

*In the matter of the
Complaints Commissioner Law (2006 Revision)*

**Written Complaint Number CO708-
10917 made 22 October 2007 against
the Department of Children and Family
Services – Client Care**

Special Report to the Legislative Assembly

**Prepared by the Office of the Complaints
Commissioner**

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Aim of the Office: To investigate in a fair and independent manner complaints against government to ascertain whether injustice has been caused by improper, unreasonable, or inadequate government administrative conduct, and to ascertain the inequitable or unreasonable nature or operation of any enactment or rule of law.

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Department of Children and Family Services – Client Care

Failure to Comply with Recommendations within a
Reasonable Time

Written complaint number CO708-10917 made 22
October 2007

Prepared by the Office of the Complaints
Commission
24 June 2009

1. Foreword

Analyst Barrie Quappé completed this report in part, in accordance with the powers conferred on the Commissioner under Section 6 (1) of the Complaints Commissioner Law (2006 Revision)(“the Law”).

His Excellency the Governor was provided with a copy of this report in advance of its presentation to the Legislative Assembly in accordance with Section 18(4) of the Law.

2. Executive summary

2.1 Background to the case

On 22 October 2007, a complainant hereinafter referred to as “H” filed a complaint against the Department of Children and Family Services (“DCFS” or “the Department”) with the Office of the Complaints Commissioner (“OCC”). The complainant and their family said they were not satisfied with a written response provided by DCFS on 27 September 2007 to a letter they had sent to the Department on 30 August 2007, which raised questions about the death of a family member, hereinafter referred to as “A”.

In August 2006, “A” completed a residency programme at substance abuse centre Caribbean Haven. On the completion of this programme, centre staff contacted the Social Work Supervisor for George Town (“SWS for GT”) on their behalf, stating that assistance was needed with food and housing while “A” completed their education and found employment. The SWS for GT replied that DCFS would be happy to support “A” in this effort, and DCFS found him a property in the government housing project at Courts Road, George Town, which is managed by the National Housing and Development Trust (“NHDT”). “A” was placed in a flat with another NHDT tenant, hereinafter referred to as “B”.

“A” was regarded by the DCFS as an ‘intake’ client, meaning that the onus was on “A” to initiate contact with the Department or a social worker. But one social worker became familiar with his case. However, on February 2007, this particular social worker was moved from the DCFS office in George Town, where “A” sought help, to an office in West Bay (and subsequently left the organisation in March 2007).

In May 2007, “A” was hospitalised and received surgery. “A” phoned the DCFS from the surgical ward of the George Town hospital on 3 May 2007. A social worker tried to return the call but was not able to reach “A”. “A” later left hospital with a letter written to DCFS by Dr. Ajit Mathew, a general surgeon with the Health Services Authority. The letter dated 15 May 2007, was hand-delivered to the Department by “A” on 17 May and revealed that

“A” had suffered a severe injury. In the letter, Dr. Ajit Mathew requested that “A” be relocated to a new address in order to help him recover from the surgery. The doctor expressed concern that “A” would be at risk of infection if “A” remained in the present government housing. But no decision was taken on the specific request made by Dr. Ajit Mathew because the letter was not opened until after “A’s” death, two weeks later, from different causes.

This report does not concern itself with the circumstances of “A’s” death but relates to the administrative issues that this tragic case has raised for DCFS.

2.2 Jurisdiction confirmed

“A’s” family requested the OCC to investigate the following issues raised by the case:

1. The process by which decisions were made to place “A” in the government housing unit with a roommate;
2. The written guidelines for placement decisions, if any;
3. The application of the guidelines in this case;
4. The applicable exceptions to the guidelines and their use;
5. The failure of DCFS to communicate with their family after the death of “A”.

During the course of this investigation, additional issues about DCFS’s administration came to the OCC’s attention, including:

6. (a) A lack of follow-up with (potential) clients;
- (b) A lack of privacy for (potential) clients at the DCFS offices;
- (c) Failure to monitor potential clients placed on intake status;
- (d) A lack of documentation on (potential) client files.

The start of the investigation was delayed while clarification was sought over the OCC’s jurisdiction over the matter. The Department sought an opinion from the Legal Department and, in turn, the OCC sought its own legal opinion. Both supported the view that the OCC had the authority to investigate administrative matters as outlined in the OCC’s opening letter to the Department and referenced above as “Issues 1-6”. The opinions supported the OCC’s obligation to investigate under the Complaints Commissioner Law (2006 Revision).

2.3 Investigation method

The OCC's investigation was conducted between January 2008 and July 2008. Some of the documented evidence gathered included a document titled "Standards for the Management of Social Work Practices – Department of Children & Family Services, Cayman Islands"; the file relating to "A" from the George Town District office for DCFS; the letter written by Dr. Ajit Mathew of George Town Hospital; and internal e-mails between DCFS staff and management.

With "A" having died, the OCC worked to re-construct events relating to this person with interviews of family and friends who may have spoken to "A" during interactions with DCFS. On-site interviews were conducted at the office of the DCFS Director, Deanna Look Loy ("Director Look Loy"), and the George Town District Office in the Mirco Centre, where "A" had interacted with the Department.

2.4 Recommendations

The OCC issued its closing letter on 8 July 2008 to DCFS and complainant "H", listing ten recommendations to address areas of maladministration. They were:

1. It is recommended that DCFS establish and put into practice written guidelines stating factors to be used in client evaluation and prioritisation for housing, within three months from the date of this letter.
2. It is recommended that DCFS establish and put into practice written guidelines outlining factors for evaluation by which people are to be placed with a flatmate. These must be established and put into practice no later than three months from the date of this letter.
3. It is recommended that DCFS establish the terms of the lease between flatmates and between flatmates and the landlord and provide written lease documents. This should be completed and put into practice no later than one month from the date of this letter.
4. It is recommended that DCFS update and put into practice management standards within six months.
5. It is recommended that DCFS design and implement processes to ensure communication with persons who have attempted to contact the department from institutions such as hospitals or police stations.

6. It is recommended that DCFS submit a proposal to the Ministry for funds to make appropriate alterations to facilitate areas for private meetings.
7. It is recommended that in the interim the conference room should be cleared of donated goods and used as a private meeting room.
8. It is recommended that the process of recording contact by individuals with DCFS and the internal notification of contact by individuals be improved.
9. It is recommended that those individuals who are left on intake status but are known to DCFS be contacted periodically to ascertain whether assistance is needed.
10. It is recommended that supervisors review files monthly to ensure that (potential) client information interactions are documented.

2.5 Monitoring of recommendations

Once the recommendations were issued on 8 July 2008, the OCC began its monitoring efforts.

By 22 August 2008, the OCC found that one of the recommendations, namely no. 3, had been complied with. But the continued monitoring efforts were subject to delays caused by the busy schedule of Director Look Loy.

There was also evidence that delays were caused by management instructing staff about the matter. When the OCC contacted DCFS about its efforts to implement recommendation no. 4, for example, the staff member supposedly assigned to update the DCFS Management Standards Manual did not know about the recommendation and went on to make a general complaint about workload and staff morale.

Elaborating, Director Look Loy explained that the caseload of each social worker (defined as assigned “severe” cases such as child protection issues) could often be 30 cases or more. By way of comparison, she stated that countries such as the UK would not wish for a social worker to be assigned more than about 15 cases (of a severe nature) at a time. She stated she has advocated increased staffing over the years but has not been successful.

On 12 February 2009, the OCC met with the DCO of the Ministry of Health and Human Services, Mr. Leonard Dilbert (“DCO Dilbert”), and his Senior Policy Advisor, Debbie-Ann Whittaker and was told of discussion between the Ministry and the Department for certain re-organization efforts. But during this meeting, DCO Dilbert also disagreed with the concerns expressed

about low staffing by the Department; it became clear that the Ministry and the Department had reached an impasse on certain resource-driven issues.

2.6 Special Report prepared

Having monitored the recommendations for compliance since 8 July 2008, with compliance on only two of the ten recommendations, and noting this apparent impasse with no immediate signs of resolution, the OCC decided that it was its duty to prepare a Special Report as required by the CCL (2006 Revision).

Section 18 (3) of the Law states that, “[w]here the Commissioner has made a recommendation under subsection (1) and within the time specified or a reasonable time thereafter, he is of the opinion that no adequate action has been taken to remedy the injustice, he shall lay before the Legislative Assembly a special report on the case”.

The OCC is of the opinion that the Department has made efforts to comply with some of the recommendations directly within its remit but has failed to comply with others. Recommendations in areas that require support, decision and/or action from the Ministry have not been complied with, despite requests from the Department for assistance.

3. Introduction

On 22 October 2007, “H” filed a complaint against the DCFS. The complainant and their family were not satisfied with the response from DCFS of 27 September 2007 to their letter of 30 August 2007, which raised questions about the death of their family member, “A”. They requested the OCC to investigate the following issues:

1. The process by which decisions were made to place “A” in the government housing unit with a roommate;
2. The written guidelines for placement decisions, if any;
3. The application of the guidelines in this case;
4. The applicable exceptions to the guidelines and their use;
5. The failure of DCFS to communicate with their family after the death of “A”.

During the course of this investigation, additional issues that came to the OCC’s attention included:

6. (a) A lack of follow-up with (potential) clients;
- (b) A lack of privacy for (potential) clients at the DCFS offices;
- (c) Failure to monitor potential clients placed on intake status;
- (d) A lack of documentation on (potential) client files.

On 24 October 2007, the OCC faxed a letter to Director Look Loy notifying her of the commencement of this investigation.

4. Legal challenge

In the OCC opening letter of 23 October 2007, the OCC requested from Director Look Loy "...copies of relevant documentation delivered to this office (including "A's" file and the guidelines) before 6 November 2007, and thereafter, any relevant documents or information you may have in regards to the matter."

On 7 November 2007, the OCC was faxed a response letter dated 5 November 2007 acknowledging receipt of the opening letter. Director Look Loy noted in her letter that she was seeking guidance from the Solicitor General, Ms. Cheryl Richards ("SG Richards"), on whether the OCC could receive the documents requested.

In the light of this undertaking by DCFS, the OCC requested an independent legal opinion on this matter.

On 6 December 2007, the OCC e-mailed Director Look Loy and inquired whether the guidance from the Legal Department had been received. The OCC did not receive a response from Director Look Loy and on 12 December 2007 the OCC wrote to SG Richards to ask if they had rendered an opinion in the matter.

On 19 December 2007, an independent legal opinion of the OCC's jurisdiction in this matter was received by the OCC. It supported the OCC's jurisdiction over "administrative matters" associated with this case.

On 31 December 2007, the OCC sent an e-mail reminder to SG Richards and received an automated response stating that she was out of office until 2 January 2008.

On 2 January 2008, Director Look Loy informed the OCC that she had taken legal advice as to the powers of the OCC and that it was agreed that the OCC had jurisdiction to investigate the listed issues. Director Look Loy

acknowledged the OCC's authority to investigate the administrative matters outlined and agreed to cooperate with the investigation.

On 14 January 2008, the OCC visited the George Town Social Services office and interviewed the SWS for GT. Also interviewed were Director Look Loy, a Senior Social Work Assistant ("SSWA") who assisted "B", and a former Senior Social Work Assistant ("former SSWA") who had assisted "A". As noted throughout this report, many other interviews were also conducted.

5. Investigation findings

5.1 The process by which decisions were made to place "A" in the government housing unit with B

DCFS conceded that there were no formal guidelines for the placement of clients in housing. This decision was left to the discretion of the assigned social worker in consultation with the SWS for GT. In this case, the decision to place "A" in the flat on Courts Road was made by the SWS for GT, based on a referral from Caribbean Haven and the fact that the NHDT had made flats available to DCFS. "A" had successfully completed a residency programme at Caribbean Haven, and the staff there appealed to the SWS for GT on "A's" behalf in August 2006, stating that assistance was needed with food and housing while completing their education and finding employment. The SWS for GT stated that DCFS was happy to support "A" in this effort.

The decision to place "A" in government housing with "B" was made on an ad hoc basis. A process must be established which is fair to all applicants and is seen to be fair to all applicants.

The proper process should first consider all the persons who need housing and then place them in categories. There should be a mechanism for establishing priority categories and then for identifying priority cases within certain categories. For example, priority might be given to single mothers or abused persons.

The second stage of the process should dictate a review of individual characteristics of persons within a category and the priority established among them accordingly. For example, priority may be reduced if the individual has family members who may assist. The applicant's relevant history may also be considered – that is, the number of times the person has been assisted by DCFS, the circumstances, and the outcome (positive or negative) of the placement. Additional changes in circumstances and suitability for placement in shared housing could be considered.

RECOMMENDATION 1: It was recommended that DCFS establish and put into practice written guidelines stating factors to be used in

client evaluation and prioritisation for housing, within three months from the date (8 July 2008) of this letter.

5.2 The written guidelines for placement decisions, if any

The SWS for GT confirmed that there were no formal written guidelines for placement decisions on housing and on long- or short-term lease agreements.

DCFS has a difficult time finding housing for clients with a history of substance abuse. The SWS for GT admitted that people in need of housing were put where there was a space and that there was no formal review of appropriateness of the placement in terms of factors such as personalities, preferences, or client history.

However, good administration requires systematic consideration of such factors. Once it was determined that “A” was to be provided with housing and that it was to be shared housing, it would have been appropriate to consider, in a systematic fashion, the appropriateness of placement with certain flatmates.

We did not need to come to a finding on the appropriateness of the placement of “A” in this situation. The failure to consider in a formal and systematic manner the appropriateness of placement of flatmates is maladministration.

RECOMMENDATION 2: It was recommended that DCFS establish and put into practice written guidelines outlining factors for evaluation by which people are to be placed with a flatmate. These must be established and put into practice no later than three months from the date of the closing letter.

5.3 Lease terms for DCFS clients placed with NHDT

With regard to the lease arrangement, the Manager of the NHDT, Ms. Maxine Gibson (“Manager Gibson”), confirmed that the NHDT had (and still has) a verbal agreement with DCFS to rent flats to DCFS clients. No written agreement exists between the two entities pertaining to all the available flats.

File notes indicate that “A” moved into the flat in August 2006. The OCC requested a copy of the rental agreement in question and the only document received was a lease for the period January 2007 through May 2007. This agreement was signed by DCFS acting as “A’s” agent, rather than by “A” directly. The date of the signature was 21 June 2007, which was after “A”’s death. NHDT Manager Gibson stated that there was no other rental agreement.

As part of their evidence, complainant “H” spoke of concern about the level of care that “A” received from DCFS while living at Courts Road. “H” recalled “A” mentioning during one telephone conversation that they were using candles for light. The former SSWA revealed that during the last two weeks of November 2006 and the first two weeks of December 2006, the government housing leased by DCFS were without utilities. According to the former SSWA, the original agreement between his department and the NHDT was that utilities were included with the rent. However, the monthly utility bills were unexpectedly high, some over \$500. DCFS then asked the clients to contribute half of this expense. Some were not able to bear this expense and went without utilities. Eventually DCFS covered the expense because, as the former SSWA stated, it was close to Christmas. This evidence was confirmed by the SWS for GT.

This is not a satisfactory process. The lack of written agreements led to confusion concerning the terms of use of the residences and did not assign responsibility for the state of the facility, which potentially placed DCFS at risk of unlimited financial exposure. This could have been avoided with proper written agreements. Written agreements need not be lengthy or complex and can be easily adapted to long or short periods of tenancy.

RECOMMENDATION 3: It was recommended that DCFS establish the terms of the lease between flatmates and between flatmates and the landlord and provide written lease documents. This should be completed and put into practice no later than one month from the date of this letter.

5.4 The application of the guidelines in this case

DCFS confirmed there were no written guidelines for placement or potential client care in use. There is a relevant document titled “Standards for the Management of Social Work Practices – Department of Children & Family Services, Cayman Islands”, but the leadership of DCFS admits it is “outdated” and was not referred to. Director Look Loy gave evidence that DCFS was “more of a reactive practice” due to extremely limited resources (budget and personnel). This had impacted the quality of care available to many (potential) clients. The OCC notes that this situation may have left “A” overlooked during this particular time of need.

Director Look Loy stated that the government at the time of this investigation shared DCFS’s philosophy for community development. It was a proactive strategy which should have been properly funded in the Financial Year 2008–09. Director Look Loy determined that she had to take some staff away from social work duties to process this strategy. She described the action as having to borrow “a piece over here to patch up there” but she stated that her staff did a good job for the community with all things considered.

RECOMMENDATION 4: It was recommended that DCFS update and put into practice management standards within six months.

5.5 The applicable exceptions to the guidelines and their use

DCFS confirmed there were no written guidelines; therefore no exceptions could be applied in this case.

5.6 The failure of DCFS to communicate with the family of "A" regarding their death

This issue was raised by "H". The complainant stated they had first heard of "A's" death through an uncle in Grand Cayman on the evening of the death. The complainant was notified later that night by a police officer, but the family was never contacted by DCFS. "A's" father said that he was in Honduras when his child died. He was notified by phone by "H".

When asked if DCFS had contacted the family following "A's" death, the SWS for GT said she wasn't aware of any family in Cayman Brac. The intake note in "A's" DCFS file lists family in Grand Cayman and a sister in Cayman Brac (no last name supplied). A report written by the SWS for GT on 15 June 2007, following "A's" death, does not refer to DCFS having made contact with the family on the death. Director Look Loy stated that she was advised that the matter of "A's" death was under investigation and therefore *sub judice*, so she could not contact the family regarding any details.

It is worth noting the timeline for this response. "A" died on 1 June 2007 and the legal opinion from the Acting Attorney General was dated 11 September 2007.

FINDING: The OCC found that the family was notified by the appropriate entity in the circumstances. An officer of the Royal Cayman Islands Police contacted "H" on the night of "A's" death.

5.7 Additional issues that came to the OCC's attention

The Department's (last) statement of standards states: "The primary goal of case management is to optimise client functioning by providing quality services in the most efficient and effective manner to persons in need. The roles and responsibilities of Social Workers vary depending on programme or system objectives; they perform a range of common tasks related to client-level intervention (comprehensive assessment with the client) and system level intervention (i.e. organisation, policies and procedures)."

Director Look Loy stated that prioritization of cases was based on the social worker's knowledge of the case and application of basic social work practices. In a submission to the OCC, the Deputy Director, Ms. Jen Dixon ("Deputy Director Dixon"), described how the process unfolds:

'When someone comes in on intake, they are assessed as to what services they are seeking. The social worker or social work assistant goes through the process, listens to the client, (to determine) what they're coming in to request. Normally he/she reviews the matter with the supervisor to determine if there is something beyond what the client is requesting. They may come in seeking financial services, but we need to get to the underlying cause for them needing that service – to make some determination as to what level of intervention they need – whether it is something straightforward that can be dealt with through intake, or whether that person needs that case to be assigned for ongoing care. So at that point on intake, the person must discuss that case with the supervisor. The supervisor then makes a determination on whether the service requested is to be approved or not and whether the case needs to be assigned to someone right off the bat to continue working it. One of the challenges we face sometimes is we may not have sufficient workers to work on each case, so we have to assign on a needs basis.'

Director Look Loy said her staff worked more than the standard hours, including weekends, to try to keep up with the workload. She said she understood that some overtime was necessary, while saying she was concerned that at times her staff might have been taken advantage of because of their dedication to the work. In Cayman, Director Look Loy said, each social worker could be assigned more than 30 'severe' cases such as child protection matters. By way of comparison, she stated that countries such as the UK would ideally have 9-15 cases (of a severe nature) assigned to each social worker. Director Look Loy stated she had advocated increased staffing over the years but had not been successful. She stated that she has been in the civil service for over 30 years and department heads used to have the privilege of explaining the budget request in detail. Director Look Loy testified that she had requested this audience but that "no-one from the Ministry has sat with us and the Chief Financial Officer hasn't sat with us".

In the specific case of "A", what is undisputed is that this individual was never assigned a case worker. "A" was classified as being on "intake", which meant that any contact had to be initiated by "A". "An able-bodied [person] would not normally access our services, but since ["A"] was referred by Caribbean Haven we agreed to provide the services they requested on their behalf," Director Look Loy stated.

5.8 Lack of follow-up with (potential) clients

The former SSWA was the last employee of DCFS to assist “A”. Their last interaction was on 27 February 2007. The former SSWA was then assigned to the district of West Bay (he subsequently resigned in March 2007).

The next contact between “A” and the Department arises from the DCFS post-death review report. The report refers to “A” phoning the DCFS from the surgical ward of the George Town hospital on 3 May 2007. SWAT phoned back but did not manage to speak to “A”. The report goes on to refer to a letter written to DCFS by Dr. Ajit Mathew, a general surgeon with the Health Services Authority. The letter, dated 15 May 2007 and hand-delivered to the Department by “A” on 17 May, revealed that “A” had suffered a severe injury. In the letter, Dr. Ajit Mathew requested that “A” be relocated to a new address in order to help recover from the surgery. The doctor expressed concern that “A” would be at risk of infection if “A” remained in the present government housing. But no decision was taken on the specific request made by Dr. Ajit Mathew because the letter was not read. Two weeks later, “A” died from different causes.

DCFS argues that it was “A’s” responsibility to make contact as “A” was on intake status. The Department further states that alternate housing was not available, and that it was not the responsibility of DCFS to provide a sterile environment. The OCC notes that, had DCFS been able to speak with “A” at the time, a review of the individual’s living arrangements might have been conducted. Equally, DCFS might have spoken with Dr. Ajit Mathew, who in turn might have tried to arrange for “A” to spend additional time in the hospital or another medical support location.

It is maladministration to not have in place processes to ensure that individuals are spoken with when they attempt to contact DCFS from institutions such as hospitals.

RECOMMENDATION 5: It was recommended that DCFS design and implement processes to ensure communication with persons who have attempted to contact the department from institutions such as hospitals or police stations.

5.9 Lack of privacy for (potential) clients

During the course of the investigation, the OCC identified a lack of privacy for visitors to DCFS. The physical layout of the George Town office was not conducive to private conversation. The space was limited and overfilled. A visitor entered a small waiting area with an attendant behind a glass partition. They had to state their business in front of the other people in the waiting room. When they attended an appointment with a social worker, they were

seated in an open cubicle, and again they had to state their business in a location where other clients could hear them. The circumstances and content of their visit did not remain confidential. The only conference room in the office was being used to store donated food and goods for clients during the time of the OCC's visit.

The layout of the office violates common sense and the Department's own "Standards for the Management of Social Work Practices" stated in Standard 4 – Client Confidentiality, Criterion number 2: "Clients should have the opportunity to be interviewed privately."

Director Look Loy said that she had inherited the cubicle layout from a previous administration. She said that she and DCFS staff did not agree with the layout but it was what was given to them.

It is maladministration not to arrange for rooms to accommodate private meetings.

RECOMMENDATION 6: It was recommended that DCFS submit a proposal to the Ministry for funds to make appropriate alterations to the office to facilitate areas for private meetings.

RECOMMENDATION 7: It was recommended that in the interim the conference room should be cleared of donated goods and used as a private meeting room.

5.10 Failure to monitor potential clients placed on intake status

"A" was designated as being on intake status. For that reason, the former SSWA had never been assigned responsibility for them. The position of DCFS is that it merely helped "A" to get settled into the government housing in August 2006. In a further intake situation, the Department said it responded to "A's" call for counseling in February 2007. As such, "A" was not a client and the department assumed no responsibility for them.

However, the report written post-death states: "Although "A's" case was not assigned to a social worker, "A" was seen consistently by the former SSWA from August 2006 until this employee resigned from the Department in March 2007. During this period, "A" received assistance on a more consistent basis as "A" had demonstrated a commitment to completing residential treatment at Caribbean Haven..."

The OCC chooses not to make a finding of fact on the issue of what status was, or should have been, assigned to "A" under the system. The question of status does, however, invite the OCC to consider the appropriateness of the

current system of recording contacts by individuals and the DCFS policy of not monitoring those persons on intake status.

There were a number of important consequences of leaving "A" on intake status. The call from the hospital was one such issue. "A" phoned DCFS during the final hospitalization (in May 2007) and asked for SWAT. SWAT told the OCC that since they had never worked with "A", they thought it might have been an unofficial call, as they knew "A" through church. SWAT tried to return "A's" call but was told "A" was not in the room, and SWAT never tried again. No one else was notified.

The fact that the letter from Dr. Ajit Mathew was not passed to a social worker was another consequence of leaving "A" on intake status. Moreover, testimony revealed that there was an evolved practice amongst the George Town Social Service staff that if a doctor or a nurse telephoned the Department directly, the matter was deemed as important/urgent. But because the letter was delivered by an individual who was not a client – even though the receptionist stated that "A" had told her it was from "A's" doctor – the staff did not consider it important/urgent. The doctor in question was a new employee of the Cayman Islands Health Services Authority (with an employment start date of 5 May 2007, only 10 days before he wrote the letter) and therefore would not have been aware of this evolved practice. It may be assumed that that the surgeon would have thought something in writing would carry more weight, given his recommendation concerning "A's" living arrangements.

The evidence showed that on Thursday, 17 May 2007, "A" delivered the letter to the DCFS office in George Town. The letter was in a brown official government envelope and was addressed to "The Director". The letter was placed with the appointment sheet since "A" could not wait for a social worker to become available and stated they would check back later. On Tuesday, 29 May 2007, before going on leave, the office assistant wrote a note, stuck it to the unopened letter, and returned the letter to the appointment book. The SWS for GT also went on bereavement leave due to a death in her family. On Friday, 1 June 2007, "A" died. On Tuesday, 5 June 2007, the letter, still unopened, was given to the SWS for GT. Thus, 12 working days elapsed before the letter was opened and read.

Failure to read the letter resulted in a missed opportunity for DCFS to understand "A's" situation, to understand the doctor's opinion, and to consider appropriate action. "A" was denied the potential assistance of DCFS as a result. "A" was denied the opportunity to be considered, or placed on a waiting list, for alternative housing (which may or may not have been available). "A" also could have been given advice on the options had alternate housing not been available. For example, a social worker might have

encouraged or assisted “A” to contact family for temporary accommodation. These options might have made a difference to the outcome.

DCFS’s policy of not monitoring people on intake status failed “A” on several counts. The facts lead to the conclusion that (potential) clients on intake status who are known to the Department (even if they do not achieve client status) should be monitored. In any event, a well-organised recording and notification system also is needed. A database should be created to record contacts made by individuals. It should include automatic notification of each contact, for example by e-mail, to the officer in charge on that day, who in turn can direct appropriate action. Placing the responsibility for follow-up on the person in need of assistance makes it more likely that people in need of help will fall through the cracks. The most vocal are likely to be helped while others too embarrassed to speak up for themselves, or unable to speak, may be neglected.

RECOMMENDATION 8: It was recommended that the process of recording contacts with DCFS made by individuals and subsequently notifying the appropriate DCFS employee of each contact be improved.

RECOMMENDATION 9: It was recommended that those individuals who are left on intake status but are known to DCFS be contacted periodically to ascertain whether assistance is needed.

5.11 Lack of documentation

The OCC’s review of the relevant files revealed that many interactions and meetings were not noted. Director Look Loy conceded that owing to staff limits and workload, some aspects of supervision and documentation were neglected from time to time. The Department’s requirement for social workers to document all client interactions (including the amount of time spent with each client) was addressed in workshops held in 2006 and 2007. It must be repeated that proper administration requires proper documentation of (potential) client files.

RECOMMENDATION 10. It was recommended that supervisors review files monthly to ensure that (potential) client interactions are documented.

6. Monitoring timeline

On 8 July 2008, the closing letters were sent from the OCC to the Department and “H”. The letters stated the finding of maladministration and made 10 recommendations.

On 22 August 2008, the OCC e-mailed Director Look Loy to formally begin the stage of monitoring the recommendations for compliance. The email noted that recommendations 1, 2, and 4 had pre-set dates and would not be monitored until that time. It also revealed that the OCC had discovered, while working on a separate case, that recommendation no. 3 had already been complied with. It asked for evidence that recommendations 5-10 had been complied with, requesting a response by 28 August 2008, and also listed all ten recommendations again for the record.

On 27 August 2008, Director Look Loy e-mailed the OCC asking for a two-week extension on the deadline due to the increased workload on her Department to prepare for the possibility that Hurricane Gustav would impact the island. The OCC agreed and set a new deadline of 23 September 2008. Three days after the deadline, Director Look Loy e-mailed the OCC on 26 September 2008 and attached her Memorandum of response dated 25 September 2008.

On 3 October 2008, the OCC e-mailed Director Look Loy a response to her submission of 25 September 2008 and listed the ten recommendations, the Department's responses and the OCC's required follow-up requests for evidence (which is further detailed in section 7 of this report). The OCC also provided the Department with an overview of the OCC process and noted that this case was in the monitoring phase. The e-mail also stated that if there were a failure to comply, this would result in a Special Report being made to the Legislative Assembly in accordance with the Complaints Commissioner Law (2006 Revision).

On 13 October 2008, the OCC e-mailed Director Look Loy to follow-up on its last request. Director Look Loy replied the same day, stating: "This is one of the numerous things I have to do and all are equally important as they affect people's lives. Most are more urgent. You will hear from me by October [or] mid-November."

A monitoring meeting was eventually held between the OCC and DCFS on 24 November 2008. The OCC recorded that this was a very positive meeting. On 2 December 2008, the OCC e-mailed its notes of the meeting to DCFS for confirmation.

On 14 January 2009, the OCC called DCFS about recommendation no.4. The staff member assigned to update the DCFS Management Standards Manual confessed they did not know about the recommendation and went on to make a general comment about stress and morale. Later that day, the OCC e-mailed Director Look Loy to inform her that the staff member was not working on the Manual.

On 30 January 2009, the OCC met with Director Look Loy and Deputy Director Dixon.

On 3 February 2009, Director Look Loy copied the OCC on an e-mail to her Social Work Supervisors reminding them that all correspondence was to be sent to Director Look Loy and when Social Workers arrange accommodation for a client, roommates were not allowed.

The following day, the OCC invited the Deputy Chief Officer ("DCO") of the Ministry of Health and Human Services, Mr. Leonard Dilbert, to a meeting.

On 12 February 2009, the OCC met with the DCO and his Senior Policy Advisor. The DCO made the following general comments regarding the manner in which the Cayman Islands address matters of social services:

"I wish to make a very general comment that underpins all that we have been talking about. It is a comment that people get sick of hearing me say but I keep saying it anyway. We are in a difficult time as far as the development of the country particularly in the area of social development and social well being. Because we made choices a long time ago about how we wish this country to develop and those choices we are now paying for. One of those choices was that we didn't pay enough attention to social infrastructure. We didn't pay enough attention to what provisions were being made for the elderly, what provision was being made for the development of young people. We are now reaping the benefits of all of that, if you can call it that. We are now finding that older people are in dire situations, in many cases because the social networks that used to exist to support them are not as strong as they used to be. They can't keep up in terms of the cost of living because you have to be very fit and able to compete in today's marketplace to possibly earn enough to keep up. The older population falls out of that picture and they become dependent in one way or another. The younger people, God help them in terms of the stressors they have to face in trying to figure out how to socialise them in a way that they can function competently in an environment that is changing as fast as this one is and creating demands on them and quite frankly our infrastructure has fallen way behind across that whole spectrum. We're just not doing enough and not good enough. As far as where DCFS is in relation to a couple of specific things- no question about it the Ministry has this particular piece of legislation, this is a social situation that affects the entire country and is going to affect us for sometime to come if we don't take some serious action very soon."

When the OCC asked DCO Dilbert about the Ministry's determination to handle these issues, he responded:

"The Ministry has been pushing for awareness on the part of the Government as a whole to make them aware of the cost implications of the situations that we are looking at; for instance one of the easier places to identify is the impact on

physical health where the failure to acknowledge and project the impact of certain lifestyle choices that people have accumulated over time and which are now having the impact on the population in the form of what, like many countries in the Western hemisphere in particular, can only be classified as an epidemic of communicable diseases. Hypertension, various other diseases of the circulatory system, diabetes – those conditions that are most of the time lifestyle related and preventable. The cost of treating those things has gone through the roof and continues to climb – and we have been working diligently to monitor, to quantify, to track the cost to make Cabinet aware of what is happening and choices that need to be made. Where resources need to be put to try to turn that around and that is in terms of implementing a primary health care intervention using the district clinics in a more effective way. Implementing a new approach to public health that pays attention to promoting wellness and preventing disease and proper management of conditions. Between public health, the new public health and primary health care on the physical side and pressing for the Government as a whole to take on social development of the country as a top priority because the idea that just because we managed to compete economically, that somehow things are going to sort themselves out, that don't work. We can see that that doesn't work - and our entire strategy as a Ministry is based upon trying to both quantify and identify and rationalize where these things occur. Exactly what they are, where they occur, how they developed in terms of the National Assessment of Living Conditions, the Public Health Report, from both ends of the spectrum. So that the information that policy makers need and information that the public needs to make them aware of the realities around them. Because without that education, people can never understand why we need the resources to be put in that area. We can promote Tourism all we want.”

7. Compliance efforts by DCFS

7.1 Efforts of the Department to comply with recommendation no. 1

RECOMMENDATION 1: It was recommended that DCFS establish and put into practice written guidelines stating factors to be used in client evaluation and prioritisation for housing, within three months from the date of the OCC's closing letter dated 8 July 2008.

Director Look Loy's 25 September 2008 memorandum to the OCC stated: "...clients are assessed for rental assistance which has been submitted to become part of the Poor Persons Relief Law Regulations. We do not provide housing as such; our agency provides the financial resources for the client to access rental accommodation. Housing is the responsibility of the District of Administration, Planning, Agriculture & Housing. Usually the client

identifies their own accommodation and if they qualify for assistance the funds are paid to the landlord.”

On 24 November 2008, Director Look Loy informed the OCC that the DCFS had asked that the criteria laid down for temporary assistance become part of the Poor Persons Relief Regulations. The Department used these criteria for housing placement. On 30 January 2009, Director Look Loy and Deputy Director Dixon admitted that the Regulations had been with the Ministry for over a year, they were most likely “on Mr. Dilbert’s desk”, and there was nothing more they could do at the Departmental level.

On 12 February 2009, DCO Dilbert stated that the Regulations had been resource-impacted. He stated that the drafting of legislation was complex and time consuming. The Regulations had been drawn up following extensive work between the Ministry and the Department, he stated, and they had been revised by the Legal Department. There had been three versions thus far. DCO Dilbert stated that the Regulations document was now back with the Legal Department for a fourth review, but the Legal Department had cautioned that it would not be able to resume work on it until March 2009 because of other priorities. DCO Dilbert added that the Ministry still had a sense of urgency to complete the Regulations.

FINDING: While the OCC accepts that the Department and the Ministry have made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.2 Efforts of the Department to comply with recommendation no. 2

RECOMMENDATION 2: It is recommended that DCFS establish and put into practice written guidelines outlining factors for evaluation by which people are to be placed with a flatmate. These must be established and put into practice no later than three months from the date of this letter.

On 25 September 2008, Director Look Loy said in a memorandum: “Staff has been advised to cease putting clients to share accommodation.” The OCC asked that this message be circulated to staff, and on 3 October 2008, Director Look Loy stated by e-mail that a message had been sent to staff instructing them not to place persons with roommates and that this message would be forwarded to the OCC.

On 3 February 2009, Director Look Loy copied the OCC on an e-mail to her Social Work Supervisors reminding them “when Social Workers are renting facilities for clients, no clients must share accommodation”.

FINDING: The OCC ruled that this e-mail was evidence of substantial compliance and marked recommendation no.2 as complied with as of 3 February 2009.

7.3 Efforts of the Department to comply with recommendation no. 3

RECOMMENDATION 3: It is recommended that DCFS establish the terms of the lease between flatmates and between flatmates and the landlord and provide written lease documents. This should be completed and put into practice no later than one month from the date of this letter.

FINDING: The OCC witnessed changes to a DCFS lease in another case and was able to utilise this as evidence of substantial compliance as of 8 August 2008.

7.4 Efforts of the Department to comply with recommendation no. 4

RECOMMENDATION 4: It is recommended that DCFS update and put into practice management standards within six months.

An OCC finding of the investigation was that no guidelines were in use. The Department is in possession of a document titled “Standards for the Management of Social Work Practices – Department of Children & Family Services, Cayman Islands – dated 1997”. But it admitted that this was “outdated” and not in use.

On 25 September 2009, Director Look Loy stated in a memorandum to the OCC: “Management Standards for the DCFS are in place and are being utilized. The Social Work Manager will review the Procedure Manual which contains these standards to determine if there is a need to update same.”

During a meeting between DCFS and the OCC on 24 November 2008, the OCC requested and received a copy of the Current Management Standards. Director Look Loy stated that staff member Ms. Leonora Wynter-Young should have the manual review completed by the end of February 2009.

On 14 January 2009, the OCC contacted DCFS to follow-up on recommendation no.4. The staff member assigned to update the DCFS Management Standards Manual admitted she did not know about it and went

on to say that there was a low level of staff morale and she was suffering from stress. The OCC then e-mailed Director Look Loy to let her know the staff member was not working on the Manual.

On 30 January 2009, the OCC met with DCFS and was told that staff member Ms. Debbie Webb had been assigned the task and an internal meeting had been scheduled for 11 February 2009 to review the matter. On 12 February 2009, the OCC met with DCO Dilbert and his Senior Policy Advisor. The OCC informed the DCO of the review of the manual and the staff member assigned. The DCO thanked the OCC for this new information.

FINDING: While the OCC accepts that the Department has made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.5 Efforts of the Department to comply with recommendation no. 5

RECOMMENDATION 5: It was recommended that DCFS design and implement processes to ensure communication with persons who have attempted to contact the Department from institutions such as hospitals or police stations.

Director Look Loy stated that a process had existed for over 20 years whereby institutions such as hospitals or police stations were able to make direct contact with the Director, Deputy Director and Supervisors. She also noted that police or hospital staff could contact on-call duty social work supervisors after 5pm on weekdays, at weekends and on public holidays.

She further stated that she had instructed all supervisors to direct all incoming mail for the satellite offices to the Director. As is already done, anything pertaining to DCFS's clients or office would be collected on the same day. Urgent matters would be faxed.

The OCC asked the Director to submit a copy of this communication and the procedure/process document and to provide the name of the individuals at the hospital and Police Service to whom the on-call service number was provided. The OCC also asked the Director to provide a copy of her communication to the supervisors asking that all incoming mail to the satellite offices be directed to the Director.

The Director admitted that the George Town office did not handle communication in this case properly. The OCC asked DCFS to send agencies and staff a reminder of what their communications policy was and to copy it

to the OCC. The DCFS was asked specifically to remind staff about general communications requirements both within the Department and also with key agencies such as police and hospitals.

On 30 January 2009, the Deputy Director undertook to copy in the OCC on their communication to outside agencies, however to date we have not received a copy of the communication.

On 12 February 2009, the OCC met with DCO Dilbert and informed him of these monitoring efforts and the fact that the matter was still outstanding.

FINDING: While the OCC accepts that the Department has made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.6 Efforts of the Department to comply with recommendation no. 6

RECOMMENDATION 6: It was recommended that DCFS submit a proposal to the Ministry for funds to make appropriate alterations to the office to facilitate areas for private meetings.

During the course of this investigation, the OCC found that there was a lack of privacy for (potential) clients at the George Town DCFS office. Visitors had to state their business in a public reception area and again in meeting areas that provided no privacy. At the time, the conference room was unavailable for meeting with clients due to the fact that it was being used as a storeroom for donated goods.

On 25 September 2008, Director Look Loy stated in a memorandum to the OCC that “no further alterations can be made to the current site. We will recommend in the 2009-2010 budget that the Ministry acquire suitable ground floor accommodation for the staff with appropriate facilities for dealing with clients.” The OCC responded with a request for a copy of the 2009-2010 budget.

On 24 November 2008, Director Look Loy told the OCC she was working with the Planning Department to find suitable space and evaluate the possible cost of renting more space. She submitted two e-mail communications to the OCC. One, dated 3 October 2008, was sent by Director Look Loy to Alan Jones, the Director of the Lands and Survey Department, describing the need for more space at the Mirco Centre office. The second communication was a trail of e-mails, the latest of which was dated 17 November 2008 from the Senior Valuation Officer for Lands and Survey, Mr. Uche Obi, regarding the

requested office space. He confirmed the proposed new space would be “two times larger” than the present space.

The OCC recorded that this demonstrated efforts to comply with this recommendation. But the OCC also needed to see evidence that a “proposal to the Ministry” regarding the office space had been submitted. Once the new space and the price were confirmed, the OCC requested that a copy of DCFS’s proposal to the Ministry be provided to the OCC.

But on 30 January 2009, Director Look Loy reported to the OCC that the process to acquire new space had come to a “grinding halt”. The Department had been told it would not be receiving additional space because of budget cuts.

Director Look Loy stated that the Ministry’s Chief Officer, Diane Montoya (“CO Montoya”), had found a space above a restaurant that may be suitable for a Children Services Unit, but this idea had run into difficulties because of the Department’s wider resource challenges.

Social Workers who offered to be assigned to children's cases only could relinquish their adult cases to other workers prior to going to the Children's unit, once available. However, Deputy Director Dixon (“DD Dixon”) reminded the OCC that in November 2008 they had talked of hiring three new staff. The Government had imposed a hiring freeze at a time when the DCFS was already under-resourced, according to CO Montoya. The CO had recently stated that she would allow the hiring of two new staff but in the meantime two additional staff had resigned and they were severely short-staffed. Deputy Director Dixon said this fact was taking its toll on the remaining staff.

However, on 12 February 2009, DCO Dilbert stated to the OCC that he felt those comments were “disingenuous”. He said that even though there was a hiring freeze, the Department still planned to replace anyone who resigned. The Department, he said, simply needed to follow the paperwork protocol to get this done.

DCO Dilbert stated that the Ministry had in the past discussed creating two separate entities, one for adults and the other to handle children’s issues. He stated that the Ministry worked strenuously with the Department and it was persuaded by the Department that due to the fact that children are intertwined with adults and their families, this would not work and the Ministry relented. The Children's unit was the agreement on the way forward.

The Director told the OCC that some of the social workers had volunteered to work in the Children's Unit once it was operational. However, with her low staffing, this would create further issues as the remaining social workers

would continue with their present case load and have to assume the additional cases of the workers transferring to the Children's Unit.

FINDING: While the OCC accepts that the Department has made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.7 Efforts of the Department to comply with recommendation no. 7

RECOMMENDATION 7: It was recommended that in the interim the conference room should be cleared of donated goods and used as a private meeting room.

During the course of its investigation, the OCC found that there was a lack of privacy for visitors to DCFS. The OCC visited the George Town DCFS office on two occasions and found the conference room being used for storage both times. This practice violates common sense and the Department's own "Standards for the Management of Social Work Practices" stated in Standard 4 – of the Client Confidentiality, Criterion number 2: "Clients should have the opportunity to be interviewed privately."

On 25 September 2008, Director Look Loy stated in a memorandum to the OCC: "The conference room was being used for storage at the time of your inspection because we had just received substantial donated items. We will have to continue to use it for this purpose when large donations are received and ensure that they are distributed expeditiously as the offices do not have storage space. The conference room was sound proofed prior to your inspection and that space along with the small interview room is used as needed for meetings."

On 24 November 2008, the OCC explained to DCFS that it was not in compliance because using the conference room as a storeroom compromised client privacy. The OCC suggested the Department find an alternative storage space until the new office facilities could be identified. The OCC stated: "Client privacy is of paramount importance and every effort to facilitate this should be made." Once this had been achieved, the OCC requested that the Department forward evidence to the OCC to support this effort. At a meeting between the OCC and DCFS on 24 November 2008, DCFS submitted that the room had been cleared but then had been filled with Hurricane Paloma supplies. Director Look Loy stated: "We try but are not always successful in giving our clients privacy." She added that once DCFS gets into the new office space it hopes to achieve increased client privacy.

On 30 January 2009, Director Look Loy submitted that the SWS for GT was “working on an interview room”.

FINDING: While the OCC accepts that the Department has made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.8 Efforts of the Department to comply with recommendation no. 8

RECOMMENDATION 8. It was recommended that the process of recording contact by individuals with DCFS and the internal notification of contact by individuals be improved.

During its investigation, the OCC found that DCFS did not monitor potential clients placed on intake status. Poor record keeping or unreliable internal notification processes meant that individuals who called or visited DCFS might not be attended to. Individuals who had been assisted by DCFS were not monitored to determine if additional assistance was needed. This had led to many problems, including the failure to read and respond to official correspondence.

On 25 September 2008, Director Look Loy stated in a memorandum to the OCC that the process for recording contact by individuals was already in place but it simply needed to be adhered to. The matter would be further discussed with supervisors, she said.

A Social Work Manager was instructed to more closely monitor unassigned cases and ensure that they were followed up or closed, if necessary. The OCC asked to see the job description of the new Social Work Manager that included the incumbent’s duties along with the employment contract. In addition, the OCC requested a copy of the Department’s policy and procedures manual, which outlined the steps to be taken to record contacts with the Department along with proof of Director Look Loy’s discussions with the supervisor. DCFS submitted the job description requested.

On 7 December 2008, the OCC documented its internal review of the new Social Work Manager job description. The job description generally addressed supervisory duties but did not specifically address the issue targeted by recommendation no. 8.

FINDING: While the OCC accepts that the Department has made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the

Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

7.9 Efforts of the Department to comply with recommendation no. 9

RECOMMENDATION 9: It was recommended that those individuals who are left on intake status but are known to DCFS be contacted periodically to ascertain whether assistance is needed.

On 25 September 2008, a memorandum to the OCC from Director Look Loy stated that the OCC should refer to her response for recommendation no. 8.

FINDING: The OCC finds no clear evidence that this recommendation has been complied with to date.

7.10 Efforts of the Department to comply with recommendation no. 10

RECOMMENDATION 10. It was recommended that supervisors review files monthly to ensure that (potential) client interactions are documented.

During its investigation, the OCC found that there was a lack of consistent documentation on client files. The files of (potential) clients of DCFS were not complete.

On 25 September 2008, Director Look Loy said in a memorandum to the OCC: "This is already in place and supervisors do their utmost in this regard but there are many competing priorities and manpower is at times an issue."

On 27 November 2008, the OCC e-mailed Director Look Loy and Deputy Director Dixon and, while acknowledging the many competing priorities and manpower issues facing the Department, stressed that the Director and her officers had already agreed that documentation was in need of improvement. DCFS argued that it had complied because the new social work manager would motivate staff to document their meetings with potential clients. The Department also revealed that it was planning to update its case management software in order to make it easier to use and more compatible with IRIS, the Government's financial information system.

On 30 January 2009, Deputy Director Dixon clarified that the software change would be on the FOXPRO system. She stated that this continued to be worked on by Computer Services and would be on an Oracle platform which would make it easier for the staff to use.

FINDING: While the OCC accepts that the Department and the Ministry have made some efforts towards compliance with the recommendation, at the time of the writing of this Report, the efforts of the Department and Ministry and the changes made are not sufficient to be ruled as substantially compliant.

8. Conclusion

The Complaints Commissioner Law (2006 revision), section 18(3) states that where the Commissioner has made a recommendation and he is of the opinion that inadequate action has been taken to carry out the recommendation, a special report must be laid before the Legislative Assembly.

In the OCC's closing letter to DCFS, the Commissioner found maladministration and made a number of recommendations that have, to date, not been complied with.

The monitoring efforts by the OCC regarding these recommendations have been ongoing since the completion of the investigation. To date, only two of the ten recommendations have been substantially complied with.

**Office of the Complaints Commissioner
24 June 2009**

