From my office’s point of view, investigations are only a small proportion of our work. In 2005/6, we finalised over 10,000 matters formally, yet we only completed 66 investigations. However, it sometimes seems like the minority of our work generates the majority of opinion about our office. Investigations resonate with agencies, and often receive the most media attention and public comment. The investigative powers provided to our office are the strongest, most compelling tools we have with which to resolve both one-off and systemic administrative failings. For these reasons, it is important that we conduct the best possible investigations.

Before discussing some case studies, I will list some of the basic requirements for an effective investigation. These may seem obvious, but they are crucial:

- assess the complaint, and decide how it should be dealt with;
- determine the nature of the investigation required: who or what is being investigated, and how it will be done;
- recognise and manage any possible conflict of interests;
- develop an investigation framework;
- gather evidence effectively;
- maintain confidentiality, and
- afford procedural fairness

There are, of course, many other considerations when conducting an investigation.

It is also important to emphasise at the outset that we will only conduct an investigation when it is necessary. We will try to first pursue alternatives to provide a quick and appropriate outcome.

Although we prefer alternative means, there are certain situations where conducting an investigation may be the best or only option available. These can include:

- agencies being difficult and uncooperative;
- major deficiencies in an agency’s internal complaint investigation process, or
- the presence of a significant systemic issue which is unable to be corrected through informal means

* NSW Ombudsman
We do not conduct investigations simply to “seek scalps”. Nor do we try to blind-side agencies. Like other Ombudsman, we:

- provide agencies with notification of our intention to conduct an investigation;
- maintain contact with the agency throughout the investigation process, and
- issue provisional findings and recommendations, allowing agencies an opportunity to respond before a final investigation report is prepared.

I have selected four investigations as case studies, each I hope offering a unique scenario to demonstrate that investigations are by their very nature different, and require different strategies.

**Investigating a deficient complaint investigation**

**Facts:**
An individual was arrested and charged with stealing from his employer. When arrested, he claimed that he had been providing some of the stolen goods to a police officer, who was then selling them on to other officers who knew the goods were stolen.

**Issue:**
We do not directly investigate many police complaint matters, instead choosing to oversee the police handling of investigations. However, when we reviewed the police investigation report in relation to this matter, we became concerned that the allegations had not been properly investigated. After examining further documentation requested from police, we decided to conduct our own direct investigation.

**Process:**
The first stage of our investigation involved making use of our legislative powers to require police to provide us with all documents relating to both the complaint investigation and the criminal investigation into the alleged theft.

We then obtained surveillance video and documents held by a private investigation firm hired to look into the theft before the police became involved. This evidence had not been considered in the initial police investigation, and proved to be very useful.

Finally, we conducted hearings, interviewing the officers who were involved in assessing and investigating the matter. This allowed us to go beyond the documents collected, and understand the thinking behind their conduct and the investigative process.

**Outcome:**
We found that the failure by police to investigate the initial allegation in a swift and effective manner meant that much of the additional evidence collected during our investigation was of greatly reduced value. We recommended that the responsibilities of the involved officers when dealing with complaint investigations should be
reinforced, and that, where necessary further investigative training should be provided.

An interesting side issue:
During our investigation, one of the police witnesses told their supervisor that the information they had previously provided in their statement had not been truthful. They did have knowledge of officers from the command receiving stolen goods. As a result of this information, a further investigation was conducted leading to the consideration of criminal charges. It is unlikely the officer would have come forward if we had not decided to investigate the matter more thoroughly.

A Complex Own Motion Investigation

Facts/Issue:
Last year, we completed a particularly complex investigation into the land valuation system in NSW. After receiving information suggesting that there were massive variations in valuations being made on similar properties, and conducting extensive preliminary enquiries, we chose to initiate an own motion investigation. This was an extremely significant issue, affecting a large proportion of NSW’s population, and approximately 3 billion dollars in rates and land tax collected each year based upon the valuations made.

In order to investigate this matter successfully, we had to overcome some fairly substantial hurdles.

Process:
Firstly, the sheer number of valuations completed was daunting. Over 2.4 million property valuations are made each year in over 150 different local government districts. In order to keep our investigation manageable, but still relevant, we decided to limit the scope of the investigation by looking at valuations made in six areas, covering both metropolitan and rural regions.

Although the Valuer General issues land valuations, privately contracted valuers generate them. The Valuer General is not required to review the accuracy of each of these before basing a decision on them. These private valuations were very important to our investigation, but we only had jurisdiction over one of the eight valuation providers. In order to overcome this limitation, we made use of our Royal Commission powers to interview a range of contract valuers and managers.

During the course of the investigation, we collected almost 15,000 individual pieces of data. The investigators involved had to develop a number of worksheets, to allow them to manage and analyse the mass of information collected. We also had to retain outside expert assistance to assist in the evaluation.

We found that the basic methodology of the mass valuation system was sound, but that it was being incorrectly implemented. Key standards and quality assurance parameters were not being met, which was affecting the accuracy of the valuations produced.
Outcome:
We made 38 recommendations in our final report, all of which were accepted. The government acted quickly and allocated almost $13 million in extra funding to assist the Valuer General to institute the necessary changes.

Investigating where an Agency fails to Act

Facts:
This was an investigation into an independent school’s handling of child abuse allegations made against one of its teachers. After monitoring the initial internal response, we met with the head of agency and the principal of the school to outline our concerns about the way in which the matter was being handled. Our greatest concern was that the students making the allegations, as well as others, might continue to be at risk. We stressed the need for a proper risk assessment and a thorough investigation.

During these preliminary meetings, we were worried by some of the comments made, with the principal describing the students making the allegations as ‘the combatants’, and the head of agency referring to the allegations as being ‘superficial.’ These comments were particularly concerning, as a range of serious criminal charges had been laid against the teacher concerned.

The school was also reluctant to suspend the teacher until the criminal matter had been finalised, because they feared civil action. We advised them that this potentially put other students at risk.

Issue:
Although we originally chose to monitor the school’s investigation, the factors I have outlined led us to conclude that the matter warranted direct investigation. The agency was resisting all attempts to respond to our initial suggestions and guidance. We were conscious of the need to have effective child protection and risk management procedures in place as quickly as possible.

Process:
We required the provision of a wide range of documents from the school.

As there was also a criminal investigation under way, we obtained relevant information from NSW Police. This allowed us to review the statements provided by the students making the allegations, as well as evidence collected during a search of the staff member’s home.

In order to assess the management response to the allegation, we conducted taped interviews with the principal, the head of administration, the head of the program for young students, and the director.
Finally, we conducted site inspections of several of the school’s buildings in order to assess the adequacy of the measures put in place to minimise the staff member’s unsupervised contact with children.

We found that the school had not undertaken an appropriate risk assessment or implemented effective risk management strategies. We also found that the head of agency had not met his legislative responsibility in ensuring that effective systems were in place to report and respond to child abuse allegations.

**Outcome:**
Ultimately the school’s response to our final recommendations was positive. The teacher was stood down, pending the outcome of the criminal charges. He was later convicted and sentenced to eight years in custody. We continue to monitor the school’s child protection policies and procedures, and are satisfied that they now have an effective system in place.

**An Investigation into the Conduct of Multiple Agencies**

**Facts:**
This investigation stemmed from our role under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act*. We review the deaths of, among others, children who die as a result of abuse or neglect, in suspicious circumstances, or who had been reported as being at risk of harm at any time in the three years before they died. After completing a review, we may choose to investigate the actions of some or all of the agencies who had contact with the child leading up to their death. It is important to note that we are the only organisation in NSW with the ability to investigate the actions of all involved agencies. This is vital to assessing the effectiveness of reporting mechanisms and cross-agency cooperation, which are some of the most important elements of the child protection system in NSW.

**Issue:**
During the review of this particular child’s death, our office examined documents provided by NSW Health, NSW Police and DoCS. These raised concerns that the actions of the agencies may have put the child at increased risk of harm. We decided to investigate their conduct to try to prevent similar risk of harm to others in the future.

**Process:**
The challenge in investigating matters such as this stems directly from the number of different agencies involved. In this case, we were investigating the responses of separate agencies on a number of occasions, as well as collecting information from a variety of other sources. Effective planning and management of such an investigation is essential to ensure all relevant information is collected and analysed.

To assess the adequacy of the actions of medical staff at several hospitals, we requested each agency appoint a suitably qualified health officer with relevant child protection experience to conduct a review of their files. This provided us with expertise we did not have access to within our office.
This case also involved several GPs. While individual medical practitioners do not fall within our jurisdiction, we still needed to look into their actions, as they formed part of the total medical response. In our provisional report to one of the agencies, we requested advice of any action proposed or already taken concerning one of the doctor’s failure to make a risk of harm report. We were advised that the matter had been referred to the agency’s legal services branch to consider possible action. The agency then advised us that, due to the time that had passed, a prosecution was not possible. However, they referred the matter to the Health Care Complaints Commission for further consideration.

Outcome:
Following our provisional recommendations:

- One of the agencies improved their child protection policy, and were in the process of reviewing their procedures in relation to discharge and follow-up cases when child protection concerns had been raised.
- Another agency advised that the case was being used as a teaching case among staff, and that their procedures had been significantly altered.
- The final agency advised that they would conduct quality reviews, restructure their intake system, and implement revised guidelines for assessment of matters such as this.

We recommended each agency continue to keep us informed about the implementation of these and any other systemic changes.

Concluding Comments

I hope that these case studies help to demonstrate a few of the important and practical considerations when conducting investigations.

Firstly, there should never be a one-size-fits-all approach to investigation. Your approach must depend upon the outcome you wish to achieve, as well as the nature and scale of your subject matter. Are you conducting a small, targeted investigation relating to a specific issue, or are you looking into a broader systemic issue, which will require a greater degree of planning, resources and intensive investigation. Are you seeking policy or legislative change, improvements to systems, or a remedy to a specific problem?

Secondly, while investigations need structure and careful planning, it is also essential to remain flexible. Circumstances will frequently change, and you have to be able to adapt. If the investigation is not progressing in the way you want, you have to be able to change your approach, even if that involves discontinuing the investigation and choosing to pursue another avenue to reach a solution.

Finally, it is vital that we complete our investigations in a professional manner, in line with our own best practice guidelines. Our investigation powers give us the ability to compel agencies to answer questions and provide information. It is important that these powers are utilised appropriately, fairly and in good faith. Our good reputation depends on it, as does our continued capacity to work constructively and effectively with those agencies we investigate.