Program Statement — Expenses and Revenues' in the financial statements only identifies the four business programs. This is because the corporate team and cross agency team costs have been pro-rated to provide a more accurate cost of the work of our office. Figure 56 shows the net expenditure for our programs for the last five years.

Revenue

Most of our revenue comes from the government in the form of a consolidated fund appropriation. This is used to meet both recurrent and capital expenditures. Consolidated funds are accounted for on the operating statement after the net cost of service is calculated to allow for the movement in accumulated funds to be determined for the year. The government also makes provision for certain employee entitlements such as long service leave.

Our initial 2007–2008 recurrent consolidated fund allocation was $20.176 million. We did not use $107,000 that had been allocated for our review of the implementation of the *Crimes Legislation Amendment Act 2002* — Detention during search warrant execution review, as this new police power had not yet come into operation. Our final allocation was $20.069 million.

Funding for our reviews of the implementation of new police powers is included in the Ombudsman's allocation. For more details about these reviews, see Chapter 5: Policing. Figure 55 shows the amount provided for the legislative reviews over the last five years. $273,000 has been allocated for our legislative review work in 2008–2009. This represents 1.37% of the Ombudsman's total recurrent allocation.

In 2007–2008 we budgeted that the Crown Entity would accept $919,000 of employee benefits and other entitlements, but the actual acceptance was about $831,000.

We were allocated $300,000 for our capital program but only spent $298,000. We upgraded our computer systems, purchased new office equipment and updated and improved our fitout.

We generated $263,000 through the sale of publications, bank interest, fee-for-service training courses and our consultancy services to AusAid (see figure 54).

There is a breakdown of our revenue, including capital funding and acceptance of employee entitlements, in figure 53.

Figure 53 — Total revenue 2007–2008

Government	Revenue
Recurrent appropriation	$20,069,000
Capital appropriation	$298,000
Acceptance of certain employee entitlements	$831,000
Total government	$21,198,000
From other sources	$263,000
Total	**$21,461,000**

Figure 54 — Revenue from other sources

Revenue from other sources	Revenue
Workshops	$132,000
Grants	$41,000
Bank interest	$66,000
Other revenue	$14,000
Publication sales	$10,000
Total	**$263,000**

Figure 55 — Legislative reviews — amount provided over 5 years

2007/2008	$1,085,000
2006/2007	$1,073,000
2005/2006	$633,000
2004/2005	$432,570
2003/2004	$751,000

Expenses

Most of our revenue is spent on employee-related expenses (see figure 57). These include salaries, superannuation entitlements, long service leave and payroll tax. Our operating statement shows that last year we spent more than $17.1 million — or 77.6% of our total expenses — on employee-related items, an increase of 4.72% over the previous reporting year.

Salary increases awarded to public servants were the main reason for the $514,000 or 3.75% increase in our salary expenses. There was a slight decrease in payroll tax expenses and a $126,000 increase in superannuation. Our workers compensation insurance reduced by around 28%, partly reflecting the positive strategies we have employed to reduce workplace injuries and our better support for staff returning to work after injury. Long service leave expenses increased by $162,000 or 59.77%, due to a review of our accounting for this liability.

The day-to-day running of our office costs over $4.2 million a year. Significant items are rent ($1.7 million), fees ($839,000), travel ($467,000), maintenance ($268,000) and training ($180,000). No consultants were engaged in 2007–2008.

The financial statements show $694,000 for depreciation and amortisation. We only spent $298,000 on our capital program so we had a decrease in our asset base.

Although capital funding is shown on the operating statement, capital expenditure is not treated as an expense — it is reflected on the balance sheet.

Figure 56 — Net cost of services by program

Program	04/05 $'000	05/06 $'000	06/07 $'000	07/08 $'000
Police	$5,801	$6,138	$6,645	$6,363
General	$4,428	$4,342	$4,755	$5,113
Child protection	$3,140	$3,026	$3,338	$3,649
Community services	$5,505	$5,518	$6,115	$6,665
Total	**$18,874**	**$19,024**	**$20,853**	**$21,790**

Figure 57 — Total expenses 2007–2008

Total expenses	Expenses
Employee-related	$17,114,000
Depreciation and amortisation	$694,000
Other operating expenses	$4,245,000
Total	**$22,053,000**

We have an accounts payable policy that requires us to pay accounts promptly and within the terms specified on the invoice. However, there are some instances where this may not be possible — for example, if we dispute an invoice or do not receive it in enough time to pay within the specified timeframe. Our aim is to pay accounts within the specified timeframe 98% of the time. During 2007–2008 we paid 98.44% of our accounts on time. This is a slight reduction in our performance from the previous year. We have not had to pay any penalty interest on outstanding accounts.

Figure 58 — Performance Indicator: Accounts paid on time

Quarter	Target %	Paid on time %	Paid on time $'000	Paid $'000
September 2007	98	99.74	$4,672	$4,684
December 2007	98	94.80	$5,218	$5,504
March 2008	98	99.34	$4,968	$5,001
June 2008	98	99.88	$6,495	$6,503
Total	**98**	**98.44**	**$21,353**	**$21,692**

Assets

Our balance sheet shows that we had $2.258 million in assets as at 30 June 2008. The value of our current assets decreased by $151,000 from the previous year and the value of our non-current asset base decreased by $396,000. This is an overall decrease of $547,000 in our asset base from the previous year.

Just over 47% of our assets are current assets, categorised as cash or receivables. Receivables are amounts owing to us and include bank interest that has accrued but not been received, fees for services that we have provided on a cost recovery basis, and GST to be recovered from the Australian Taxation Office. Also included in receivables are amounts that we have prepaid. We had $152,000 in prepayments as at 30 June 2008. The most significant prepayments were maintenance renewals for office equipment and software support.

Our cash balance includes a $47,000 advance payment from the Commonwealth and other state Ombudsman to cover the cost of developing guidelines and training Australian Ombudsman staff in dealing with unreasonable complainant conduct. We also received $35,000 from the Department of Immigration and Citizenship for our young people and the internet project. We cannot use this cash for any other purpose, so it is classified as a 'restricted asset'.

Our non-current assets, which are valued at $1.191 million, are categorised as:

- plant and equipment — which includes our network infrastructure, computers and laptops, fitout and office equipment
- intangible assets — which includes our network operating software and case management software.

We were allocated $300,000 in 2007–2008 for asset purchases and spent $298,000. This is reflected in our capital consolidated fund appropriation. We will receive $559,000 in 2008–2009.

Figure 59 — Major assets

Description	06/07	Acquisition	Disposal	07/08
File servers	22	2	0	24
Switches	15	0	0	15
Computers	221	5	0	226
Printers	12	2	0	14
Photocopiers	5	0	0	5
Telephone systems	1	0	0	1

Financial summary

Liabilities

Our total liabilities as at 30 June 2008 are $1.893 million, an increase of $45,000 over the previous year. Over 81% of this amount is the provision that we make for employee benefits and related on-costs. This includes accounting for untaken recreation (annual) leave that is valued at $905,000. The Crown Entity accepts the liability for long service leave.

We have $197,000 of goods or services that we have received, but have not yet been invoiced. The value of accounts on hand (those accounts we have processed but not yet paid) at 30 June 2008 is detailed in figure 60. We monitor the amounts that we owe on a regular basis to ensure that we are paying accounts on time.

Figure 60 — Aged analysis of accounts on hand at the end of each quarter

	September 2007	December 2007	March 2008	June 2008
Current (i.e. within due date)	$108,775	$89,038	$155,588	$21,716
Less than 30 days overdue	$167,582	$170,315	$921	$0
Between 30 days and 60 days overdue	$0	$0	$873	$0
Between 60 days and 90 days overdue	–$230	$0	$0	$3,015
More than 90 days overdue	$0	$0	–$140	$0
Total accounts on hand	**$276,127**	**$259,352**	**$157,242**	**$24,731**

Financial statements

Our financial statements are prepared in accordance with legislative provisions and accounting standards. They are audited by the NSW Auditor General (or delegate), who is required to express an opinion as to whether the statements fairly represent the financial position of the office. The office received an unqualified audit report. The audit report as well as the financial statements follow.

GPO Box 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

OMBUDSMAN'S OFFICE

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Ombudsman's Office (the Department), which comprises the balance sheet as at 30 June 2008, the operating statement, statement of recognised income and expense, cash flow statement, program statement - expenses and revenues, and a summary of compliance with financial directives for the year then ended, and a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Department as at 30 June 2008, and its financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

My opinion should be read in conjunction with the rest of this report.

Department Head's Responsibility for the Financial Report

The Ombudsman is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making these risk assessments, the auditor considers internal controls relevant to the Department's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Ombudsman, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Financial statements

My opinion does not provide assurance

- about the future viability of the Department,
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal controls, or
- on the assumptions used in formulating the budget figures disclosed in the financial report.

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.

Peter Achterstraat
Auditor-General

19 September 2008
SYDNEY

NSW Ombudsman

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STATEMENT BY THE OMBUDSMAN

Pursuant to section 45F of the *Public Finance and Audit Act 1983* to the best of my knowledge and belief state that:

(a) the accompanying financial statements have been prepared in accordance with the provisions of the Australian Accounting Standards (which include Australian Accounting Interpretations), the *Public Finance and Audit Act 1983*, the Financial Reporting Code for Budget Dependent General Government Sector Agencies, the applicable clauses of the Public Finance and Audit Regulation 2005 and the Treasurer's Directions;

(b) the statements exhibit a true and fair view of the financial position of the Ombudsman's Office as at 30 June 2008, and transactions for the year then ended;

(c) there are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

Bruce Barbour
Ombudsman
17 September 2008

Financial statements

Start of the audited financial statements

OMBUDSMAN'S OFFICE

Operating Statement for the Year Ended 30 June 2008

	Notes	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
Expenses excluding losses				
Operating expenses				
Employee related	2(a)	17,114	17,804	16,342
Other operating expenses	2(b)	4,245	3,813	4,041
Depreciation and amortisation	2(c)	694	698	647
TOTAL EXPENSES EXCLUDING LOSSES		**22,053**	**22,315**	**21,030**
Revenue				
Sale of goods and services	3(a)	142	72	79
Investment revenue	3(b)	66	50	66
Grants and contributions	3(c)	41	–	–
Other revenue	3(d)	14	68	32
TOTAL REVENUE		**263**	**190**	**177**
Net Cost of Services	17	**21,790**	**22,125**	**20,853**
Government Contributions				
Recurrent appropriation	4(a)	20,069	20,176	19,610
Capital appropriation	4(b)	298	300	253
Acceptance by the Crown Entity of employee benefits and other liabilities	5	831	919	610
TOTAL GOVERNMENT CONTRIBUTIONS		**21,198**	**21,395**	**20,473**
DEFICIT FOR THE YEAR		**(592)**	**(730)**	**(380)**

The accompanying notes form part of these financial statements.

OMBUDSMAN'S OFFICE

Statement of Recognised Income and Expense for the Year Ended 30 June 2008

	Notes	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		–	–	–
Deficit for the Year		(592)	(730)	(380)
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR	15	**(592)**	**(730)**	**(380)**

The accompanying notes form part of these financial statements.

Financial statements

OMBUDSMAN'S OFFICE

Balance Sheet as at 30 June 2008

	Notes	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
ASSETS				
Current Assets				
Cash and cash equivalents	7	707	523	584
Receivables	9	360	623	634
Total Current Assets		**1,067**	**1,146**	**1,218**
Non-Current Assets				
Property, plant and equipment				
Plant and equipment	10	850	879	992
Intangible assets	11	341	313	595
Total Non-Current Assets		**1,191**	**1,192**	**1,587**
TOTAL ASSETS		**2,258**	**2,338**	**2,805**
LIABILITIES				
Current Liabilities				
Payables	12	357	350	259
Provisions	13	1,386	1,639	1,434
Other	14	128	98	98
Total Current Liabilities		**1,871**	**2,087**	**1,791**
Non-Current Liabilities				
Provisions	13	13	15	14
Other	14	9	9	43
Total Non-Current Liabilities		**22**	**24**	**57**
TOTAL LIABILITIES		**1,893**	**2,111**	**1,848**
Net Assets		**365**	**227**	**957**
EQUITY				
Accumulated funds	15	365	227	957
TOTAL EQUITY		**365**	**227**	**957**

The accompanying notes form part of these financial statements.

OMBUDSMAN'S OFFICE

Cash Flow Statement for the Year Ended 30 June 2008

	Notes	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee related		(16,285)	(16,588)	(15,722)
Other		(4,349)	(4,357)	(4,447)
TOTAL PAYMENTS		**(20,634)**	**(20,945)**	**(20,169)**
Receipts				
Sale of goods and services		153	72	79
Interest received		85	45	56
Other		448	594	429
TOTAL RECEIPTS		**686**	**711**	**564**
Cash Flows from Government				
Recurrent appropriation		20,069	20,176	19,610
Capital appropriation (excluding equity appropriations)		300	300	253
Net Cash Flows from Government	17	**20,369**	**20,476**	**19,863**
NET CASH FLOWS FROM OPERATING ACTIVITIES		**421**	**242**	**258**
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Leasehold Improvements, Plant and Equipment and Infrastructure Systems		(298)	(303)	(253)
NET CASH FLOWS FROM INVESTING ACTIVITIES		**(298)**	**(303)**	**(253)**
NET INCREASE/(DECREASE) IN CASH		**123**	**(61)**	**5**
Opening cash and cash equivalents		584	520	579
CLOSING CASH AND CASH EQUIVALENTS	7	**707**	**459**	**584**

The accompanying notes form part of these financial statements.

OMBUDSMAN'S OFFICE

Program Statement — Expenses and Revenues for the Year Ended 30 June 2008

AGENCY'S EXPENSES AND REVENUES	Program 1*		Program 2*		Program 3*		Program 4*		Not Attributable		Total	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000	2008 $'000	2007 $'000	2008 $'000	2007 $'000	2008 $'000	2007 $'000	2008 $'000	2007 $'000
Expenses excluding losses												
Operating expenses												
Employee related	4,937	5,185	4,148	3,811	2,900	2,677	5,129	4,669	–	–	17,114	16,342
Other operating expenses	1,246	1,275	941	876	662	572	1,396	1,318	–	–	4,245	4,041
Depreciation and amortisation	211	216	173	157	120	105	190	169	–	–	694	647
Total Expenses excluding losses	**6,394**	**6,676**	**5,262**	**4,844**	**3,682**	**3,354**	**6,715**	**6,156**	**–**	**–**	**22,053**	**21,030**
Revenue												
Sale of goods and services	(3)	(5)	(115)	(51)	(1)	(3)	(23)	(20)	–	–	(142)	(79)
Investment revenue	(20)	(22)	(17)	(16)	(11)	(11)	(18)	(17)	–	–	(66)	(66)
Grants and contributions	(7)	–	(6)	–	(20)	–	(8)	–	–	–	(41)	–
Other revenue	(1)	(4)	(11)	(22)	(1)	(2)	(1)	(4)	–	–	(14)	(32)
Total Revenue	**(31)**	**(31)**	**(149)**	**(89)**	**(33)**	**(16)**	**(50)**	**(41)**	**–**	**–**	**(263)**	**(177)**
Net Cost of Services	**6,363**	**6,645**	**5,113**	**4,755**	**3,649**	**3,338**	**6,665**	**6,115**	**–**	**–**	**21,790**	**20,853**
Government contributions**	–	–	–	–	–	–	–	–	(21,198)	(20,473)	(21,198)	(20,473)
NET EXPENDITURE/(REVENUE) FOR THE YEAR	**6,363**	**6,645**	**5,113**	**4,755**	**3,649**	**3,338**	**6,665**	**6,115**	**(21,198)**	**(20,473)**	**592**	**380**

* The name and purpose of each program is summarised in Note 6.

** Appropriations are made on an agency basis and not to individual programs. Consequently, government contributions are included in the 'Not Attributable' column.

OMBUDSMAN'S OFFICE

Summary of Compliance with Financial Directives

	2008				2007			
	RECURRENT APP'N	EXPENDITURE/ NET CLAIM ON CONSOLIDATED FUND	CAPITAL APP'N	EXPENDITURE/ NET CLAIM ON CONSOLIDATED FUND	RECURRENT APP'N	EXPENDITURE/ NET CLAIM ON CONSOLIDATED FUND	CAPITAL APP'N	EXPENDITURE/ NET CLAIM ON CONSOLIDATED FUND
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
ORIGINAL BUDGET APPROPRIATION/EXPENDITURE								
* Appropriation Act	20,176	20,069	300	298	19,654	19,547	245	245
* Additional Appropriations	–	–	–	–	–	–	–	–
* s.21A PF&AA — special appropriation	–	–	–	–	–	–	–	–
* s.24 PF&AA — transfers of functions between departments	–	–	–	–	–	–	–	–
* s.26 PF&AA — Commonwealth specific purpose payments	–	–	–	–	–	–	–	–
	20,176	**20,069**	**300**	**298**	**19,654**	**19,547**	**245**	**245**
OTHER APPROPRIATIONS/ EXPENDITURE								
* Treasurer's Advance	–	–	–	–	63	63	8	8
* Section 22 — expenditure for certain works and services	–	–	–	–	–	–	–	–
* Transfers to/from another agency (s.28 of the Appropriation Act)	–	–	–	–	–	–	–	–
	–	**–**	**–**	**–**	**63**	**63**	**8**	**8**
Total Appropriations/Expenditure/Net claim on Consolidated Fund	20,176	20,069	300	298	19,717	19,610	253	253
Amount drawn down against Appropriation		20,069		300		19,610		253
Liability to Consolidated Fund		–		2		–		–

The Summary of Compliance is based on the assumption that Consolidated Fund monies are spent first (except where otherwise identified or prescribed).

The Liability to Consolidated Fund represents the difference between the 'Amount drawn down against Appropriation' and the 'Total Expenditure/Net claim on Consolidated Fund'.

Financial statements

OMBUDSMAN'S OFFICE

Notes to the financial statements for the Year Ended 30 June 2008

1 Summary of significant accounting policies

(a) Reporting entity

The Ombudsman's Office is a NSW government department. Our role is to make sure that public and private sector agencies and employees within jurisdiction fulfil their functions properly. We help agencies to be aware of their responsibilities to the public, to act reasonably and to comply with the law and best practice in administration.

The Office is a not-for-profit entity (as profit is not its principal objective) and has no cash generating units. There are no other entities under our control.

The Office is consolidated as part of the NSW Total State Sector Accounts.

This financial report has been authorised for issue by the NSW Ombudsman on 17 September 2008.

(b) Basis of preparation

Our financial report is a general purpose financial report, which has been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations);
- the requirements of the *Public Finance and Audit Act 1983* and Regulation; and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer.

The financial statements have been prepared in accordance with the historical cost convention.

Judgements, key assumptions and estimations made are disclosed in the relevant notes to the financial report.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of compliance

The financial statements and notes comply with Australian Accounting Standards, which include Australian Accounting Interpretations.

(d) Income recognition

Income is measured at the fair value of the consideration or contribution received or receivable. Additional comments regarding the accounting policies for the recognition of income are discussed below.

(i) Parliamentary appropriations and contributions

Parliamentary appropriations and contributions from other bodies (including grants) are generally recognised as income when we obtain control over the assets comprising the appropriations/contributions. Control over appropriations and contributions is normally obtained upon the receipt of cash.

An exception to this is when appropriations remain unspent at year end. In this case, the authority to spend the money lapses and generally the unspent amount must be repaid to the Consolidated Fund in the following financial year. As a result, unspent appropriations are accounted for as liabilities rather than revenue. The liability is disclosed in Note 14 as part of 'Other Current Liabilities'.

(ii) Sale of goods

Revenue from the sale of goods such as publications are recognised as revenue when we transfer the significant risks and rewards of ownership of the assets.

(iii) Rendering of services

Revenue from the rendering of services such as conducting training programs, is recognised when the service is provided or by reference to the stage of completion, for instance based on labour hours incurred to date.

(iv) Investment revenue

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement*.

(e) Employee benefits and other provisions

(i) Salaries and wages, annual leave and on-costs

Liabilities for salaries and wages (including non-monetary benefits), and annual leave that fall due wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

Long-term annual leave is measured at the 10 year bond rates at present value in accordance with AASB 119 *Employee* Benefits. Market yields on government bonds of 6.45% are used to discount long-term annual leave.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and Fringe Benefits Tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(ii) Long service leave and superannuation

Our liabilities for long service leave and defined benefit superannuation are assumed by the Crown Entity. We account for the liability as having been extinguished, resulting in the amount assumed being shown as part of the

non-monetary revenue item described as 'Acceptance by the Crown Entity of employee benefits and other liabilities'.

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 07/04) to employees with five or more years of service, using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurer's Directions. The expense for defined contribution superannuation schemes (i.e. Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For defined benefit superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

(f) Insurance

Our insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for government agencies. The expense (premium) is determined by the Fund Manager based on past claims experience.

(g) Accounting for the Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of GST, except where:

- GST incurred by us as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the acquisition of an asset or as part of an item of expense, or
- receivables and payables are stated with GST included.

Cash flows are included in the cash flow statement on a gross basis. However, the GST components of cash flows arising from investing and financing activities which is recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

(h) Acquisitions of assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by us. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or, where applicable, the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

(i) Capitalisation thresholds

Plant and equipment and intangible assets costing $5,000 and above individually are capitalised. For those items that form part of our IT network, the threshold is $1,000 individually.

(j) Revaluation of plant and equipment

Physical non-current assets are valued in accordance with the 'Valuation of Physical Non-Current Assets at Fair Value' Policy and Guidelines Paper (TPP 07-1). This policy adopts fair value in accordance with AASB 116 *Property, Plant and Equipment and AASB 140 Investment Property*.

Plant and equipment is measured on an existing use basis, where there are no feasible alternative uses in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

Fair value of plant and equipment is determined based on the best available market evidence, including current market selling prices for the same or similar assets. Where there is no available market evidence, the asset's fair value is measured at its market buying price, the best indicator of which is depreciated replacement cost.

Non-specialised assets with short useful lives are measured at depreciated historical cost, as a surrogate for fair value.

When revaluating non-current assets by reference to current prices for assets newer than those being revalued (adjusted to reflect the present condition of the assets), the gross amount and the related accumulated depreciation are separately restated.

For other assets, any balances of accumulated depreciation at the revaluation date in respect of those assets are credited to the asset accounts to which they relate. The net asset accounts are then increased or decreased by the revaluation increments or decrements.

Revaluation increments are credited directly to the asset revaluation reserve, except that, to the extent that an increment reverses a revaluation decrement in respect of that class of asset previously recognised as an expense in the surplus/deficit, the increment is recognised immediately as revenue in the surplus/deficit.

Revaluation decrements are recognised immediately as expenses in the surplus/deficit, except that, to the extent that a credit balance exists in the asset revaluation reserve in respect of the same class of assets, they are debited directly to the asset revaluation reserve.

As a not-for-profit entity, revaluation increments and decrements are offset against each other within a class of non-current assets, but not otherwise.

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Where an asset that has previously been revalued is disposed of, any balance remaining in the asset revaluation reserve in respect of that asset is transferred to accumulated funds.

Our assets are short-lived and their costs approximate their fair values.

(k) Impairment of plant and equipment

As a not-for-profit entity with no cash generating units, we are effectively exempted from AASB 136 *Impairment of Assets* and impairment testing. This is because AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are material. Selling costs are regarded as immaterial.

(l) Depreciation of plant and equipment

Depreciation is provided for on a straight-line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life.

All material separately identifiable components of assets are depreciated over their shorter useful lives.

Depreciation rates used are:

Computer hardware — prior to 1 July 2005	33.33%
Computer hardware — from 1 July 2005	25%
Office equipment	20%
Furniture & fittings	10%
Leasehold improvements	Useful life of 10 years (or to the end of the lease, if shorter)

(m) Restoration costs

Wherever applicable, the estimated cost of dismantling and removing an asset and restoring the site is included in the cost of an asset, to the extent it is recognised as a liability.

(n) Maintenance

The costs of day-to-day servicing or maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

(o) Leased assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits.

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

Lease incentives received on entering non-cancellable operating leases are recognised as a lease liability. This liability is reduced on a straight line basis over the lease term.

We do not have any finance leases.

(p) Intangible assets

We recognise intangible assets only if it is probable that future economic benefits will flow to the Office and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.

The useful lives of intangible assets are assessed to be finite.

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for our intangible assets, they are carried at cost less any accumulated amortisation.

Our intangible assets are amortised using the straight-line method over a period of 3 to 5 years depending on the year of acquisition. The amortisation rates used are:

Computer software — prior to 1 July 2003	33.33%
Computer software — from 1 July 2003	20%

In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity, the Office is effectively exempted from impairment testing (refer to paragraph 1(k)).

(q) Receivables

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Operating Statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(r) Payables

These amounts represent liabilities for goods and services provided to us as well as other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(s) Budgeted amounts

The budgeted amounts are drawn from the budgets formulated at the beginning of the financial year with any adjustments for the effects of additional appropriations approved under s 21A, s 24 and/or s 26 of the *Public Finance and Audit Act 1983*.

The budgeted amounts in the Operating Statement and Cash Flow Statement are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Balance Sheet, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts; i.e. per audited financial report (rather than carried forward estimates).

(t) Comparative information

Comparative figures, where appropriate, are reclassified so as to be comparable with the figures presented in the current financial year.

(u) New Australian Accounting Standards

At the reporting date, the following new Accounting Standards (which include Australian Accounting Interpretations) have not been applied and are not yet effective as per Treasury mandate:

- AASB 3 (March 2008), AASB 127 and AASB 2008–3 regarding business combinations;
- AASB 8 and AASB 2007-3 regarding operating segments;
- AASB 101 (Sept 2007) and AASB 2007–8 regarding presentation of financial statements;
- AASB 123 (June 2007) and AASB 2007–6 regarding borrowing costs;
- AASB 1004 (Dec 2007) regarding contributions;
- AASB 1049 (Oct 2007) regarding the whole-of-government and general government sector financial reporting;
- AASB 1050 (Dec 2007) regarding administered items;
- AASB 1051 (Dec 2007) regarding land under roads;
- AASB 1052 (Dec 2007) regarding disaggregated disclosures;
- AASB 2007–9 regarding amendments arising from the review of AAS's 27, 29 and 31;
- AASB 2008–1 regarding share based payments;
- AASB 2008–2 regarding puttable financial instruments;
- Interpretation 4 (Feb 2007) regarding determining whether an arrangement contains a lease;
- Interpretation 12 and AASB 2007–2 regarding service concession arrangements;
- Interpretation 13 on customer loyalty programmes;
- Interpretation 14 regarding the limit on a defined benefit asset;
- Interpretation 129 (Feb 2007) regarding service concession disclosures;
- Interpretation 1038 (Dec 2007) regarding contributions by owners.

The Office has elected not to early adopt Exposure Draft ED 125 Financial Reporting by Local Governments. If adopted, the standard requires that revenue is not recognised until:

- we have supplied the related goods and services, where grants are 'in-substance agreements for the provision of goods and services' or
- conditions have been satisfied, where grants are 'in-substance conditional grants (but not 'in-substance agreements for the provision of goods and services').

(v) Going concern

The current liabilities exceeded current assets as at 30 June 2008. The current liabilities include provision for leave of $1.4 million of which $460,000 is payable within 12 months. To meet current liabilities from current assets, the Office receives fortnightly funding from the Crown Entity for recurrent and capital expenditure. The NSW Ombudsman Office is a going concern public sector agency based on sufficient Parliamentary appropriations for 2008–2009 and forward estimates for 2009–2010.

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Notes to the financial statements for the Year Ended 30 June 2008

	2008 $'000	2007 $'000
2 Expenses Excluding Losses		
(a) Employee related expenses		
Salaries and wages (including recreation leave)	14,227	13,713
Maintenance — employee related	82	79
Superannuation — defined benefit plans	375	320
Superannuation — defined contribution plans	997	926
Long service leave	433	271
Workers' compensation insurance	67	93
Payroll tax and fringe benefit tax	831	851
Payroll tax on superannuation	82	75
Payroll tax on long service leave	20	14
	17,114	16,342
(b) Other operating expenses include the following:		
Auditor's remuneration-audit or review of financial reports	25	25
Operating lease rental expense-minimum lease payments	1,731	1,700
IT leasing — minimum lease payments	–	24
Insurance	18	14
Fees	839	609
Telephones	177	177
Stores	139	165
Training	180	222
Printing	120	139
Travel	467	431
Books, periodicals and subscriptions	47	47
Advertising	60	83
Energy	45	39
Motor vehicle	33	36
Postal and courier	36	47
Maintenance — non-employee related	268	223
Other	60	60
	4,245	4,041
* *Reconciliation — Total maintenance*		
Maintenance expenses — contracted labour and other	268	223
Employee related maintenance expense included in Note 2(a)	82	79
Total maintenance expenses included in Notes 2(a) and 2(b)	**350**	**302**

	2008 $'000	2007 $'000
(c) Depreciation and amortisation expense		
Depreciation		
Plant, equipment and leasehold improvements	328	343
Total depreciation expense	**328**	**343**
Amortisation		
Intangible assets	366	304
Total amortisation expense	**366**	**304**
TOTAL DEPRECIATION AND AMORTISATION EXPENSES	**694**	**647**

3 Revenue

(a) Sale of goods and services		
Sale of publications	10	9
Rendering of services	132	70
	142	**79**
(b) Investment revenue		
Interest	66	66
	66	**66**
(c) Grants and contributions		
Unreasonable Complainants Conduct Project	26	–
Young People and Internet Project	15	–
	41	**–**
(d) Other revenue		
Miscellaneous	14	32
	14	**32**

4 Appropriations

(a) Recurrent appropriation		
Total recurrent draw-downs from Treasury (per Summary of Compliance)	20,069	19,610
	20,069	**19,610**
Comprising:		
Recurrent appropriations (per Operating Statement)	20,069	19,610
	20,069	**19,610**
(b) Capital appropriation		
Total capital draw-downs from Treasury (per Summary of Compliance)	300	253
Less: Liability to consolidated fund (per Summary of Compliance)	(2)	–
	298	**253**
Comprising:		
Capital appropriations (per Operating Statement)	298	253
	298	**253**

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Notes to the financial statements for the Year Ended 30 June 2008

	2008 $'000	2007 $'000
5 Acceptance by the Crown Entity of Employee Benefits and Other Liabilities		
The following liabilities and/or expenses have been assumed by the Crown Entity or other government agencies:		
Superannuation — defined benefit	375	320
Long service leave	433	271
Payroll tax on superannuation	23	19
	831	**610**

6 Programs/Activities of the Agency

(a) Program 1: Resolution of complaints about police

Objectives: Oversight and scrutinise the handling of complaints about the conduct of police. Promote fairness, integrity and practical reforms in the NSW Police.

(b) Program 2: Resolution of local government, public authority and prison complaints and review of Freedom of Information complaints

Objectives: Resolve complaints and protected disclosures about the administrative conduct of public authorities and local councils. Promote fairness, integrity and practical reforms in New South Wales public administration.

(c) Program 3: Resolution of child protection related complaints

Objectives: Scrutiny of complaint-handling systems and monitoring of the handling of notifications of alleged child abuse.

(d) Program 4: Resolution of complaints about and the oversight of the provision of community services

Objectives: Provide for independent monitoring of community services and programs, keep under scrutiny complaint handling systems and provide for and encourage the resolution of complaints. Review the deaths of certain children and people with a disability and formulate recommendations for the prevention or reduction of deaths of children in care, children at risk of death due to abuse or neglect, children in detention and correctional centres or disabled people in residential care.

	2008 $'000	2007 $'000
7 Current Assets — Cash and Cash Equivalents		
Cash at bank and on hand	707	584
	707	**584**
For the purposes of the Cash Flow Statement, cash and cash equivalents include cash at bank and on hand.		
Cash and cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the year to the Cash Flow Statement as follows:		
Cash and cash equivalents (per Balance Sheet)	707	584
Closing cash and cash equivalents (per Cash Flow Statement)	**707**	**584**
Refer Note 19 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.		

8 Restricted Assets — Cash

	2008 $'000	2007 $'000
Unreasonable Complainants Conduct Project	47	63
Young People and Internet Project	35	–
Liability to Consolidated Fund	2	–
	84	**63**

The Ombudsman received funding of $123,000 in 2007–2008 in the form of an advance payment from Commonwealth and other state Ombudsman's offices and from the Department of Immigration and Citizenship. This funding was provided to cover the costs relating to the development of guidelines and the training of staff in appropriately dealing with unreasonable complainant conduct ($73,000) and Young People and Internet Project ($50,000). $82,000 of this funding is to cover expenses expected to be incurred in 2008–2009. Therefore, this amount is classifed as a restricted asset. The liability of $2,000 to the Consolidated Fund is due to an asset costing less than estimated.

9 Current Assets — Receivables

	2008 $'000	2007 $'000
Sale of goods and services	–	1
Transfer of leave	8	10
Workshops	11	27
Bank interest	37	37
GST receivable	133	88
Legal fees	3	13
Other	16	1
Prepayments	152	457
	360	**634**

We consider all amounts to be collectible and as such, no allowance for impairment was established. Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired, are disclosed in Note 19.

Prepayments

Salaries and wages	–	19
Maintenance	108	118
Prepaid rent	11	150
Worker's compensation insurance	–	76
Subscription/membership	14	17
Training	7	7
Motor vehicle	2	3
Employee assistance program	6	5
Insurance	–	18
Cleaning	–	4
Travel	4	10
International Ombudsman Conference	–	29
Other	–	1
	152	**457**

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Notes to the financial statements for the Year Ended 30 June 2008

10 Non-Current Assets — Plant and Equipment

	1 July 2007 $'000	1 July 2006 $'000	30 June 2008 $'000	30 June 2007 $'000
Gross carrying amount	3,023	2,860	3,209	3,023
Accumulated depreciation	(2,031)	(1,736)	(2,359)	(2,031)
Net carrying amount at fair value	**992**	**1,124**	**850**	**992**

Reconciliation

A reconciliation of the fair value of plant and equipment at the beginning and end of financial years is set out below:	2008 $'000	2007 $'000
Fair value at start of year	992	1,124
Additions	186	211
Depreciation expense:		
Computer hardware	(145)	(130)
Office equipment	(43)	(46)
Furniture and fittings	(47)	(43)
Leasehold improvements	(93)	(124)
Fair value at end of year	**850**	**992**

11 Non-Current Assets — Intangible Assets

	1 July 2007 $'000	1 July 2006 $'000	30 June 2008 $'000	30 June 2007 $'000
Software				
Gross carrying amount	2,763	2,803	2,875	2,763
Accumulated amortisation	(2,168)	(1,946)	(2,534)	(2,168)
Fair value	**595**	**857**	**341**	**595**

Reconciliation

A reconciliation of the fair value of software at the beginning of and end of financial years is set out below:	2008 $'000	2007 $'000
Fair value at start of year	595	857
Additions	112	42
Amortisation expense	(366)	(304)
Fair value at end of year	**341**	**595**

12 Current Liabilities — Payables

Accrued salaries, wages and on-costs	135	85
Creditors	222	174
	357	**259**

	2008 $'000	2007 $'000
13 Current/Non-Current Liabilities — Provisions		
Current employee benefits and related on-costs		
Recreation leave	905	931
Annual leave loading	174	168
Payroll tax on recreation leave	54	66
Workers' compensation on recreation and long service leave	9	6
Payroll tax on long service leave	156	169
Other on-costs on recreation and long service leave	88	94
	1,386	**1,434**
Non-current employee benefits and related on-costs		
Payroll tax on recreation and long service leave	8	9
Other on-costs on recreation and long service leave	5	5
	13	**14**
Aggregate employee benefits and related on-costs		
Provisions — current	1,386	1,434
Provisions — non-current	13	14
Accrued salaries, wages and on-costs (Note 12)	135	85
	1,534	**1,533**

The value of annual leave and associated on-costs expected to be taken within 12 months is $432,000 and $648,000 after twelve months.

The value of long service leave and associated on-costs expected to be settled within 12 months is $28,000 and $238,000 after 12 months.

14 Current/Non-Current Liabilities — Other		
Current		
Unreasonable Complainants Conduct Project	47	63
Young People and Internet Project	35	–
Prepaid income	10	1
Liability to Consolidated Fund	2	–
Lease incentive	34	34
	128	**98**
Non-current		
Lease incentive	9	43
	9	**43**

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Notes to the financial statements for the Year Ended 30 June 2008

15 Changes in Equity

	Accumulated Funds		Total Equity	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
Balance at the beginning of the financial year	957	1,337	957	1,337
Changes in equity — other than transactions with owners as owners	–	–	–	–
Deficit for the year	(592)	(380)	(592)	(380)
Balance at the end of the financial year	**365**	**957**	**365**	**957**

16 Commitments for Expenditure

	2008 $'000	2007 $'000
Operating lease commitments		
Future non-cancellable operating lease rentals not provided for and payable:		
Not later than one year	1,876	1,972
Later than one year and not later than five years	470	2,564
Later than five years	–	–
Total (including GST)	**2,346**	**4,536**

The leasing arrangements are generally for leasing of property. The lease is a non-cancellable lease with a 10-year term, with rent payable monthly in advance. An option exists to renew the lease at the end of the 10-year term for an additional term of five years. The total operating lease commitments include GST input tax credits of $213,300 which are expected to be recoverable from the Australian Taxation Office.

17 Reconciliation of Cash Flows from Operating Activities to Net Cost of Services

	2008 $'000	2007 $'000
Net cash used on operating activities	421	258
Cash flows from Government/Appropriations	(20,369)	(19,863)
Acceptance by the Crown Entity of employee benefits and other liabilities	(831)	(610)
Depreciation and amortisation	(694)	(647)
Decrease/(increase) in provisions	49	(64)
Increase in payables	(98)	(9)
Increase/(decrease) in receivables	(274)	49
Decrease in other liabilities	6	33
Net cost of services	**(21,790)**	**(20,853)**

18 Budget Review

Net cost of services

The actual net cost of services is lower than budget by $335,000. There was a $690,000 decrease in employee related expenses as Ombudsman engaged contractors to fill some vacancies. This contributed to an increases of $432,000 in other operating expenses. Revenue increased by $73,000 as the office conducted more workshops than anticipated following the distribution of the unreasonable complainant conduct guidelines. Employee related expenses were lower than anticipated for a number of reasons. Funding provided to employ staff to conduct a legislative review of a new police power were not used, as the review provisions had not been proclaimed. There was also an increase in superannuation expenses and long service leave over 2006–2007.

Assets and liabilities

Current assets are higher than budget by $79,000, mostly due to an increase in cash, including funds that were provided for specific projects continuing into 2008–2009.

Cash flows

Net cash flows from operating activities were higher than budget by $179,000. Total payments were lower as were receipts and government contributions.

19 Financial Instruments

The Office's principal financial instruments which are outlined below, arise directly from our operations. We do not enter into or trade financial instruments for speculative purposes. We do not use financial derivates.

(a) Financial instrument categories

Class:	Note	Category	Carrying Amount 2008 $'000	Carrying Amount 2007 $'000
Financial Assets				
Cash and cash equivalents	(7)	N/A	707	584
Receivables	(9)	Receivables (at amortised cost)	75	89
Financial Liabilities				
Payables	(12)	Financial liabilities measured at amortised cost	338	256

(b) Credit risk

Credit risk arises when there is the possibility of the Ombudsman's debtors defaulting on their contractual obligations, resulting in a financial loss to the Ombudsman's Office. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from the financial assets of the Ombudsman's Office, including cash, receivables and authority deposits. No collateral is held by the Ombudsman's Office and the office has not granted any financial guarantees.

Cash

Cash comprises cash on hand and bank balances within the Treasury Banking System. Interest is earned on daily bank balances at the monthly average NSW Treasury Corporation (TCorp) 11am unofficial cash rate, adjusted for a management fee to Treasury.

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Receivables — trade debtors
All trade debtors are recognised as amounts receivable at balance date. Collectibility of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that we will not be able to collect all amounts due. The credit risk is the carrying amount (net of any allowance for impairment, if there is any). No interest is earned on trade debtors. The carrying amount approximates fair value. Sales are made on 14–day terms.

Other assets
All other assets are current and are mainly prepaid rent and maintenance agreements. The credit risk is the carrying amount. There is no interest earned on prepayments.

	Total	Past due but not impaired $'000	Considered impaired $'000
2008			
< 3 months overdue	28	28	–
3 months — 6 months overdue	–	–	–
> 6 months overdue	–	–	–
2007			
< 3 months overdue	19	19	–
3 months — 6 months overdue	13	13	–
> 6 months overdue	–	–	–

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

(c) Liquidity risk

Liquidity risk is the risk that the Ombudsman's Office will be unable to meet its payment obligations when they fall due. The Ombudsman's Office continuously manages risk through monitoring future cash flows planning to ensure adequate holding of high quality liquid assets.

Bank overdraft
The Office does not have any bank overdraft facility.

Trade creditors and accruals
The liabilities are recognised for amounts due to be paid in the future for goods and services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment. We did not pay any penalty interest during the year.

The table below summarises the maturity profile of the Ombudsman's Office financial liabilities.

	Weighted Average Effective Int. Rate	Nominal Amount $'000	<1yr	1–5yrs	>5yrs
2008					
Payables:					
Accrued salaries, wages and on-costs	–	135	135	–	–
Creditors	–	203	203	–	–
	–	338	338	–	–
2007					
Payables:					
Accrued salaries, wages and on-costs	–	85	85	–	–
Creditors	–	171	171	–	–
	–	256	256	–	–

(d) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The Ombudsman's Office exposures to market risk are primarily through interest rate risk. The Ombudsman's Office has no exposure to foreign currency risk and does not enter into commodity contracts.

The effect on the result and equity due to a reasonably possible change in risk variable is outlined in the information below for interest rate risk. A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Ombudsman's Office operates and the time frame for the assessment (i.e. until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2007.

		–1%		+1%	
	Carrying amount	Profit $'000	Equity $'000	Profit $'000	Equity $'000
2008					
Financial assets					
Cash and cash equivalents	707	(7)	(7)	7	7
Receivables	75	–	–	–	–
Financial liabilities					
Payables	338	–	–	–	–
2007					
Financial assets					
Cash and cash equivalents	584	(6)	(6)	6	6
Receivables	89	–	–	–	–
Financial liabilities					
Payables	256	–	–	–	–

(e) Fair value

Financial instruments are carried at cost. The fair value of all financial instruments approximates their carrying value.

End of the audited financial statements

Appendices

Contents

Appendix A Corrected

Profile of notifiable police complaints 2007–2008

Figure 61 — Action taken on finalised notifiable complaints about police officers, categorised by allegation

Note: This is a corrected table following discovery of errors in the original Annual Report table [inserted 13/07/09]

Category	Allegations declined	Allegations subject of investigation	Allegations conciliated or informally resolved	Total
Arrest				
Improper failure to arrest	8	12	0	20
Unlawful arrest	29	40	2	71
Unnecessary use of arrest	26	41	4	71
Total	**63**	**93**	**6**	**162**
Complaint-handling				
Deficient complaint investigation	1	12	1	14
Fail to report misconduct	6	59	0	65
Fail to take a complaint	4	10	0	14
Inadequacies in informal resolution	0	3	0	3
Provide false information in complaint investigation	4	59	0	63
Total	**15**	**143**	**1**	**159**
Corruption/misuse of office				
Explicit threats involving use of authority	1	18	0	19
Improper association	29	94	0	123
Misuse authority for personal benefit or benefit of an associate	20	103	1	124
Offer or receipt of bribe/corrupt payment	13	56	0	69
Protection of person(s) involved in criminal activity (other)	2	0	0	2
Total	**65**	**271**	**1**	**337**
Custody/detention				
Death/serious injury in custody	1	3	0	4
Detained in excess of authorised time	1	6	0	7
Escape from custody	0	13	0	13
Fail to allow communication	0	4	0	4
Fail to caution/give information	1	10	0	11
Fail to meet requirements for vulnerable persons	2	15	2	19
Improper refusal to grant bail	1	1	0	2
Improper treatment	17	65	2	84
Unauthorised detention	5	11	1	17
Total	**28**	**128**	**5**	**161**
Driving related offences/misconduct				
Breach pursuit guidelines	1	16	0	17
Dangerous driving causing GBH/ Death	0	2	0	2
Drink driving offence	3	21	0	24
Improper use/disclosure of In Car Video	0	1	0	1
Negligent/dangerous driving	9	26	1	36
Unnecessary speeding	7	21	0	28
Total	**20**	**87**	**1**	**108**
Drug related offences/misconduct				
Cultivate/ manufacture prohibited drug	2	0	0	2
Drinking/ under the influence on duty	1	14	0	15
Protection of person(s) involved in drug activity	18	26	0	44
Supply prohibited drug	17	27	0	44
Use/possess restricted substance	1	5	0	6
Use/Possession of prohibited drug	8	31	0	39
Total	**47**	**103**	**0**	**150**
Excessive use of force				
Assault	139	482	13	634
Firearm discharged	0	2	0	2
Firearm drawn	2	11	0	13
Improper use of handcuffs	7	14	1	22
Total	**148**	**509**	**14**	**671**

Category	Allegations declined	Allegations subject of investigation	Allegations conciliated or informally resolved	Total
Information				
Fail to create/maintain records	9	139	3	151
Falsify official records	10	37	1	48
Misuse e-mail/Internet	20	22	1	43
Provide incorrect or misleading information	10	67	4	81
Unauthorised access/disclosure/alteration of information/ data	36	280	8	324
Unreasonable refusal to provide information	5	8	0	13
Total	**90**	**553**	**17**	**660**
Inadequate/improper investigation				
Delay in investigation	16	33	0	49
Fail to advise outcome of investigation	8	10	1	19
Fail to investigate (customer service)	190	210	10	410
Improper/Unauthorised forensic procedure	0	4	0	4
Improperly fail to investigate offence committed by another officer	2	1	0	3
Improperly interfere in investigation of offence committed by another police officer	3	23	1	27
Inadequate investigation	140	277	17	434
Total	**359**	**558**	**29**	**946**
Misconduct				
Allow unauthorised use of weapon	0	2	0	2
Conflict of interest	6	45	0	51
Detrimental action against a whistleblower	1	11	0	12
Dishonesty in recruitment/promotion	3	13	0	16
Disobey reasonable direction	4	53	0	57
Fail Performance/Conduct Plan	0	2	0	2
Failure to comply with statutory obligation/procedure/code of conduct (other)	95	500	3	598
False claiming for duties/allowances	3	18	0	21
Inadequate management/ maladministration	19	129	2	150
Inadequate security of weapon/appointments	1	27	2	30
Inappropriate intervention in civil dispute	1	5	0	6
Minor workplace related misconduct	3	39	0	42
Other improper use of discretion	1	24	0	25
Unauthorised secondary employment	5	33	0	38
Unauthorised use of vehicle/ facilities/equipment	8	59	0	67
Workplace harassment/victimisation/ discrimination	23	141	3	167
Total	**173**	**1101**	**10**	**1,284**
Other criminal conduct				
Conspiracy to commit offence	1	9	1	11
Fraud	0	16	0	16
Murder/Manslaughter	8	4	0	12
Officer in breach of domestic violence order	0	1	0	1
Officer perpetrator of domestic violence	3	21	0	24
Officer subject of application for domestic violence order	2	7	0	9
Other Indictable offence	16	65	0	81
Other summary offence	24	94	1	119
Sexual assault/ indecent assault	10	44	0	54
Total	**64**	**261**	**2**	**327**
Property/exhibits/theft				
Damage to	7	15	1	23
Fail to report Loss	1	3	0	4
Failure or delay in returning to owner	22	16	3	41
Loss of	9	62	0	71
Theft	15	50	0	65
Unauthorised removal/destruction/use of	6	52	1	59
Total	**60**	**198**	**5**	**263**

Category	Allegations declined	Allegations subject of investigation	Allegations conciliated or informally resolved	Total
Prosecution related inadequacies/misconduct				
Adverse comment by Court/ Costs awarded	1	25	1	27
Fail to attend Court	2	31	0	33
Fail to check brief/inadequate preparation of brief	2	52	0	54
Fail to notify witness	1	26	0	27
Fail to serve brief of evidence	3	31	0	34
Failure to charge/prosecute	8	9	1	18
Failure to use Young Offenders Act	0	4	0	4
Improper prosecution	27	14	0	41
Legal representation for withdrawal of charge	2	0	0	2
Mislead the Court	1	5	0	6
PIN/TIN inappropriately/wrongly issued	15	1	0	16
Total	**62**	**198**	**2**	**262**
Public justice offences				
Fabrication of evidence (other than perjury)	12	13	0	25
Make false statement	11	28	0	39
Other pervert the course of justice	36	67	1	104
Perjury	6	8	1	15
Withholding or suppression of evidence	4	9	0	13
Total	**69**	**125**	**2**	**196**
Search/entry				
Failure to conduct search	1	9	0	10
Property missing after search	0	4	0	4
Unlawful entry	3	9	0	12
Unlawful search	12	52	2	66
Unreasonable/Inappropriate conditions/Damage	1	16	1	18
Wrongful seizure of property during search	3	5	0	8
Total	**20**	**95**	**3**	**118**
Service delivery				
Breach Domestic Violence SOPS	4	30	1	35
Fail to provide victim support	27	36	7	70
Fail/delay attendance to incident/'000'	4	12	4	20
Harassment/Intimidation	102	113	23	238
Improper failure to WIPE	7	24	2	33
Improper request for identity/proof of identity	0	1	0	1
Improper use of move on powers	2	6	0	8
Neglect of duty (not specified elsewhere)	36	60	4	100
Other (customer service)	133	168	18	319
Rudeness/verbal abuse	117	198	16	331
Threats	24	55	7	86
Total	**456**	**703**	**82**	**1,241**
Summary of allegations	**1,739**	**5,126**	**180**	**7,045**

The number of allegations is larger than the number of complaints received because a complaint may contain more than one allegation about a single incident or involve a series of incidents.

Appendix B

Status of legislative reviews — as at 30 June 2008

Status	Legislation	Brief description
Review reports tabled in Parliament in 2007–2008	*Law Enforcement Legislation Amendment (Public Safety) Act 2005*	Additional powers to police to prevent or control large-scale public disorder.
Review reports provided to the responsible Minister	*Justice Legislation (Non-association and Place Restriction) Act 2001*	Allows police and courts to put restrictions — when determining bail conditions, imposing a sentence or allowing parole — on the places that a person can be in and the people they can associate with. Provided to the Attorney General December 2006 and not yet tabled.
	Police Powers (Drug Detection Trial) Act 2003	Allows police to use drug sniffer dogs on vehicles randomly stopped in 'outer metropolitan' areas. Provided to the responsible Ministers June 2008 and tabled in Parliament 21 August 2008.
Current reviews	*Terrorism (Police Powers) Act 2002* — Part 3	Allows police and the Crime Commission to execute covert search warrants.
	Terrorism (Police Powers) Act 2002 — Part 2A	Allows police to hold people suspected of involvement in terrorist-related activities in preventative detention.
	Law Enforcement (Powers and Responsibilities) Act 2002 — Part 4, Divisions 2 and 4	Regulates the safeguards connected with searching people after they have been arrested or while they are in police custody.
	Law Enforcement (Powers and Responsibilities) Act 2002 — Part 5, Division 3	Allows police to issue notices to financial institutions to produce information about their customers for criminal investigations.
	Law Enforcement (Powers and Responsibilities) Act 2002 — Part 7	Regulates police powers for establishing crime scenes.
	Criminal Procedure Act 1986 — Part 3 'Penalty notice offences'	Allows police to issue penalty notices for certain criminal offences. Focus of review is the impact on Aboriginal and Torres Strait Islander communities.

Appendix C

Child and family services

Figure 62 — Complaints issues for child and family services received in 2007–2008

Figure 62 shows the issues that were complained about in 2007–2008 in relation to child and family services. Please note that each complaint we received may have more than one issue.

Program area	Child protection		Out-of-home care		Children's services		Family support		Adoption		Total
Issue	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	
Casework	113	183	79	130	0	2	1	0	0	1	509
Meeting individual needs	29	50	99	117	0	1	0	1	0	0	297
Object to decision	35	104	29	57	0	2	0	0	1	1	229
Case management	59	61	44	16	0	1	2	1	0	0	184
Customer service	37	54	27	53	1	1	1	1	1	2	178
Complaints	33	26	12	27	1	2	0	1	0	0	102
Information	21	31	17	19	1	0	1	1	0	1	92
Assault/abuse in care	16	46	3	15	2	2	0	0	0	0	84
Investigation	30	40	7	4	0	1	0	0	0	0	82
Professional conduct	18	24	6	11	2	3	0	0	0	0	64
Allowances/fees	3	4	22	21	0	3	0	0	2	0	55
Clients rights/ choice/participation	2	15	6	3	2	0	0	0	0	1	29
Policy/procedure/law	2	12	2	3	1	1	0	2	0	0	23
Legal problems	7	8	0	7	0	1	0	0	0	0	23
Service management	1	3	8	1	1	3	2	1	0	0	20
Access to service	2	4	0	0	2	0	0	0	0	0	8
File/record management	1	1	3	1	0	0	0	0	0	0	6
Safety	1	1	1	2	0	0	0	0	0	0	5
Client finances and property	1	0	2	0	1	0	0	0	0	0	4
Service funding/ licensing/monitoring	0	0	0	0	2	0	0	0	0	0	2
Outside our jurisdiction	9	64	1	4	2	7	1	1	0	0	89
Not applicable	1	36	0	12	0	1	0	0	0	0	50
Total	421	767	368	503	18	31	8	9	4	6	2,135

Figure 63 — Child and family services — formal complaints finalised

Figure 63 shows the outcomes of formal complaints finalised about child and family services this year.

Program area	A	B	C	D	E	F	G	Total
Child protection services	25	132	69	10	0	10	16	262
Out-of-home care	12	58	107	3	1	0	4	185
Children services	2	2	4	0	0	0	1	9
Family support services	0	0	1	0	0	0	1	2
Adoption	1	1	1	0	0	0	0	3
Total	40	193	182	13	1	10	22	461

Description

A	Complaint declined at outset
B	Complaint declined after inquiries
C	Complaint resolved after inquiries, including local resolution by the agency concerned
D	Service improvement comments or suggestions to agency
E	Referred to agency concerned or other body for investigation
F	Direct investigation
G	Complaint outside jurisdiction

Appendix D

Disability services

Figure 64 — Complaints issues for disability services received in 2007–2008

Figure 64 shows the issues that were complained about in 2007–2008 in relation to disability services. Please note that each complaint we received may have more than one issue.

Program area	Disability accommodation		Disability support		Total
Issue	Formal	Informal	Formal	Informal	
Meeting individual needs	78	40	21	11	150
Case management	34	13	19	7	73
Assault/abuse in care	46	15	6	4	71
Service management	26	19	11	6	62
Customer service	5	6	19	21	51
Professional conduct	10	8	13	10	41
Access to service	10	3	15	13	41
Complaints	15	4	15	7	41
Client rights/choice/participation	12	12	5	6	35
Object to decision	8	7	4	12	31
Safety	12	8	1	3	24
Casework	1	3	7	3	14
Information	3	2	5	3	13
Investigation	6	1	3	2	12
Service funding/licensing/monitoring	3	5	0	2	10
Client finances and property	2	6	1	0	9
Policy/procedure/law	3	1	3	1	8
File/record management	3	1	2	0	6
Allowances/fees	1	0	2	2	5
Legal problems	0	0	1	0	1
Outside our jurisdiction	3	2	2	8	15
Not applicable	0	0	2	13	15
Total	281	156	157	134	728

Figure 65 — Disability services — formal complaints finalised

Figure 65 shows the outcomes of formal complaints we received about disability services this year.

Program area	A	B	C	D	E	F	G	Total
Disability accommodation services	5	26	92	2	5	2	4	136
Disability support services	8	28	43	1	1	2	2	85
Total	13	54	135	3	6	4	6	221

Description

A	Complaint declined at outset
B	Complaint declined after inquiries
C	Complaint resolved after inquiries, including local resolution by the agency concerned
D	Service improvement comments or suggestions to agency
E	Referred to agency concerned or other body for investigation
F	Direct investigation
G	Complaint outside jurisdiction

Appendix E

Other community services

Figure 66 — Number of formal and informal matters received in 2007–2008 about other community services — by agency category

Agency category	Formal	Informal	Total
DoCS			
Supported accommodation and assistance program services	0	2	2
General community services	5	8	13
Aged services	0	0	0
Disaster welfare services	0	1	1
Sub total	**5**	**11**	**16**
DADHC			
Supported accommodation and assistance program services	0	0	0
General community services	0	0	0
Aged services	7	21	28
Disaster welfare services	0	0	0
Sub total	**7**	**21**	**28**
Other government agencies			
Supported accommodation and assistance program services	0	0	0
General community services	0	1	1
Aged services	0	2	2
Disaster welfare services	0	0	0
Sub total	**0**	**3**	**3**
Non-government funded or licensed services			
Supported accommodation and assistance program services	43	20	63
General community services	38	8	46
Aged services	6	6	12
Disaster welfare services	0	0	0
Sub total	**87**	**34**	**121**
Other (general inquiries)	0	32	32
Agency unknown	0	28	28
Sub total	**0**	**60**	**60**
Total	**99**	**129**	**228**

Some complaints about supported accommodation and general community services may involve complaints about children and family and disability services.

Figure 67 — Complaints issues for other community services received in 2007–2008

Figure 67 shows the issues that were complained about in 2007–2008 in relation to general community services. Please note that each complaint we received may have more than one issue.

Program area	Other community services		
Issue	Formal	Informal	Total
Access to service	18	14	32
Customer service	13	19	32
Professional conduct	13	10	23
Complaints	10	13	23
Meeting individual needs	5	13	18
Object to decision	7	10	17
Allowances/fees	2	12	14
Information	7	6	13
Clients rights/choice/participation	1	10	11
Case management	5	3	8
Service funding/licensing/monitoring	4	4	8
Files/record management	7	0	7
Assault/abuse in care	2	4	6
Casework	1	5	6
Service management	2	4	6
Policy/procedure/law	2	2	4
Investigation	1	2	3
Safety	2	0	2
Legal problems	0	1	1
Client finances and property	1	0	1
Outside our jurisdiction	10	30	40
Not applicable	4	35	39
Total	117	197	314

Figure 68 — Outcomes of formal complaints by program area — other community services

Figure 68 shows the outcomes of formal complaints finalised about general community services this year.

Program area	A	B	C	D	E	F	G	Total
Supported accommodation and assistance program services	0	9	8	0	0	0	1	18
General community services	0	7	4	7	0	0	0	18
Aged services	0	2	5	0	0	0	0	7
Other	1	0	0	0	0	0	11	12
Total	1	18	17	7	0	0	12	55

Description

A	Complaint declined at outset
B	Complaint declined after inquiries
C	Complaint resolved after inquiries, including local resolution by the agency concerned
D	Service improvement comments or suggestions to agency
E	Referred to agency concerned or other body for investigation
F	Direct investigation
G	Complaint outside jurisdiction

Appendix F

Figure 69 — Action taken on formal complaints finalised in 2007–2008 about all public sector agencies — summary table

Figure 69 shows the action we took on each of the written complaints that we finalised this year about public sector agencies (except NSW Police, DoCS and DADHC and those relating to child protection notifications), broken down into agency groups. See appendices G, H, I and J for a further breakdown into specific agencies in those groups.

Complaint about	Assessment only	Preliminary or informal investigation								Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Bodies outside jurisdiction	364	0	0	0	0	0	0	0	0	0	0	0	0	364
Departments and authorities	526	31	402	25	268	76	12	2	0	2	1	5	4	1,354
Freedom of Information	75	4	21	12	60	14	7	0	0	1	0	0	3	197
Local government	346	11	247	7	95	51	29	0	0	0	0	0	2	788
Corrections and Justice Health	139	187	216	16	227	42	4	0	0	0	0	0	0	831
Juvenile Justice	5	12	43	0	33	5	0	0	0	0	0	0	0	98
Total	1,455	245	929	60	683	188	52	2	0	3	1	5	9	3,632

Description

A **Decline after assessment only, including:**

Conduct outside jurisdiction, Trivial, Remote, Insufficient interest, Commercial matter, Right of appeal or redress, Substantive explanation or advice provided, Premature — referred to agency, Concurrent representation, Investigation declined on resource/priority grounds

Preliminary or informal investigation:

B Substantive advice, information provided without formal finding of wrong conduct

C Advice/explanation provided where no or insufficient evidence of wrong conduct

D Further investigation declined on grounds of resource/priority

E Resolved to Ombudsman's satisfaction

F Resolved by agency prior to our intervention

G Suggestions/comment made

H Consolidated into other complaint

I Conciliated/mediated

Formal investigation:

J Resolved during investigation

K Investigation discontinued

L No adverse finding

M Adverse finding

Appendix G

Departments and authorities

Figure 70 — Action taken on general formal complaints about departments and authorities finalised in 2007–2008

Agency	Assessment only	Preliminary or informal investigation									Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Aboriginal Housing Office	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Ambulance Service of NSW	3	0	2	0	0	0	0	0	0	0	0	0	0	5
Anti-Discrimination Board	4	0	0	0	1	1	0	0	0	0	0	0	0	6
Attorney General's Department	8	2	2	0	1	1	0	0	0	0	0	0	0	14
Board of Studies	1	0	1	0	0	0	0	0	0	0	0	0	0	2
Board of Vocational Education and Training	1	0	0	0	1	1	0	0	0	0	0	0	0	3
Building and Construction Industry Long Service Payments Corporation	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Building Professionals Board	1	0	2	0	0	1	0	0	0	0	0	0	0	4
Charles Sturt University	1	0	1	1	0	0	0	0	0	0	0	0	0	3
Commission for Children and Young People	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Consumer, Trader and Tenancy Tribunal	8	0	0	0	0	0	0	0	0	0	0	0	0	8
Country Energy	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Dental Board of NSW	0	0	1	0	1	0	1	0	0	0	0	0	0	3
Department of Arts, Sport and Recreation	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Department of Commerce	20	2	17	2	7	2	0	0	0	0	0	0	0	50
Department of Community Services	0	0	0	0	3	0	0	0	0	1	0	3	2	9
Department of Education and Training	50	1	12	3	8	6	0	0	0	0	0	0	1	81
Department of Environment and Climate Change	3	1	1	2	3	1	1	0	0	0	0	0	0	12
Department of Health	37	1	13	3	6	2	2	0	0	0	0	1	1	66
Department of Housing	49	4	104	0	51	15	2	0	0	0	1	0	0	226
Department of Lands	12	1	10	0	2	2	0	0	0	0	0	0	0	27
Department of Local Government	0	0	1	0	1	0	0	0	0	0	0	0	0	2
Department of Natural Resources	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Department of Planning	5	0	3	0	2	0	0	0	0	0	0	0	0	10
Department of Premier and Cabinet	1	0	1	0	0	0	0	0	0	0	0	0	0	2
Department of Primary Industries	6	0	4	1	1	0	0	0	0	0	0	0	0	12
Department of Water and Energy	2	0	1	0	1	1	0	1	0	0	0	0	0	6
Director of Public Prosecutions	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Electoral Commission NSW	1	0	1	0	0	1	0	0	0	0	0	0	0	3
Energy Australia	1	0	0	0	0	0	0	0	0	0	0	0	0	1
First State Superannuation Trustee Corporation	1	0	0	0	2	0	0	0	0	0	0	0	0	3
Game Council of NSW	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Geographical Names Board	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Growth Centres Commission	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Health Care Complaints Commission	16	0	7	1	0	0	0	0	0	0	0	0	0	24
Housing Appeals Committee	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Hunter Water Corporation Limited	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Integral Energy	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Internal Audit Bureau of NSW	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lake Illawarra Authority	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Landcom (NSW Land and Housing Corporation)	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lands Board	0	0	1	0	1	0	0	0	0	0	0	0	0	2
Legal Aid Commission of NSW	5	1	5	0	3	0	1	0	0	0	0	0	0	15
Macquarie University	4	1	2	0	8	0	0	0	0	0	0	0	0	15
Marine Parks Authority NSW	0	0	2	0	0	0	0	0	0	0	0	0	0	2
Mental Health Review Tribunal and Psychosurgery Review Board	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Ministry of Transport	6	0	5	0	3	0	0	0	0	0	0	0	0	14
Motor Accidents Authority	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Murrumbidgee Catchment Management Authority	0	0	1	0	0	0	0	0	0	0	0	0	0	1

Agency	Assessment only	Preliminary or informal investigation								Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Newcastle Port Corporation	0	0	2	0	0	0	0	0	0	0	0	0	0	2
NSW Fire Brigades	5	0	1	0	0	1	0	0	0	0	0	0	0	7
NSW Food Authority	2	0	1	0	0	0	0	0	0	0	0	0	0	3
NSW Heritage Office	0	0	1	0	0	0	0	0	0	0	0	0	0	1
NSW Lotteries	1	0	1	0	0	0	0	0	0	0	0	0	0	2
NSW Maritime Authority	5	0	3	0	2	0	0	0	0	0	0	0	0	10
NSW Medical Board	0	0	0	0	0	0	1	0	0	0	0	0	0	1
NSW Office of Liquor, Gaming and Racing	0	0	0	0	1	0	0	0	0	0	0	0	0	1
NSW Police Force	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Nurses Registration Board	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Office of Minister for Natural Resources	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Office of Protective Commissioner	9	2	23	0	32	2	0	0	0	0	0	0	0	68
Office of Public Guardian	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Office of State Revenue	70	9	78	1	63	17	0	0	0	0	0	0	0	238
Pillar Administration	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Podiatrists Registration Board	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Public Trustee	8	1	2	0	4	0	0	0	0	0	0	0	0	15
Rail Corporation New South Wales	26	2	7	1	8	1	3	0	0	0	0	0	0	48
Registry of Births, Deaths and Marriages	3	0	3	0	8	4	0	0	0	0	0	0	0	18
Roads and Traffic Authority	67	3	34	1	29	11	0	0	0	1	0	0	0	146
Rural Assistance Authority	1	0	1	1	0	0	0	0	0	0	0	0	0	3
Rural Fire Service NSW	2	0	1	0	0	1	0	0	0	0	0	0	0	4
Rural Lands Protection Board	3	0	4	0	0	0	0	0	0	0	0	0	0	7
Southern Cross University	2	0	1	0	0	0	0	0	0	0	0	0	0	3
State Authorities Superannuation Trustee Corporation	0	0	0	0	0	1	0	0	0	0	0	0	0	1
State Parole Authority	0	0	0	0	1	0	0	0	0	0	0	0	0	1
State Transit Authority of NSW	7	0	2	1	2	0	0	0	0	0	0	0	0	12
Sydney Catchment Authority	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Sydney Ferries Corporation	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Harbour Foreshore Authority	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Sydney Ports Corporation	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Sydney Water Corporation	6	0	1	2	0	0	0	0	0	0	0	0	0	9
Transport Infrastructure Development Corporation	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Unnamed agency	3	0	0	0	0	0	0	1	0	0	0	0	0	4
University of New England	0	0	0	0	1	1	0	0	0	0	0	0	0	2
University of New South Wales	5	0	2	2	2	0	1	0	0	0	0	0	0	12
University of Newcastle	4	0	3	0	2	1	0	0	0	0	0	0	0	10
University of Sydney	2	0	3	0	3	1	0	0	0	0	0	0	0	9
University of Technology	4	0	6	0	1	0	0	0	0	0	0	0	0	11
University of Western Sydney	5	0	5	0	0	0	0	0	0	0	0	0	0	10
University of Wollongong	1	0	1	1	0	1	0	0	0	0	0	0	0	4
Valuer General	3	0	1	0	0	0	0	0	0	0	0	0	0	4
Workcover Authority	7	0	6	0	1	0	0	0	0	0	0	0	0	14
WSN Environmental Solutions	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Total	526	31	404	23	268	76	12	2	0	2	1	5	4	1,354

Description

A **Decline after assessment only, including:**
Conduct outside jurisdiction, Trivial, Remote, Insufficient interest, Commercial matter, Right of appeal or redress, Substantive explanation or advice provided, Premature — referred to agency, Concurrent representation, Investigation declined on resource/priority grounds

Preliminary or informal investigation:

B Substantive advice, information provided without formal finding of wrong conduct

C Advice/explanation provided where no or insufficient evidence of wrong conduct

D Further investigation declined on grounds of resource/priority

E Resolved to Ombudsman's satisfaction

F Resolved by agency prior to our intervention

G Suggestions/comment made

H Consolidated into other complaint

I Conciliated/mediated

Formal investigation:

J Resolved during investigation

K Investigation discontinued

L No adverse finding

M Adverse finding

Appendix H

Local government

Figure 71 — Action taken on formal complaints finalised in 2007–2008 about local government

Figure 71 shows the action we took on each of the written complaints finalised this year about individual councils.

Council	Assessment only	Preliminary or informal investigation								Formal investigation					Total
	A	B	C	D	E	F	G	H	I	J	K	L	M		
Accredited Certifier	2	0	3	0	1	0	0	0	0	0	0	0	0		6
Albury City Council	0	0	2	0	3	0	0	0	0	0	0	0	0		5
Armidale Dumaresq Council	2	0	0	0	0	0	0	0	0	0	0	0	0		2
Ashfield Municipal Council	3	0	0	0	0	1	0	0	0	0	0	0	0		4
Auburn Council	2	0	0	0	0	0	1	0	0	0	0	0	0		3
Ballina Shire Council	1	0	2	0	0	0	0	0	0	0	0	0	0		3
Bankstown City Council	3	0	1	0	1	1	0	0	0	0	0	0	0		6
Bathurst Regional Council	3	0	0	0	0	0	1	0	0	0	0	0	0		4
Baulkham Hills Shire Council	5	0	1	0	0	1	1	0	0	0	0	0	0		8
Bega Valley Shire Council	4	0	2	0	2	1	0	0	0	0	0	0	0		9
Bellingen Shire Council	2	0	2	0	0	0	0	0	0	0	0	0	0		4
Blacktown City Council	1	0	4	0	0	1	0	0	0	0	0	0	0		6
Bland Shire Council	0	0	0	0	0	1	0	0	0	0	0	0	0		1
Blue Mountains City Council	4	0	6	0	1	0	0	0	0	0	0	0	0		11
Bombala Council	1	0	1	0	0	0	0	0	0	0	0	0	0		2
Broken Hill City Council	0	0	1	0	0	0	0	0	0	0	0	0	0		1
Burwood Council	1	0	2	0	0	0	0	0	0	0	0	0	0		3
Byron Shire Council	0	0	2	0	0	1	0	0	0	0	0	0	0		3
Cabonne Shire Council	1	0	1	0	1	0	0	0	0	0	0	0	0		3
Camden Council	0	0	0	0	0	1	1	0	0	0	0	0	0		2
Campbelltown City Council	4	0	1	0	1	0	0	0	0	0	0	0	0		6
Canterbury City Council	3	0	2	0	1	0	0	0	0	0	0	0	0		6
Central Darling Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0		1
Central Tablelands Water	0	0	0	0	1	0	0	0	0	0	0	0	0		1
Cessnock City Council	5	0	2	0	1	1	1	0	0	0	0	0	0		10
City of Botany Bay Council	2	0	0	0	0	0	0	0	0	0	0	0	0		2
City of Canada Bay Council	4	0	3	0	0	1	0	0	0	0	0	0	0		8
Clarence Valley Council	4	0	1	0	0	0	0	0	0	0	0	0	0		5
Coffs Harbour City Council	4	0	1	0	0	0	1	0	0	0	0	0	0		6
Cooma-Monaro Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0		1
Cootamundra Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0		1
Cowra Shire Council	2	0	0	0	0	3	0	0	0	0	0	0	0		5
Dubbo City Council	1	0	1	0	0	1	0	0	0	0	0	0	0		3
Dungog Shire Council	1	0	2	0	0	0	0	0	0	0	0	0	0		3
Eurobodalla Shire Council	8	0	3	0	0	0	0	0	0	0	0	0	1		12
Fairfield City Council	3	0	1	0	1	0	1	0	0	0	0	0	0		6
Glenn Innes Severn Council	0	0	0	0	1	0	0	0	0	0	0	0	0		1
Goldenfields Water County Council	1	0	0	0	1	0	0	0	0	0	0	0	0		2
Gosford City Council	19	2	10	0	4	2	0	0	0	0	0	0	0		37
Goulburn Mulwaree Shire Council	0	0	2	1	0	0	0	0	0	0	0	0	0		3
Great Lakes Council	5	0	2	0	0	1	1	0	0	0	0	0	0		9
Greater Hume Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0		1
Greater Taree City Council	2	0	1	0	0	0	0	0	0	0	0	0	0		3
Griffith City Council	1	0	0	0	1	0	0	0	0	0	0	0	0		2
Gunnedah Shire Council	2	1	1	0	0	0	0	0	0	0	0	0	0		4
Harden Shire Council	2	0	3	1	0	0	0	0	0	0	0	0	0		6

Council	Assessment only	Preliminary or informal investigation									Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Hawkesbury City Council	0	0	3	0	1	1	0	0	0	0	0	0	0	5
Holroyd City Council	1	0	1	0	1	0	0	0	0	0	0	0	0	3
Hornsby Shire Council	7	0	7	0	1	0	0	0	0	0	0	0	0	15
Hunters Hill Municipal Council	3	1	2	0	0	0	0	0	0	0	0	0	0	6
Hurstville City Council	3	0	2	0	1	0	0	0	0	0	0	0	0	6
Junee Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Kempsey Shire Council	5	0	2	0	1	1	0	0	0	0	0	0	0	9
Kogarah Municipal Council	3	0	3	0	3	0	0	0	0	0	0	0	0	9
Ku-ring-gai Council	6	0	3	1	0	1	1	0	0	0	0	0	0	12
Kyogle Shire Council	2	0	0	0	1	0	0	0	0	0	0	0	0	3
Lachlan Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lake Macquarie City Council	6	0	8	0	2	2	0	0	0	0	0	0	0	18
Lane Cove Municipal Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Leeton Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Leichhardt Municipal Council	3	0	5	0	2	0	0	0	0	0	0	0	0	10
Lismore City Council	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Lithgow City Council	8	0	1	0	0	3	1	0	0	0	0	0	0	13
Liverpool City Council	3	0	2	0	2	2	0	0	0	0	0	0	0	9
Liverpool Plains Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Maitland City Council	2	1	2	0	3	0	0	0	0	0	0	0	0	8
Manly Council	4	0	1	0	0	1	0	0	0	0	0	0	0	6
Marrickville Council	1	0	4	0	2	1	0	0	0	0	0	0	0	8
Midcoast Water	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Mid-Western Regional Council	1	0	3	0	1	1	1	0	0	0	0	0	1	8
Moree Plains Shire Council	1	0	0	0	0	1	0	0	0	0	0	0	0	2
Mosman Municipal Council	1	0	0	0	1	0	0	0	0	0	0	0	0	2
Murray Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Muswellbrook Shire Council	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Nambucca Shire Council	5	0	3	0	0	0	1	0	0	0	0	0	0	9
Narrabri Shire Council	2	0	2	0	1	0	0	0	0	0	0	0	0	5
Narrandera Shire Council	1	0	2	0	0	0	0	0	0	0	0	0	0	3
Narromine Shire Council	2	0	1	0	0	0	0	0	0	0	0	0	0	3
Newcastle City Council	3	1	9	0	1	0	0	0	0	0	0	0	0	14
North Sydney Council	4	0	2	0	0	0	0	0	0	0	0	0	0	6
Oberon Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Orange City Council	2	0	1	0	0	0	0	0	0	0	0	0	0	3
Palerang Council	14	0	2	0	1	1	1	0	0	0	0	0	0	19
Parramatta City Council	5	0	3	0	1	0	0	0	0	0	0	0	0	9
Penrith City Council	5	0	4	0	1	3	0	0	0	0	0	0	0	13
Pittwater Council	6	0	4	0	2	1	0	0	0	0	0	0	0	13
Port Macquarie-Hastings Council	6	0	6	1	3	0	0	0	0	0	0	0	0	16
Port Stephens Shire Council	4	0	2	0	3	0	0	0	0	0	0	0	0	9
Randwick City Council	3	0	2	0	0	1	0	0	0	0	0	0	0	6
Richmond Valley Council	7	0	1	0	1	1	0	0	0	0	0	0	0	10
Rockdale City Council	5	0	3	0	1	0	0	0	0	0	0	0	0	9
Ryde City Council	4	1	3	0	5	0	0	0	0	0	0	0	0	13
Shellharbour City Council	2	0	1	0	0	0	12	0	0	0	0	0	0	15
Shoalhaven City Council	4	0	9	0	2	3	0	0	0	0	0	0	0	18
Singleton Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Snowy River Shire Council	2	0	1	0	0	0	0	0	0	0	0	0	0	3
Strathfield Municipal Council	3	0	1	0	2	0	0	0	0	0	0	0	0	6
Sutherland Shire Council	6	0	7	0	4	4	1	0	0	0	0	0	0	22
Sydney City Council	15	1	9	0	7	2	0	0	0	0	0	0	0	34
Tamworth City Council	1	0	1	0	1	0	0	0	0	0	0	0	0	3
Temora Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1

Council	Assessment only	Preliminary or informal investigation								Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Tenterfield Shire Council	0	0	3	0	0	0	0	0	0	0	0	0	0	3
Tumbarumba Shire Council	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Tumut Shire Council	2	0	3	0	0	0	0	0	0	0	0	0	0	5
Tweed Shire Council	7	1	5	1	0	0	0	0	0	0	0	0	0	14
Upper Hunter Shire Council	1	0	0	0	1	1	0	0	0	0	0	0	0	3
Uralla Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Wagga Wagga City Council	0	0	1	1	1	0	0	0	0	0	0	0	0	3
Walgett Shire Council	0	0	2	2	0	0	0	0	0	0	0	0	0	4
Warringah Council	17	1	2	0	0	0	0	0	0	0	0	0	0	20
Warrumbungle Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Waverley Council	8	0	0	0	2	1	0	0	0	0	0	0	0	11
Willoughby City Council	0	0	3	0	0	0	0	0	0	0	0	0	0	3
Wingecarribee Shire Council	5	1	4	0	0	0	0	0	0	0	0	0	0	10
Wollondilly Shire Council	2	0	1	0	0	0	0	0	0	0	0	0	0	3
Wollongong City Council	8	0	10	0	2	2	1	0	0	0	0	0	0	23
Woollahra Municipal Council	3	0	3	0	2	0	1	0	0	0	0	0	0	9
Wyong Shire Council	3	0	2	1	1	0	0	0	0	0	0	0	0	7
Yass Valley Council	1	0	2	0	2	0	0	0	0	0	0	0	0	5
Young Shire Council	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Total	346	11	245	9	95	51	29	0	0	0	0	0	2	788

Description

A **Decline after assessment only, including:**

Conduct outside jurisdiction, Trivial, Remote, Insufficient interest, Commercial matter, Right of appeal or redress, Substantive explanation or advice provided, Premature — referred to agency, Concurrent representation, Investigation declined on resource/priority grounds

Preliminary or informal investigation:

B Substantive advice, information provided without formal finding of wrong conduct

C Advice/explanation provided where no or insufficient evidence of wrong conduct

D Further investigation declined on grounds of resource/priority

E Resolved to Ombudsman's satisfaction

F Resolved by agency prior to our intervention

G Suggestions/comment made

H Consolidated into other complaint

I Conciliated/mediated

Formal investigation:

J Resolved during investigation

K Investigation discontinued

L No adverse finding

M Adverse finding

Appendix I

Corrections

Figure 72 — Action taken on formal complaints finalised in 2007–2008 about corrections

Figure 72 shows the action we took on each of the formal complaints finalised this year about corrections.

Agency	Assessment only	Preliminary or informal investigation								Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Department of Corrective Services	124	148	178	15	172	31	4	0	0	0	0	0	0	672
Justice Health	9	15	14	0	17	4	0	0	0	0	0	0	0	59
GEO Australia	6	24	24	1	38	7	0	0	0	0	0	0	0	100
Department of Juvenile Justice	5	12	43	0	33	5	0	0	0	0	0	0	0	98
Total	144	199	259	16	260	47	4	0	0	0	0	0	0	929

Description

A — Decline after assessment only, including:
Conduct outside jurisdiction, Trivial, Remote, Insufficient interest, Commercial matter, Right of appeal or redress, Substantive explanation or advice provided, Premature — referred to agency, Concurrent representation, Investigation declined on resource/priority grounds

Preliminary or informal investigation:

- **B** Substantive advice, information provided without formal finding of wrong conduct
- **C** Advice/explanation provided where no or insufficient evidence of wrong conduct
- **D** Further investigation declined on grounds of resource/priority
- **E** Resolved to Ombudsman's satisfaction
- **F** Resolved by agency prior to our intervention
- **G** Suggestions/comment made
- **H** Consolidated into other complaint
- **I** Conciliated/mediated

Formal investigation:

- **J** Resolved during investigation
- **K** Investigation discontinued
- **L** No adverse finding
- **M** Adverse finding

Figure 73 — Number of formal and informal complaints received in 2007–2008 about correctional centres, DCS and GEO

Institution	Formal	Informal	Total
Bathurst Correctional Centre	24	121	145
Berrima Correctional Centre	6	18	24
Broken Hill Correctional Centre	4	16	20
Cessnock Correctional Centre	11	72	83
Community Offender Services	13	32	45
Compulsory Drug Treatment Correctional Centre	3	3	6
Cooma Correctional Centre	2	12	14
Corrective Services Department	117	181	298
Court Escort/Security Unit	23	21	44
Dawn De Loas Special Purpose Centre	10	31	41
Department of Corrective Services Head Office	2	10	12
Dillwinya Correctional Centre	17	89	106
Emu Plains Correctional Centre	26	87	113
GEO Australia	13	55	68
Glenn Innes Correctional Centre	2	9	11
Goulburn Correctional Centre	51	198	249
Grafton Correctional Centre	9	53	62
High Risk Management Unit	14	67	81

Institution	Formal	Informal	Total
Ivanhoe "Warakirri" Correctional Centre	1	2	3
John Morony Correctional Centre	4	44	48
Junee Correctional Centre	83	258	341
Justice Health	61	241	302
Kariong Juvenile Correctional Centre	5	11	16
Kirkconnell Correctional Centre	14	61	75
Lithgow Correctional Centre	31	128	159
Long Bay Hospital Area One	12	51	63
Long Bay Hospital Area Two	0	3	3
Mannus Correctional Centre	0	7	7
Metropolitan Remand Reception Centre	49	204	253
Metropolitan Special Programs Centre	72	272	344
Mid North Coast Correctional Centre	27	162	189
Oberon Correctional Centre	2	17	19
Parklea Correctional Centre	23	116	139
Parramatta Correctional Centre	4	25	29
Periodic Detention Centre	2	9	11
Silverwater Correctional Centre	28	153	181
Silverwater Women's Correctional Centre	11	87	98
Special Purpose Prison Long Bay	3	3	6
St Heliers Correctional Centre	3	26	29
Tamworth Correctional Centre	4	15	19
Wellington Correctional Centre	56	173	229
Yetta Dhinnakkal (Brewarrina) Correctional Centre	0	1	1
Total	842	3,144	3,986

*Some complaints may involve more than one centre.

Figure 74 — Number of formal and informal complaints received in 2007–2008 about juvenile justice centres and DJJ

Institution	Formal	Informal	Total
Acmena Juvenile Justice Centre	5	18	23
Cobham Juvenile Justice Centre	6	49	55
Frank Baxter Juvenile Justice Centre	41	68	109
Juniperina Juvenile Justice Centre	17	19	36
Department of Juvenile Justice	12	20	32
Keelong Juvenile Justice Centre	7	21	28
Orana Juvenile Justice Centre	5	12	17
Reiby Juvenile Justice Centre	3	21	24
Riverina Juvenile Justice Centre	3	15	18
Total	99	243	342

Appendix J

Freedom of information

Figure 75 — Action taken on formal complaints finalised in 2007–2008 about FOI

Figure 75 shows the action we took on each of the written complaints finalised this year about individual public sector agencies relating to freedom of information.

Agency	Assessment only	Preliminary or informal investigation									Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Ashfield Municipal Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Attorney General's Department	0	0	0	0	1	0	1	0	0	0	0	0	0	2
Ballina Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Blacktown City Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Bombala Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Campbelltown City Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Charles Sturt University	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Cooma-Monaro Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Community Services	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Corrective Services	2	0	1	1	3	0	0	0	0	0	0	0	0	7
Department of Education and Training	1	0	0	0	8	3	1	0	0	0	0	0	0	13
Department of Health	14	1	2	1	7	4	1	0	0	0	0	0	0	30
Department of Housing	1	0	0	0	2	0	0	0	0	0	0	0	0	3
Department of Lands	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Department of Planning	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Department of Premier and Cabinet	1	0	0	0	0	0	1	0	0	0	0	0	0	2
Department of Primary Industries	0	0	0	0	3	1	0	0	0	0	0	0	0	4
Department of Water and Energy	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Director of Public Prosecutions	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Fairfield City Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Film and Television Office	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Gosford City Council	2	0	0	0	1	0	0	0	0	0	0	0	0	3
Goulburn Mulwaree Shire Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Health Care Complaints Commission	1	0	1	0	0	1	0	0	0	0	0	0	0	3
Infringement Processing Bureau	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Lake Macquarie City Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Legal Aid Commission of NSW	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lismore City Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Macquarie University	0	0	1	1	0	1	0	0	0	0	0	0	0	3
Ministry for Police	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Ministry of Transport	2	0	0	0	0	0	1	0	0	0	0	0	0	3
Northern Sydney Central Coast Area Health Service	0	0	0	0	1	0	0	0	0	0	0	0	0	1
NSW Fire Brigades	0	0	0	0	1	0	0	0	0	0	0	0	0	1
NSW Food Authority	1	0	0	0	0	0	1	0	0	0	0	0	0	2
NSW Maritime Authority	0	0	0	0	2	0	0	0	0	0	0	0	0	2
NSW Ombudsman	1	0	0	0	0	0	0	0	0	0	0	0	0	1
NSW Police Force	22	3	6	0	19	2	1	0	0	0	0	0	0	53
NSW Treasury	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Office of Protective Commissioner	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Office of State Revenue	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Palerang Council	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Pittwater Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Rail Corporation New South Wales	3	0	0	0	0	0	0	0	0	0	0	0	2	5
Richmond Valley Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1

Agency	Assessment only	Preliminary or informal investigation								Formal investigation				Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	
Riverina Conservatorium of Music	1	0	1	0	0	0	0	0	0	0	0	0	0	2
Roads and Traffic Authority	1	0	0	0	2	1	0	0	0	0	0	0	1	5
Rural Fire Service NSW	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Rural Lands Protection Board	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Southern Cross University	0	0	0	1	0	0	0	0	0	0	0	0	0	1
State Rescue Board of NSW	1	0	0	0	0	0	0	0	0	0	0	0	0	1
State Transit Authority of NSW	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Sydney Ferries Corporation	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Sydney Harbour Foreshore Authority	1	0	0	0	1	0	0	0	0	0	0	0	0	2
Sydney Ports Corporation	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Tumbarumba Shire Council	0	0	0	0	1	0	0	0	0	0	0	0	0	1
University of New England	0	0	0	1	0	0	0	0	0	0	0	0	0	1
University of New South Wales	0	0	0	1	0	0	0	0	0	0	0	0	0	1
University of Newcastle	1	0	1	1	0	0	0	0	0	0	0	0	0	3
University of Sydney	0	0	0	1	0	0	0	0	0	0	0	0	0	1
University of Technology	0	0	0	1	0	0	0	0	0	0	0	0	0	1
University of Western Sydney	0	0	0	1	0	0	0	0	0	0	0	0	0	1
University of Wollongong	0	0	1	1	0	0	0	0	0	0	0	0	0	2
Veterinary Surgeons Investigating Committee	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Warrumbungle Shire Council	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Total	75	4	21	12	60	14	7	0	0	1	0	0	3	197

Description

A **Decline after assessment only, including:**

Conduct outside jurisdiction, Trivial, Remote, Insufficient interest, Commercial matter, Right of appeal or redress, Substantive explanation or advice provided, Premature — referred to agency, Concurrent representation, Investigation declined on resource/priority grounds

Preliminary or informal investigation:

B Substantive advice, information provided without formal finding of wrong conduct

C Advice/explanation provided where no or insufficient evidence of wrong conduct

D Further investigation declined on grounds of resource/priority

E Resolved to Ombudsman's satisfaction

F Resolved by agency prior to our intervention

G Suggestions/comment made

H Consolidated into other complaint

I Conciliated/mediated

Formal investigation:

J Resolved during investigation

K Investigation discontinued

L No adverse finding

M Adverse finding

Appendix K

FOI report

The following information is provided in accordance with the *Freedom of Information Act 1989* (FOI Act), the Freedom of Information Regulation 2005 and the NSW Ombudsman's FOI Procedure Manual.

We processed six new FOI applications during 2007–2008 and two internal reviews, one of which related to an application initially received and determined in 2006–2007.

We did not hold any documents that fell within the scope of the three applications. Two of those FOI applications requested documents related to certain controlled operations and one application requested documents relating to a complaint about a local council.

This year we refused access to documents to three applicants on the basis that we are exempt from the operation of the FOI Act, by virtue of Schedule 2 and section 9 of the FOI Act, in relation to applications that ask only for documents that relate to our complaint-handling, investigative and reporting functions. The NSW Supreme Court made a decision in 2007 that confirmed the exemption available to agencies listed in Schedule 2 of the FOI Act (*Independent Commission Against Corruption v Gerard Michael McGuirk* [2007] NSWSC 147).

Only one of the applicants asked for an internal review and also appealed our decision to the ADT. The ADT upheld our original determination.

We refunded the application fees where we held no documents or the documents were exempt by virtue of Schedule 2 and section 9 of the FOI Act.

The number of FOI applications we dealt with this year has dropped from 16 to 6 and is the same as the number of applications we dealt with in 2005–2006.

Section A: New FOI applications

	Number of FOI applications					
	Personal		Other		Total	
FOI requests	2007	2008	2007	2008	2007	2008
New	1	1	15	5	16	6
Brought forward	0	0	0	0	0	0
Total to be processed	1	1	15	5	16	6
Completed	1	1	15	5	16	6
Discontinued	0	0	0	0	0	0
Total processed	1	1	15	5	16	6
Unfinished (carried forward)	0	0	0	0	0	0

Section B: Discontinued applications

We had no discontinued applications in either 2008 or 2007.

Section C: Completed applications

	Number of completed FOI applications					
	Personal		Other		Total	
FOI requests	2007	2008	2007	2008	2007	2008
Granted or otherwise available in full	0	0	4	0	4	0
Granted or otherwise available in part	1	0	5	0	6	0
Refused	0	1	6	2	6	3
No documents held	0	0	0	3	0	3
Completed	1	1	5	5	16	6

Section D: Applications granted or otherwise available in full

	Number of FOI applications (granted or otherwise available in full)					
	Personal		Other		Total	
	2007	2008	2007	2008	2007	2008
Provided to the applicant	0	0	4	0	4	0
Provided to the applicant's medical practitioner	0	0	0	0	0	0
Available for inspection	0	0	0	0	0	0
Available for purchase	0	0	0	0	0	0
Library material	0	0	0	0	0	0
Subject to deferred access	0	0	0	0	0	0
Available by a combination of any of the reasons listed above	0	0	0	0	0	0
Total	0	0	4	0	4	0

Section E: Applications granted or otherwise available in part

	Number of FOI applications (granted or otherwise available in part)					
	Personal		Other		Total	
	2007	2008	2007	2008	2007	2008
Provided to the applicant	1	0	5	0	6	0
Provided to the applicant's medical practitioner	0	0	0	0	0	0
Available for inspection	0	0	0	0	0	0
Available for purchase	0	0	0	0	0	0
Library material	0	0	0	0	0	0
Subject to deferred access	0	0	0	0	0	0
Available by a combination of any of the reasons listed above	0	0	0	0	0	0
Total	1	0	5	0	6	0

Section F: Refused FOI applications

	Number of refused FOI applications					
	Personal		Other		Total	
	2007	2008	2007	2008	2007	2008
Exempt	0	1	6	2	6	3
Deemed refused	0	0	0	0	0	0
Total refused	0	1	6	2	6	3

Section G: Exempt documents

This is the first year that this type of information is being collected by agencies. Therefore, we have not provided figures for 2006–2007. All applications we dealt with this year were refused by virtue of Schedule 2 and section 9 of the FOI Act.

	Number of FOI applications (refused or access granted or otherwise available in part only)					
	Personal		Other		Total	
	2007	2008	2007	2008	2007	2008
Schedule 2 exempt agency documents containing information confidential to Olympic Committees (Clause 22)	0	1	0	2	0	3

Section H: Ministerial certificates (s.59)

No ministerial certificates were issued in relation to FOI applications to the Ombudsman in 2007–2008 or 2006–2007.

Section I: Formal consultations

	Number of formal consultations conducted	
	2007	2008
Number of applications requiring formal consultation	1	0
Number of persons formally consulted	1	0

Section J: Amendment of personal records

We received no requests for the amendment of personal records in 2007–2008 or 2006–2007.

Section K: Notation of personal records

We received no requests for notation of personal records in 2007–2008 or 2006–2007.

Section L: Fees and costs

	Assessed costs		Fees received	
	2007	2008	2007	2008
All completed applications	$711	$185	$711	$185

We refunded all the FOI fees received in 2007–2008.

Section M: Fee discounts

	Number of FOI applications (where fees were waived or discounted)					
	Personal		Other		Total	
	2007	2008	2007	2008	2007	2008
Processing fees waived in full	0	1	0	3	0	4
Public interest discounts	0	0	0	0	0	0
Financial hardship discounts — pensioner or child	0	0	0	0	0	0
Financial hardship discounts — non-profit organisation	0	0	0	0	0	0
Total	0	1	0	3	0	4

Section N: Fee refunds

We did not refund any fees as a result of significant correction of personal records.

Section O: Days taken to complete request

	Number of completed FOI applications					
	Personal		Other		Total	
Days to process	2007	2008	2007	2008	2007	2008
0–21 days — statutory determination period	1	1	11	5	12	6
22–35 days — extended statutory determination period for consultation or retrieval of archived records (s.59B)	0	0	1	0	1	0
Over 21 days — deemed refusal where no extended determination period applies	0	0	3	0	3	0
Over 35 days —deemed refusal where extended determination period applies	0	0	0	0	0	0
Total	1	1	15	5	16	6

Section P: Processing time

	Number of completed FOI applications					
	Personal		Other		Total	
Processing hours	2007	2008	2007	2008	2007	2008
0–10 hours	1	1	10	5	11	6
11–20 hours	0	0	4	0	4	0
21–40 hours	0	0	1	0	1	0
Over 40 hours	0	0	0	0	0	0
Total	1	1	15	5	16	6

Section Q: Number of reviews

	Number of completed reviews	
	2007	2008
Internal reviews	6	2
Ombudsman reviews	n/a	n/a
ADT reviews	0	4

Section R: Results of internal reviews

We received two requests for internal reviews, one in relation to an application dealt with in the previous year and one of an application dealt with in 2008. They were not requests for personal information. The internal reviews upheld the original decision to refuse access to documents.

Appendix L

Significant Committees

Our staff members are members of the following inter-organisational committees:

Staff member	Committee name
Ombudsman — Bruce Barbour	Regional Vice President for the Australasian and Pacific Ombudsman Regional Group; Director on the Board of the International Ombudsman Institute; Institute of Criminology Advisory Committee; Reviewable Disability Death Advisory Committee; Reviewable Child Death Advisory Committee
Deputy Ombudsman — Chris Wheeler	Protected Disclosures Act Implementation Steering Committee; Security Committee; Whistle While They Work Steering Committee
Deputy Ombudsman/Community and Disability Services Commissioner — Steve Kinmond	Police Aboriginal Strategic Advisory Committee (PASAC); Reviewable Disability Death Advisory Committee; Reviewable Child Death Advisory Committee
Assistant Ombudsman (Police) — Greg Andrews	International Network for the Independent Oversight of Police; Early Intervention System Steering Committee; South Pacific Ombudsman Network
Assistant Ombudsman (Children and Young People) — Anne Barwick	Child Protection and Sex Crimes Squad Advisory Council
Assistant Ombudsman (Police) — Simon Cohen	NSW Police Force Internal Witness Advisory Committee; International Network for the Independent Oversight of Police
Cross Agency Team Manager — Julianna Demetrius	PASAC; Youth Justice Coalition, NSW Police Force Domestic Violence Steering Committee
Senior Investigation Officer (Aboriginal Unit) — Laurel Russ	PASAC
Team Manager — Anne Radford	Joint Initiatives Group
Inquiries and Resolution Team Manager — Vince Blatch	Joint Initiatives Group
Youth Liaison Officer — Mandy Loundar	Multicultural Youth Issues Network, NSW Police Force Youth Issues Advisory Group
Manager, Projects & Major Investigations — Helen Ford	Corruption Prevention Network
Project Manager (Police) — Brendan Delahunty	Network of Government Agencies: Gay, Lesbian, Bisexual and Transgender Issues; PASAC

Appendix M

Expert advisory committees

Two expert advisory committees assist us to perform our reviewable deaths functions. In 2007–2008, the Reviewable Child Death Advisory Committee and the Reviewable Disability Death Advisory Committee each met on two occasions. Our advisory committees continue to provide the Ombudsman with valuable advice on complex child and disability death matters, policy issues and health practice issues.

Reviewable Disability Death Advisory Committee

Mr Bruce Barbour	Ombudsman (Chair)
Mr Steve Kinmond	Deputy Ombudsman/Community and Disability Services Commissioner
Ms Margaret Bail	Human Services Consultant
Dr Helen Beange	Clinical Professor, Faculty of Medicine, University of Sydney
Ms Linda Goddard	Course Coordinator, Bachelor of Nursing, Charles Sturt University
Associate Professor Alvin Ing	Senior Staff Specialist, Respiratory Medicine, Bankstown-Lidcombe Hospital and Senior Visiting Respiratory Physician, Concord Hospital
Dr Cheryl McIntyre	General practitioner (Inverell)
Dr Ted O'Loughlin	Paediatric Gastroenterologist, The Children's Hospital, Westmead
Associate Professor Ernest Somerville	Prince of Wales Clinical School, Neurology
Ms Anne Slater	Physiotherapist, Allowah Children's Hospital
Dr Julian Troller	MD FRANZCP, Senior Research Fellow Neuropsychiatric Institute, Prince of Wales Hospital
Dr Rosemary Sheehy	Geriatrician/Endocrinologist, Central Sydney Area Health Service

Reviewable Child Death Advisory Committee

Mr Bruce Barbour	Ombudsman (Chair)
Mr Steve Kinmond	Deputy Ombudsman/Community and Disability Services Commissioner
Dr Judy Cashmore	Associate Professor, Faculty of Law, University of Sydney; Honorary Research Associate, Social Policy Research Centre, University of New South Wales; Adjunct Professor, Arts, Southern Cross University.
Dr Ian Cameron	CEO, NSW Rural Doctors Network
Dr. Michael Fairley	Consultant Psychiatrist, Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital
Dr Jonathan Gillis	Senior Staff Specialist in Intensive Care, The Children's Hospital, Westmead
Dr Bronwyn Gould	Child protection consultant and medical practitioner
Ms Pam Greer	Community worker, trainer and consultant
Dr Ferry Grunseit	Consultant paediatrician, former Chair of the NSW Child Protection Council and NSW Child Advocate
Associate Professor Jude Irwin	Associate Professor, Faculty of Education and Social Work, University of Sydney
Ms Toni Single	Clinical Psychologist, former Senior Clinical Psychologist, Child Protection Team, John Hunter Hospital, Newcastle
Ms Tracy Sheedy	Manager, Children's Court of NSW

Appendix N

Mandatory annual reporting requirements

Under the *Annual Reports (Departments) Act 1985*, the Annual Reports (Departments) Regulation 2005 and various Treasury circulars, our office is required to include in this report information on the following topics. All references to sections are to sections in the Annual Reports (Departments) Act and all references to clauses are to clauses in the Annual Reports (Departments) Regulation, except where stated otherwise. TC means Treasury Circular, PC means Premier's Circular.

Legislative provision	Topic	Comment
s.11A	Letter of submission	See the inside front cover
s.16(5)	Particulars of extensions of time	No extension applied for
s.11	Charter	See pages 18 – 19 and this Appendix (Legislation administered)
Sch. 1 to the Annual Reports (Departments) Regulation 2005 TC 01/12	Aims and objectives	See pages 20 – 27
	Access	See inside back cover
	Management and structure: • names of principal officers, appropriate qualifications • organisational chart indicating functional responsibilities	See pages 32 – 33
	Summary review of operations	See pages 15 – 17
	Funds granted to non-government community organisations	We did not grant any funds of this sort
	Legal change	See this Appendix
	Economic or other factors	See page 39 and pages 164 – 166
	Management and activities	See pages 14 – 40 and pages 41 – 56
	Major works in progress	There were no such works
	Research and development	See pages 108, 112 – 114, 164 and Appendix B.
	Human resources	See pages 34 – 39
	Consultants	We used no consultants this year
	Equal Employment Opportunity	See pages 35 – 36
	Disability plans	See this Appendix
	Land disposal	We do not own and did not dispose of any land or property
	Promotion – overseas visit	The Ombudsman was sponsored to attend a consultation meeting between the National Ombudsman Commission of Indonesia and members of its National Parliament in Jakarta, Indonesia in July 2007 and participated in the Pacific Island Ombudsman Network held in Vanuatu to discuss the Regional Ombudsman Initiative of the Pacific Plan in May 2008. The Deputy Ombudsman attended the 5th International Conference of Information Commissioners in Wellington, New Zealand in March 2008. The General Division Manager and Principal Researcher (Police) attended the National Ombudsman Commission in Indonesia in June 2008 as part of the Indonesian Australian Linkages and Strengthening Project to scope a major project about the complaint-handling capacity of Indonesia's Land agency. The Assistant Ombudsman (General) attended meetings of the South Pacific Ombudsman Network in Auckland, New Zealand in November 2007 and Port Vila, Vanuatu in May 2008 and met with government ministers in the Federated States of Micronesia, Marshall Islands and Palau in March 2008 to explore and progress the development of the Regional Ombudsman initiative of the Pacific Plan. These consultancy services were all funded by the Commonwealth Government.

Legislative provision	Topic	Comment
s.11 Sch. 1 to the Annual Reports (Departments) Regulation 2005	Promotion – overseas visit cont.	The Assistant Ombudsman (Police) attended a meeting of the International Network for the Independent Oversight of Police Steering Committee held in conjunction with the National Association for Civilian Oversight of Law Enforcement 13th Annual Conference in San Jose, United States, in September 2007.
TC 01/12 cont.	Promotions — publications	See Appendix O
	Consumer response	See pages 12 – 13
	Guarantee of service	See pages 18 – 19
	Payment of accounts	See page 166
	Time for payment of accounts	See page 165
	Risk management and insurance activities	See pages 28 – 29 and 36 – 37
	Controlled entities	We have no controlled entities
	Ethnic affairs priorities statement and any agreement with the CRC	See this Appendix
	NSW Government Action Plan for Women	See this Appendix
	Occupational health and safety	See pages 36 – 37
	Waste	See pages 39 – 40
s.9(1)	Financial statements	Auditor general statement pages 167 – 189
cl.4	Identification of audited financial statements	See pages 170 – 189
cl.6	Unaudited financial information to be distinguished by note	Not applicable
cl.5	Major assets	See page 165
TC 00/16	Copy of any amendments made to the code of conduct	The code of conduct was reviewed and there were no substantial changes made. A copy of the current Code of Conduct may be accessed on our website at www.ombo.nsw.gov.au
	Particulars of any matter arising since 1 July 2007 that could have a significant effect on our operations or a section of the community we serve	Not applicable
	Total external costs incurred in the production of the report	$32,168 (including $16,157 to print 1,000 copies)
	Is the report available in non-printed formats?	Yes
	Is the report available on the internet?	Yes, at www.ombo.nsw.gov.au
cl.7, 8; TC 00/24; PC 92/4	Executive positions	See page 35
s.68 *Freedom of Information Act 1989*	Statistical and other information about our compliance with the Freedom of Information Act	See Appendix K
Privacy and Personal Information Protection Act 1998	Privacy management plan	We have a privacy management plan as required by s.33(3) of the *Privacy and Personal Information Protection Act 1988.* This also covers our obligations under the *Health Records and Information Privacy Act 2002.* We had no requests for an internal review under Part 5 of the Act this year.
PM 91–3	Evaluation of programs worth at least 10% of expenses and the results	We reviewed our work processes and how we capture and report on data across all our programs. We reviewed the effectiveness of our cross agency team and permanently established it.
PM 94–28	Departures from *Subordinate Legislation Act 1989*	This year we did not depart from the requirements of the Subordinate Legislation Act.
PM 98–35	Energy management	See pages 39 – 40
PM 00–12	Electronic service delivery	We have an electronic service delivery program to meet the government's commitment that all appropriate government services be available electronically. We provide an online complaints form, an online publications order form and a range of information brochures on our website.
TC 99/6	Credit card certification	The Ombudsman certifies that credit card use in the office has met best practice guidelines in accordance with Premier's memoranda and Treasury directions.
s.42(8) *Ombudsman Act 1974*	Must distinguish between complaints made directly to our office and those referred to us	There were three complaints referred to us from other agencies.

Legislation relating to Ombudsman functions

Ombudsman Act 1974

Community Services (Complaints Reviews and Monitoring) Act 1993

Enabling legislation for each NSW University as amended by the *Universities Legislation Amendment (Financial and Other Powers) Act 2001*

Freedom of Information Act 1989

Police Act 1990

Protected Disclosures Act 1994

Witness Protection Act 1995

Law Enforcement (Controlled Operations) Act 1997

Telecommunications (Interception and Access) (NSW) Act 1987

Children and Young Persons (Care and Protection) Act 1998

Law Enforcement Legislation Amendment (Public Safety) Act 2005

Law Enforcement (Powers and Responsibilities) Act 2002

Terrorism (Police Powers) Act 2002

Criminal Procedure Act 1986

Police Powers (Drug Detection Trial) Act 2003

Surveillance Devices Act 2007

Law Enforcement (Controlled Operations) Regulation 2007

Litigation

In the last year we have been a party to a number of legal actions.

FOI related proceedings

- *Cianfrano v NSW Ombudsman* (2007) NSW ADT 275 (judgement delivered 5 October 2007, application dismissed).
- *Cianfrano v NSW Ombudsman* (2007) NSW ADT 273 (judgement delivered 23 November 2007, application dismissed).
- *Challitta v NSW Ombudsman* (2008) — NSW ADT 238 (judgement delivered 25 August 2008, application dismissed).
- *McGuirk v NSW Ombudsman* (2007) NSWADT 269 (judgement delivered 21 November 2007, application dismissed).
- *McGuirk v NSW Ombudsman* (2008) NSWADTAP 20 (judgement delivered 14 March 2008, appeal dismissed).

General proceedings

- *McGuirk v NSW Ombudsman* (2007) NSWSC 1286 — Rothman J — 13 November 2007 — summary dismissal of summons.
- *Clarkson v Commonwealth & ors* (High Court SL 00/2007) — 11 December 2007 — special leave application refused.
- *Manning v Ombudsman* (Workers Compensation Commission) — February 2008 — workers compensation proceedings withdrawn against Ombudsman.
- *McGuirk v NSW Ombudsman* — Court of Appeal — 13 November 2007 — current — appeal against decision of Rothman J.

Legal changes

Police Amendment Act 2007

This Act commenced in February 2008 and brings into law the remaining recommendations of the 2006 review of the *Police Act 1990*, in particular recommendations relating to complaints under Part 8A of the Act. The amendment improves the capacity of the Ombudsman to consult and provide reports to the Minister for Police and the Police Commissioner in relation to police complaints. The amendment also assists police to better protect the identity of complainants and permits police to take a more flexible approach to complaint resolution.

Statute Law Miscellaneous Provisions Act 2008

This Act was passed to amend section 10 of the *Ombudsman Act 1974* regarding delegations. Specifically, the amendment allows for largely administrative reporting functions to be delegated beyond the Assistant Ombudsman, to include a special officer of the Ombudsman, at the Ombudsman's discretion. Section 141(1A) has also been inserted into the Police Act to allow the Police Commissioner or Ombudsman to refer to additional information when assessing whether to investigate a police complaint. This Act is awaiting assent.

Child Protection (Offenders Registration) Amendment Act 2007

Removal of provision for monitoring of Act by Ombudsman as statutory review period has ended.

Crimes (Administration of Sentence) Legislation Amendment Act 2008

Amendment to section 152 of the Crimes (Administration of Sentence) Regulation 2001. Definition of "withdrawable privilege" clarified to include "exempt bodies" such as the Ombudsman. This means that inclusion of provisions relating to telephone contact with exempt bodies including the Ombudsman not being withdrawn as punishment.

External legal advice sought

- Mr Michael Sexton, Solicitor General of NSW — advice regarding interpretation of clause 13(a) Schedule 1 *Freedom of Information Act 1989*.
- Peter Garling SC and Kate Morgan — advice regarding statutory review provisions in *Law Enforcement (Powers and Responsibilities) Act 2002*.
- John Grifffiths SC — advice regarding application of the *Disability Services Act 1993*.

Ethnic Affairs Priority Statement (EAPS) — future plan

Key result area	Initiative	Time frame	Intended outcome
Planning	Coordinate office EAPS activities to ensure the implementation of EAPS action plan. This year we conducted preliminary research (literature review and consultations) into government responses (at state, federal and local levels) to newly emerging communities to identify issues and to determine whether individual agencies are responding in a planned, appropriate and coordinated way to address these issues.	Ongoing	A coordinated approach in our effort to improve access and awareness by culturally and linguistically diverse (CALD) communities. Community needs and gaps in government services identified and addressed.
Social justice	Establish and maintain effective communication with key CALD organisations and workers. Address any specific access issues identified.	Ongoing	Improved participation by CALD communities in our decision-making on access issues.
	Form partnership with other complaint-handling bodies and key agencies relevant to CALD communities to improve access to the NSW complaint system by CALD communities.	Ongoing	Improved access by CALD communities to NSW complaint system.
	Develop and implement effective communication strategies to raise awareness of our role among CALD communities.	Ongoing	Improved awareness of the role of the Ombudsman.
	Consult with key CALD organisations and workers to identify any barriers to access and develop strategies to minimise these.	Ongoing	Improved access by CALD communities to the Ombudsman.
	Implement any new strategies identified in our EAPS action plan for 2007–10.	Ongoing	Improved access by CALD communities to the Ombudsman.
Community harmony	Provide training on cross cultural issues and effective communication skills with CALD communities to our frontline staff, project officers, managers and liaison officers. Participate in cultural activities and festivals.	Ongoing	Increased staff competence in service provision to CALD communities.
		Ongoing	Improved community relations.

Disability Strategic Plan

Priority area for action	Goal	Strategy	Outcomes
Physical access	Ensuring that our office and any other locations we use are accessible to people with a disability.		Our office is situated in a building that has wheelchair access (ramp and lift) and tactile ground surface indicators near all staircases, ramps and escalators. The tenant directory is in a reasonable sized font in a well-lit area. Our public access areas are accessible by wheelchair, and we have toilet facilities for people with a disability. We have also modified some of our workstations to meet the needs of staff with a disability.
Promoting positive community attitudes	Actively promote people with a disability as valuable members of the community.	Working in partnership with peak organisations to promote positive community attitudes.	We have reached an agreement with DADHC and become a partner in the celebration of 2008 International Day for People with Disability. We will be organising a range of activities to actively promote people with a disability. This year we conducted an investigation into accessible taxis and made recommendations to Department of Transport for improvements in physical access of wheelchair accessible taxis.
Staff training	Staff are trained and competent in providing services for people with a disability.	Conduct disability awareness training for staff.	This year we developed an in-house disability awareness training program that offers a general awareness of disability and focuses on attitudinal and practical issues for people with a disability. This training course is compulsory and will be presented to all staff members in the next financial year.
Information about services	Our office and the services we provide are accessible to people with a disability.		Our general information brochure is available in a number of accessible formats including large print, Braille, discs with Braille labels and audiotapes. We also have a poster specifically designed for people with intellectual disability using the Compic symbols. We widely distributed the Rights Stuff Toolkit to consumers and service providers throughout the year.
Employment in the public sector	To employ more staff who have a disability.		6% of our staff have a disability, with 2% requiring work related adjustments.

Disability Strategic Plan cont.

Priority area for action	Goal	Strategy	Outcomes
Complaints procedure	Our office and the services we provide are accessible to people with a disability.	Develop strategies to let people with a disability know about our compliments and complaints policy.	We provided training to about 60 consumers of community services on their rights to use the services and to make complaints. We worked with consumers from CALD backgrounds, older people who use HACC services and families of young children with disability to improve their access to our services. We formed partnerships with other complaint-handling bodies and held a series of joint information forums for disability workers. We also made presentations to a number of key contact points about the role of the Ombudsman and issues in community services. We have an internal compliments and complaints policy, and we inform people who use our services about how to make a complaint about us. We gave special consideration to complaints by vulnerable members of the community, including people with a disability.

Action Plan for Women — progress report

Objective	Outcomes
Reduce violence against women	This year we continued to actively monitor the implementation by the NSW Police Force (NSWPF) of the recommendations contained in our 2006 report to Parliament on the policing of domestic violence. We meet with the NSWPF regularly to discuss progress and to provide detailed advice and feedback where appropriate.
Promote safe and equitable workplaces that are responsive to all aspects of women's lives	We have adopted flexible working conditions including flexible working hours, part-time work, work at home and job share arrangements, and leave for family responsibilities. We promote a safe workplace free from harassment and have procedures in place for dealing with staff complaints and grievances. We also offer training courses on equal employment opportunity, managing grievances and depression in the workplace.
Maximise the interests of women	We participate in the NSW Spokeswoman interagency meetings with spokeswomen from other agencies. Our Spokeswoman is available to provide information to all women staff about issues that affect their employment. We also reviewed our fact sheet for women widely distributed the information throughout the year. This year we delivered three workshops on complaint-handling and advocacy to people who work in the area of domestic violence. We also conducted presentations on the role of the Ombudsman to the Assyrian, Middle Eastern, Turkish and Arabic Women's Groups at the Fairfield Immigrant Women's Health Service.
Improve the access of women to educational and training opportunities	We have provided women in our office with educational and training opportunities to further their careers, including specialised in-house training on building a career in the public sector. We select and promote staff on merit.
Promote the position of women	We have a diverse and skilled workforce. Women make up 73% of total staff and 68.9% of staff grade six or above. All but two of our team managers are women, all three of our senior officers are women and one of our six statutory officers is a woman. We participated in this year's main International Women's Day (IWD) event at Hyde Park where we distributed brochures and fact sheets and spoke to women about how our office can help in dealing with their complaints about NSW government and certain non-government agencies.

Appendix O

Publications list

The following is a list of reports to Parliament and other publications issued between 1 July 2007 and 30 June 2008. To obtain a copy of these reports, contact us or visit our website at www.ombo.nsw.gov.au. All listed publications are available at the website in Acrobat PDF.

Reports to Parliament

Review of Emergency Powers to Prevent or Control Disorder

Annual reports

Law Enforcement (Controlled Operations) Act Annual Report 2006–2007

NSW Ombudsman Annual Report 2006–2007

Official Community Visitors Annual Report 2006–2007

Report of Reviewable Deaths in 2006 Volume 1: Deaths of people with disabilities in care

Report of Reviewable Deaths in 2006 Volume 2: Child deaths

Discussion and issues papers

Care Proceedings in the Children's Court

Ombudsman's Submission to the review of the *Children and Young Persons (Care and Protection) Act 1998*

Fact sheets and guidelines

Guidelines for dealing with youth complaints

Information sheet: The Ombudsman and you

Information sheet: Protection of whistleblowers: Practical alternatives to confidentiality

Information sheet: Are you an international student who has been excluded from your university or TAFE course?

NSW Ombudsman's work with Juvenile Justice

Reviewable Disability Deaths: Frequently asked questions

Apologies: a practical guideline

The NSW FOI manual (for a hard copy contact the Department of Premier and Cabinet)

Unreasonable complainant conduct manual: interim practice manual (hard copies not available)

Reports tabled

Review of the *Police Powers (Drug Detection Trial) Act 2003*.

Reports not yet tabled

The following report has been provided to the Attorney General and relevant Minister but has not yet been tabled. It will not be available on our website until tabled.

Review of the *Justice Legislation Amendment (Non-association and Place Restriction) Act 2001*. Provided to the Attorney General in December 2006.

Brochures

General information: making a complaint to the Ombudsman

Other

Family Support Services Complaint-Handling Review

Complaint-Handling Systems Survey Report — Councils

Complaint-Handling Systems Survey Report — Departments and Authorities

Appendix P

Our staff

Abdipranoto Luci
Adofaci Monique
Afflick Monalyn
Agius Jennifer
Akrivos Maria
Allen Janine
Andreallo Daniel
Andrews Greg
Ansari Ayishah
Arestides Tracylee
Arora Sharat
Aswani Bina
Banwell Kirsteen
Barbour Bruce
Barlow Ruth
Barton Margo
Barwick Anne
Basnov Ann
Bates Linda
Bautista Zaldy
Bayler Trisha
Bernard Megan
Blatch Vince
Blundell Nicole
Borg Kelly
Borg Maryanne
Borthwick Maya
Boyle Stephanie
Bradlova Lenka
Britton Maxwell
Brogden Veronica
Brough Heather
Brunt Christine
Burford Elizabeth
Burford Jillian
Burford Peter
Busby Jane
Cameron Tamaris
Campbell Scott
Campbell-McLean Carolyn
Carter Christine
Chapple Kym
Chard Janeane
Chen Steven
Cheung Trinh
Chie David
Choo Selena
Christodoulou Andrew
Chung Chi
Ciano Cathy
Ciliegi Anna
Clarke Louise
Clements Melissa
Cohen Alice
Cohen Simon
Cohen Terri
Conaty Michael
Coombes Padmadakini
Coppin Janet
Coughlan Janette
Craig Irene
Curran Rebecca
Dacey Matthew
Dawson Gary
Delahunty Brendan
Demetrius Julianna
Dening Matthew
Denning Emma
Di Bartolomeo Rebecca
Doherty Kate
Donaldson Stella
Donnelly Terry
Doyle Shelagh
Du Lisa
Dulfer-Hyams Yvette
Duller Joanne
Edmonds Claire
Eisenhuth Brooke
Enders Lily
Evans Frances
Fenton Sheena
Fernandez Claire
Fitzpatrick Amie
Flanagan Jo
Ford Helen
Formby Lisa
Garcia Rebeca
Gazzard Kerrie
Gennery Joan
Gleeson Michael
Graham Eileen
Grant Judith
Griffith Therese
Grima Jacqueline
Hanna Evette
Harris Sarah
Haydon Sally
Heazlewood Alice
Hemmings David
Hermanto Lucky
Hicks Alex
Hitzegrad Reinhard
Humphrys Elizabeth
Hy Jenny
Hynd Stephen
Janson Philomena
Jeffries Todd
Johnson Emily
Johnston Adam
Joyce Charlene
Kaye Margaret
Kell-Clarke Bridgette
Kelly Patricia
Kenny Kim
Kinmond Steve
Kiriczenko Sophia
Koorey Emma
Koren Diana
Kosh Wayne
Kuiters Frank
Kwan Ivy
Kwo Angel
Lai Alexandra
Lam Helen
Law Teresa
Lazzari Sophia
Leahy Jayson
Lee Justin
Legg Bronwyn
Lobos Jacqueline
Loundar Mandy
Lowe Tim
Lumbewe Adrian
Macklin Paul
Magnus Jonathan
Maguire Steven
Maigre Michelle
Mallia Mark
Malthus Henry
Maniruzzaman Mani
Manns Terry
Martin Tania
McAuley Barbara
McCallan-Jamieson Ian
McCleary Mary
McDonald Kate
McKenzie Alison
McKenzie John
McKenzie Kathryn
McKinlay Stuart
McNamara Gabrielle
Meade Sue
Mellon Rebecca
Meneguz Lilia
Mewing Natasha
Middledorp Kate
Millett Tom
Morris Katrina
Morse Oliver
Mueller Helen
Munro Wendy
Newman Nicole
Nguyen Bao
Noble Jenny
Noble-Paulinich Michele
O'Donahue Rodney
O'Donovan Sheila
O'Hallaran Marie
Ovenden Katharine
Owen Jennifer
Palma Claudio
Paneras Katerina
Parsons Kylie
Paxman Marina
Phelan Sue
Philip Joy
Phillips Lin
Piga Yvon
Piper Rebecca
Powell Michele
Power Julie
Premarajah Risha
Price-Kelly Sonya
Primmer Glenn
Purches Bryce
Quiohilag Jeremie
Quirke Michael
Radford Anne
Ralph Nina
Reynolds Ben
Rigby Aiden
Riordan Vincent
Robertson Cathy
Robinson Gareth
Rose Elizabeth
Rowe Dominique
Rowley Pamela
Russ Laurel
Ryan Carol
Ryan David
Ryan Janette
Ryan Louise
Sanders Katrina
Sandler Marissa
Savage Kelly
Seeto Belinda
Shea Alison
Shivakotee Binam
Shone Kate
Silver Sanya
Simon Kelvin
Simpkins Justine
Slowik Teresa
Smithers Kate
Smithett Penny
Smithson Marie
Smyth Frances
Snell David
Stacey Karen
Stanford Storm
Stewart Michelle
Swan Kim
Szaraz Les
Talbot-Sapsford Samantha
Tan Aimee
Tapa Mele
Tran Cuong
Vasquez-Lord Merly
Waciega Stan
Ware Carla
Webb De'Arne
Wheeler Chris
White Candice
Whittaker Anita
Williams Greg
Williams Marcelle
Wingrove Robert
Withers Julie
Wolf Monica
Woodward Nadine
Yetzotis Nick
Zurek Yvette

Appendix Q

Glossary

AAT	Administrative Appeals Tribunal
ADT	Administrative Decisions Tribunal
AIS	Association of Independent Schools
APOR	Australasian and Pacific Ombudsman Region
AVO	Apprehended violence order
CALD	Culturally and linguistically diverse
CAT	Cross agency team
CCER	Catholic Commission for Employment Relations
CCTV	Closed-circuit television
CINs	Criminal infringement notices
CCYP	Commission for Children and Young People
CS-CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993*
CTTT	Consumer, Trader and Tenancy Tribunal
DADHC	Department of Ageing, Disability and Home Care
DCS	Department of Corrective Services
DET	Department of Education and Training
DJJ	Department of Juvenile Justice
DoCS	Department of Community Services
DoH	Department of Housing
DSA	*Disability Services Act 1993*
DVLO	Domestic violence liaison officer
EAPS	Ethnic affairs priority statement
EEO	Equal employment opportunity
EWON	Energy and Water Ombudsman (NSW)
FOI	Freedom of information
HACC	Home and community care
ICAC	Independent Commission Against Corruption
IOI	International Ombudsman Institute
JCC	Joint Consultative Committee
JGoS	Joint Guarantee of Service for people with mental health problems and disorders living in Aboriginal, community and public housing
JIG	Joint Issues Group
JIRT	Joint Investigation Response Team
LEPRA	*Law Enforcement (Powers and Responsibilities) Act 2002*
LG Act	*Local Government Act 1993*
MRC	Migrant Resource Centre
MRRC	Metropolitan reception and remand centre
NSWPF	NSW Police Force
OCV	Official community visitor
OFT	Office of Fair Trading
OH&S	Occupational health and safety
OOHC	Out-of-home care
OSR	Office of State Revenue
PADP	Program of appliances for disabled people
PASAC	Police Aboriginal Strategic Advisory Committee
PD Act	*Protected Disclosures Act 1994*
PIC	Police Integrity Commission
PJC	Parliamentary Joint Committee on the Office of the Ombudsman and the Police Integrity Commission
PPIP Act	*Privacy and Personal Information Act 1998*
PSC	Professional Standards Command
SAAP	Supported accommodation assistance program
YLO	Youth liaison officer

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Acknowledgments

Our annual report is a public record of our work and through it we are accountable to the people of NSW.

Our report is prepared against criteria set out by NSW Treasury and the Annual Report Awards. It is available from our office or our website at www.ombo.nsw.gov.au.

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