Ombudsman
New South Wales

Casebook July 2024: Investigations and complaint-handling case studies

NSW Ombudsman

Pursuing fairness for
the people of NSW.

Ombudsman
New South Wales

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The Hon. Ben Franklin, MLC
President
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Parliament House
SYDNEY NSW 2000

The Hon. Greg Piper, MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

Pursuant to section 31 of the *Ombudsman Act 1974*, I am providing you with a report titled: *Casebook July 2024: Investigations and complaint-handling case studies*.

I draw your attention to s 31AA of the *Ombudsman Act 1974* and request that you make the report public forthwith.

Yours sincerely

Paul Miller
NSW Ombudsman
30 July 2024

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Introduction

The NSW Ombudsman

The NSW Ombudsman is an independent integrity agency that pursues fairness for the people of NSW. We strive to ensure that those entrusted with public power and resources fulfil their responsibilities and treat everyone fairly.

One of our central functions is to receive and respond to complaints from the public about NSW public authorities, local councils and community service providers funded by the NSW Government.

Anyone can contact us to complain if they believe they have been treated unfairly by any of the bodies we can handle complaints about, or to report concerns about possible maladministration.

Our services are free to the public. We are fully independent, and we act impartially in the public interest. People who complain to us are protected by law if anyone tries to retaliate against them. Additional protections apply for public official whistleblowers who report serious wrongdoing to us under the *Public Interest Disclosures Act 2022*.

Under the *Ombudsman Act 1974* (Ombudsman Act) the Ombudsman may conduct an investigation into the conduct of a public authority[1] or a community service provider[2] if it appears to the Ombudsman that the conduct, or any part of it, may be:

- contrary to law
- unreasonable, unjust, oppressive or improperly discriminatory
- in accordance with any law or established practice but the law or practice is, or may be, unreasonable, unjust, oppressive or improperly discriminatory
- based wholly or partly on improper motives, irrelevant grounds or irrelevant considerations
- based wholly or partly on a mistake of law or fact
- conduct for which reasons should be given but are not given, or
- otherwise wrong.[3]

In the case of complaints about community service providers, in addition to the above, the Ombudsman may also investigate a complaint if it appears to the Ombudsman that it raises a significant issue of public safety or public interest, or a significant question as to the appropriate care or treatment of a person by a service provider.[4]

Investigations can be commenced whether or not anyone has complained to the Ombudsman about the conduct in question.

Most complaints we receive do not result in a formal investigation. This is because we generally aim to resolve complaints at the earliest stage possible. If a satisfactory outcome can be achieved through inquiries or conciliatory engagement with the agency and the complainant, we will take that action.

Our office has a range of other statutory functions in addition to complaint handling and investigation, including monitoring and reviewing government programs and services. See our website and annual reports for more information.

1. Under Section 246 of the *Crimes (Administration of Sentences) Act 1999*, the Ombudsman Act also applies to the management company, governors and staff of privately-run correctional centres as if they were public authorities.
2. Under Section 24 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA), the Ombudsman Act applies to complaints about community service providers as it does to complaints about public authorities.
3. Section 26 Ombudsman Act.
4. Section 27 CS CRAMA.

About this report

Our strategic outcomes include:

- effective complaint resolution
- holding public authorities and community service providers to account for serious wrong conduct
- fostering improvements in public administration and community services delivery, and
- supporting Parliament in the exercise of its functions.

This report contains a range of case studies to promote shared learning about how to improve decision-making and administrative processes for those we oversight.

Additionally, the case studies inform Parliament and the public about the work of the Ombudsman by demonstrating ways in which we have held agencies to account and how we have reached positive outcomes for the people of NSW.

The structure of the report is as follows:

- Part 1 includes a summary of each of the formal investigations finalised between 1 October 2023[5] and 30 June 2024.
- Part 2 includes a selection of case studies relating to complaint matters finalised over the same period.

Appended to the report is a summary of the *6 principles for effective complaint management*. These principles are a guide for all public sector agencies on the essential requirements for effective complaint management.

A note about investigation reports

If, following investigation, wrong conduct (of the kind referred to above) is found to have occurred, the Ombudsman must produce an investigation report. That report must be provided to the relevant public authority and to the relevant minister. The Ombudsman may also report the outcomes of the investigation to the complainant.

The investigation report is not otherwise made public by the Ombudsman, unless the Ombudsman decides to table a special report to Parliament.

Any request for a copy of an investigation report would need to be made to the relevant public authority or the relevant minister, who would need to consider any public interest considerations for and against disclosure. The investigation report is 'excluded information' under the *Government Information (Public Access) Act 2009* (GIPA Act) and an application cannot be made to the Ombudsman for it under the GIPA Act.

The Ombudsman may, however, make a special report to Parliament at any time on any matter arising in connection with the discharge of the Ombudsman's functions. Following the completion of an investigation, the Ombudsman may consider tabling a separate, special report concerning the investigation. That is typically done where the investigation (or a series of investigations) raises particularly significant issues of broader public interest.

This report includes a summary of all investigations concluded in the period, regardless of whether a special report has also been tabled in respect of the particular investigation.

Confidentiality

We do not use real names of complainants, and otherwise seek as far as possible to omit other identifying information in this report.

Agencies that are identified have been given an opportunity to comment on the factual accuracy of any case studies concerning their actions.

5. This report replaces our previous practice of publishing annual summary reports of formal investigations. The last such report covered the period to 30 September 2023. Going forward it is intended that reports of this type will be published on a six monthly basis.

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Part 1:

Investigations Summaries

Part 1: Investigations summaries

This Part provides a summary of formal investigations we finalised during the period 1 October 2023 to 30 June 2024.

We finalised 6 investigations in the above reporting period. Most were started in response to individual complaints and also considered broader systemic issues.

Common issues seen in investigations

Coupled with the specific substantive issues, at the heart of many of the individual complaint investigations were failures of the respective agency to either deal with the initial complaint appropriately or to communicate effectively with the complainant. That is, of course, the main reason why complainants seek the assistance of the Ombudsman.

For example, in the investigation into Victims Services (page 11), the agency failed to recognise repeated contacts as 'complaints' and took no action in response. In the case of NSW Fair Trading (page 14), there was a failure to respond to as many as 7 complaints from the complainant, which may have contributed to the need for them to commence protracted legal proceedings. Similarly, inadequate communication and failure to provide information led to an escalation of complaints that may have been avoidable in the cases of the Department of Education (page 17) and Life Without Barriers (page 19).

The cases further highlight that delays and small administrative oversights – such as not checking the spelling of a name in the Victims Services case (page 11) – can compound. While mistakes may be unavoidable, good internal complaint management systems and a culture that aims to quickly identify, learn from and rectify errors in a timely manner is key to avoiding the impact of mistakes compounding and escalating.

The investigations into Fair Trading (page 14), Revenue NSW (page 23) and the National Heavy Vehicle Regulator (page 21) underscore the importance of understanding and acting within the limits of legislation – which may mean ensuring that legal advice is obtained before taking action where there may be legal questions.

Monitoring compliance of recommendations

Monitoring agency progress against our recommendations is a key step in holding agencies to account and ensuring that our work leads to tangible and positive change.

In most instances, when agencies accept our recommendations, they undertake to act on them over time. We monitor their progress through regular updates.

In our investigations during the period 1 October 2023 to 30 June 2024, we made 23 recommendations to 6 agencies. Of these, 6 have been fully implemented and 17 are in progress.

Our recommendations are not legally binding on agencies. However, in accordance with s 27(1) of the Ombudsman Act, the Ombudsman may decide to make a report to Parliament in the event he or she is not satisfied that sufficient steps have been taken by an agency in response to a recommendation.

In addition, where a recommendation is made in an investigation of a community service provider, administrative review proceedings can be brought in the NSW Civil and Administrative Tribunal to review the service provider's decision to not implement, or to not implement fully, the recommendation.[6]

6. Section 28 CS CRAMA.

Delays and errors in processing an application for recognition payment:

The case of Victims Services

Public authority:	Victims Services, Department of Communities and Justice
Responsible minister:	Attorney General
Investigation report issued:	19 January 2024
Findings:	Conduct that was unreasonable and unjust and conduct that was unreasonable
Recommendations:	Apology and ex-gratia payment

In May 2022 a person who had been a victim of violent crime complained to us about Victims Services' handling of their application for a recognition payment. The application, first made in 2015, had not been finalised and Victims Services was not responding to the person's complaints about the delay. When we made inquiries of Victims Services, it expeditiously finalised the claim and made the payment.

However, we had concerns about the agency's conduct in handling the application and responding to complaints, and decided to investigate.

Background

The *Victims Rights and Support Act 2013* (the Act) provides, among other things, for victims of violent crime to access counselling and financial support under the Victims Support Scheme (the Scheme).

Under the Scheme a victim of violent crime can apply to Victims Services for a 'recognition payment'. Payments range from $1,500 (for sexual and other assaults not causing serious bodily injury) up to $15,000 (for family dependents of a homicide victim).

An applicant for a recognition payment under the scheme complained to us in 2022 that Victims Services had not processed their application. The application had been submitted 7 years prior in 2015. Victims Services had also not responded to the person's complaints about significant delays in processing the application. The complainant said that, at least by 2019, Victims Services had all documentary evidence that might be required to support the application, but Victims Services had still not finalised the assessment.

When applying in 2015, the complainant had consented to Victims Services obtaining any required records from relevant agencies that might be necessary to support their application, as was the process at the time. When doing so the complainant advised that they had previously gone by a different name, and that their consent extended to obtaining records under both names.

Between 2016 and 2017, Victims Services received supporting documentary evidence from all but one of the agencies named in the complainant's application.

The other agency was unable to find the relevant records. That was because it had searched its records

under a misspelled name. It appeared Victims Services did not notice this error or ask the agency to check again. In any case, the complainant was able to provide a copy of the records they held from that agency to support their claim, and did so in 2019. Victims Services requested the same supporting documents again from the complainant later that year, and again in 2021.

The complainant declined to provide the documents again, because Victims Services already had them, and because they were concerned that the process of going through the documents again would be re-traumatising. The complainant continued to raise complaints about delays, and eventually complained to us in May 2022.

In July 2022, we made preliminary inquiries of Victims Services. The claim was determined and paid within 16 days of us making those inquiries.

What did we find?

We found it was unreasonable and unjust for Victims Services to determine the claim for a recognition payment 7 years after it was applied for, and 3½ years after it had received all the required documentary evidence, specifically:

- Victims Services made errors when seeking information from agencies; Victims Services' Requirement to Produce (RTP) forms to those agencies did not include full details of the complainant's name/s, and in one case misspelled their name. These administrative errors slowed the process down and contributed to the delays.
- Victims Services made errors in its review and analysis of the complainant's documentary evidence. The agency records provided to Victims Services by the complainant met the requirements under the Act. It was open to Victims Services at that time to refer the claim to the assessment team, but it failed to take this step.
- Victims Services took another 3½ years to determine the complainant's application after it received all the required documentary evidence.

We found that Victims Services' failure to consider the complainant's verbal and emailed complaints about the delays was unreasonable and not in line with its own complaint handling policy:

- Victims Services' *Complaint Handling Procedure* states that anyone who has dealt with Victims Services can make a complaint in person, by phone, email or online. Contrary to this procedure, Victims Services did not consider the complainant's concerns to be 'formal complaints' and therefore took no further action. At no time did Victims Services consider the contacts had become complaints, explain how to submit a complaint, or direct the complainant to its complaint handling policy.
- Victims Services failed to acknowledge the impact of the delays and the poor complaint handling actions have had on the complainant.

What did we recommend?

We recommended that Victims Services apologise to the complainant for:

- the errors which contributed to the delays in obtaining records from third parties
- requesting required records from the complainant which Victims Services had already obtained
- the delay in determining the complainant's claim and the impact on the complainant in not complying with its own complaint handling policy.

We also recommended, in accordance with s 26A of the Ombudsman Act, that Victims Services make an ex-gratia payment to the complainant.

Victims Services accepted and acted on both recommendations.

Mutual recognition of occupations:
The case of NSW Fair Trading

Public authority:	NSW Fair Trading
Responsible minister:	Minister for Better Regulation and Fair Trading
Investigation report issued:	27 October 2023
Findings:	Conduct that was contrary to law, conduct that was based on a mistake of law, and conduct that was unreasonable
Recommendations:	Apology and compensation, policy and process improvements

We investigated the way NSW Fair Trading dealt with a man's application for a NSW builder's licence under the national mutual recognition of occupations scheme.

Under the scheme, the man, who had moved from Victoria, was entitled to be registered in NSW with an equivalent occupational licence he had while he worked in Victoria.

He eventually obtained the licence to which he was entitled, after appealing to the Administrative Appeals Tribunal (AAT), and more than two and a half years after he had applied to Fair Trading.

Background

The mutual recognition of occupations

The licensing of certain occupations, such as building trades, is primarily a state responsibility. The national mutual recognition scheme, governed by the *Mutual Recognition Act 1992* (Cth), allows a person who is registered for an occupation in one state or territory to be registered in a second state for an equivalent occupation, after they have notified the second state's local registration authority. Fair Trading was the local registration authority in NSW.[7]

The registration process is intended to be fast and relatively straightforward.

Equivalent occupations are defined as those which are 'substantially the same'. In some cases, there are licence categories that are directly equivalent in different states.

However, for some types of work, licensing categories differ between states. So, determining equivalence may require a careful comparison of the types of work allowed under similar licences in the respective states.

Local registration authorities can also impose conditions on the licence applied for to make it equivalent with the interstate licence.

7. The functions are now performed by the NSW Building Commission.

What happened in this matter?

The applicant held a Victorian licence for a 'domestic builder (limited to carpentry)'. When he relocated to NSW in early 2020, he applied to Fair Trading for a NSW 'Individual Contractor – Builder (General Building Work)' licence.

When Fair Trading received the application, it neither granted nor refused the requested licence registration, but instead postponed the matter. It then sought to negotiate with the man. It gave notice of the postponement decision more than a month after the application had been made.

Without undertaking a thorough consideration of the types of work the man could perform under his Victorian licence, Fair Trading asked him if he would accept a standard NSW carpenter's licence.

The man said he would not, as the NSW carpentry licence was more limited than his Victorian licence and did not permit all the types of work he was allowed to carry out in Victoria.

Fair Trading then offered him an additional category of licence that would also allow him to carry out kitchen, bathroom and laundry renovations.

After the man also declined this second offer (again because it was inferior to his Victorian licence), Fair Trading formally refused to grant registration, and informed him of his right to appeal to the AAT, which he pursued.

There were ultimately two AAT decisions, after an error in the first decision was taken by Fair Trading to the Federal Court.

Eventually, in late 2022, the AAT determined that the applicant should be issued a NSW general builder's licence (the licence he had sought) with two additional conditions imposed.

At the same time as he was in dispute with Fair Trading about which licence categories he was entitled to, the man also made multiple complaints about Fair Trading's decision to postpone his application.

He pointed out that the mutual recognition legislation states that any postponement must be made within one month after an application is lodged. If that does not happen, and if no decision has been made within that month, then the applicant is automatically entitled to registration in the licence category they applied for. Fair Trading did not respond to these complaints.

What did we find?

Fair Trading failed to carry out the required comparison between the Victorian licences and potentially comparable licences in NSW, and failed to follow its own guidance when initially determining whether licences were equivalent.

It also failed to consider whether licences could be made equivalent by imposing conditions on the licence the man applied for.

We noted that decisions as to which licence categories across jurisdictions are equivalent can be highly complex when there is no direct equivalency between licences. However, the failures of Fair Trading in this case did not relate primarily to the complexity of that task, but to its failure to undertake it.

Fair Trading would not undertake a thorough assessment of the scope of work allowed under the applicant's Victorian licence until July 2021, some 18 months after the application was lodged. That assessment occurred because a different matter was then being heard in the AAT, which happened to also concern the same Victorian licence type.

Although the AAT proceedings (including the error in the first AAT decision) inevitably compounded the delays, Fair Trading's decision-making had led directly to those proceedings and consequently to the delays.

In relation to the 7 complaints the man had made claiming that Fair Trading had breached statutory provisions by postponing his application out of time, Fair Trading explained to us that it never responded to those complaints because it thought the man was wrong and that its own interpretation of the legislation was correct. As it turned out, the man's complaints were well founded, and the AAT held that Fair Trading's postponement decision had indeed been out of time.

On the basis of the above, the Ombudsman made findings under s 26 of the Ombudsman Act that the conduct of Fair Trading was unreasonable and contrary to law because it failed to comply with the requirement of the mutual recognition legislation to properly assess equivalency between the two licences.

The Ombudsman also found that Fair Trading's action in postponing the application more than a month after it had been made was conduct made on the basis of a mistake of law.

What did we recommend?

We recommended that Fair Trading apologise to the man for the errors and delays made in assessing his application.

We also recommended that it compensate him for any economic loss, as well as for the stress, time and expense caused to him and his family by the unreasonable and protracted process involved in finalising his application under the mutual recognition legislation.

In addition, we recommended that:

- Fair Trading's guidelines for assessing mutual recognition applications be reviewed and revised to align with the mutual recognition legislation and ensure they provide sufficient guidance for staff undertaking assessments.
- Fair Trading make information about how to make a complaint, including its complaints policy, more easily accessible on its website.

Fair Trading accepted our recommendations. It has apologised to the man and his family for the errors and delays made in assessing his application. Matters related to compensating the man are being considered.

Fair Trading has improved the accessibility of information on its website about how to make a complaint about its services and about its complaints policy. It has reviewed its mutual recognition guidelines, the associated guide to equivalence and its initial assessment sheet for Home Building Licensing. Once they are finalised, we will review these documents to ensure they address the issues we raised with Fair Trading.

Management of reports of alleged sexually harmful behaviour by students:

The case of the Department of Education

Public authority:	Department of Education
Responsible minister:	Minister for Education and Early Learning
Investigation report issued:	16 November 2023
Findings:	Conduct that was unreasonable and conduct that was otherwise wrong
Recommendations:	Letter of apology and provision of further information to complainant

In February 2022, we received a complaint from the father of a high school student raising concerns about the school's handling of a series of complaints and reports made in 2019 by his daughter and others about sexually harmful behaviours by a group of male students. He was also dissatisfied with the Department's subsequent investigation of how the school had handled the complaints.

Background

In September 2019, a teacher and several female students, including the complainant's daughter, A, raised concerns with their school, alleging that a group of male students engaged in sexually harmful behaviours, including sexually threatening comments and sexual harassment.

The school investigated the concerns and took disciplinary action against some of the male students.

In October 2020, A told the school that shortly after these events, she had been sexually assaulted by a student, X, at a party outside of school. X was one of the students about whom allegations had been made in 2019; however, no disciplinary action had been taken against him by the school at that time[8].

The allegation of sexual assault was immediately reported to the Police. While the police investigation was under way, the school put in place steps to allow A to avoid contact with X when at school, including by allowing her to arrive late and leave classes early. This arrangement remained in place until X transferred to another school.

Following his daughter's disclosure, the complainant made a formal complaint to the Department of Education. Among other concerns, he stated that the alleged sexual assault may not have happened had the school taken disciplinary action against X at the time of the 2019 incidents.

The Department's Professional and Ethical Standards (PES) Unit undertook an investigation into the school's handling of the 2019 incidents. This included the school's decision not to discipline X.

The complainant was not satisfied with how the Department communicated with him about the progress, conduct and outcome of the PES investigation and made a complaint to the Ombudsman. Following initial preliminary inquiries, we commenced an investigation.

8. The allegation of sexual assault was not within the scope of the Ombudsman's investigation. Criminal proceedings in respect of the alleged sexual assault were finalised in 2023 with X's acquittal.

What did we find?

The PES investigation had concluded that the school had had enough information at the time to indicate that X was involved in the reported incidents in 2019, but that it had failed to make the additional inquiries it could and should have made to establish his involvement and take disciplinary action. We agreed with that finding.

We also found that the Department failed to communicate adequately with the complainant about the scope, progress and outcome of the PES investigation, including about why it had decided not to interview him or his daughter.

After the report of the alleged sexual assault, the Department had also failed to conduct a risk assessment. Nor had it sought advice from Police about how to assess and manage potential risks in the school environment while a police investigation was underway.

In these respects, the Ombudsman made findings under s 26 of the Ombudsman Act that the Department's conduct was unreasonable or otherwise wrong.

What did we recommend?

In our report to the Department, we noted that there was no consistent or clear mechanism for schools to seek and obtain information from Police about criminal matters involving school students to assist them to manage the situation. In its response to us, the Department advised that it was looking at ways to facilitate better information exchange with Police.

We also noted that there was inadequate departmental guidance to support school practice in relation to managing contact between alleged victims and alleged perpetrators within a school. In response, the Department advised that it had engaged a consultant to review international best practice in relation to this issue, and that a range of work was underway to provide advice and guidance to schools about supporting students in circumstances of sexual offending.

Taking into account the Department's advice as to the work underway to address our concerns and, in particular, to provide guidance to schools about managing sexually harmful behaviours by students, we focused our recommendations on addressing the issues raised by the complainant.

We recommended that the Department:

- formally apologise to the complainant for failing to communicate with him about the scope, progress and outcome of the PES investigation, and for providing him with conflicting advice about his status in the PES investigation and his entitlement to information about the outcome of the investigation, and
- provide the complainant with as much information as it could lawfully provide about the outcomes of the investigation directly related to the issues in his complaint.

The Department accepted and implemented our recommendations.

Management of children's contact and connection with family and culture:
The case of Life Without Barriers

Public authority:	Life Without Barriers
Responsible ministers:	Minister for Families and Communities
Investigation report issued:	12 June 2024
Findings:	Conduct that was unreasonable and conduct that was otherwise wrong
Recommendations:	Letter of apology and change to policy

Between February 2019 and August 2022, we received three complaints from a mother of children living in out-of-home care. She complained about a lack of action by Life Without Barriers (LWB) to enable her to have contact with them.

Background

When the children had been placed under the parental responsibility of the Minister, the Children's Court had made orders for contact with the mother to occur several times a year. However, a few years into the arrangement, the mother was informed that the children were refusing to attend contact visits.

The mother came to our office after attempting to resolve the issues directly with LWB for many years.

She believed that LWB was not doing enough to address the barriers that were impeding contact. She complained that she was also not receiving regular updates about the children's progress and development from LWB. At the same time, she raised concerns about lack of cultural planning for the children, and lack of effort to maintain the children's connection to their Aboriginal culture and community.

What did we find?

The right of children and young people who live in out-of-home care to maintain connection with their families and culture is enshrined in the *Children and Young Person's (Care and Protection) Act 1998* (the Care Act).

Unless it is contrary to the child or young person's best interests, this means that they are entitled to retain relationships with their birth families and other significant people. However, the child or young person's wishes in this regard should be taken into account.

The complainant's children were at a young age when they began refusing to have contact with their mother. LWB was therefore in a difficult position, which required it to balance the children's wishes, the importance of maintaining their connections with their birth family, as well as the mother's rights.

LWB's policy places the responsibility on case managers to actively seek and understand a child or young person's views when planning family contact. If a child or young person has no (or very limited) connections with family members at the time of placement with LWB, it is the responsibility of the case manager to try to re-establish appropriate family contact.

In this case, we found that LWB accepted the children's wishes even at very young ages without challenging their perceptions or attempting to understand the reasons behind their reluctance to engage with their mother and then working with them early to overcome the barriers.

Under the Care Act, the mother was entitled to receive information about the progress and development of each child. LWB failed to inform her of the children's progress sufficiently and consistently, as it did so at irregular intervals and at times provided little or no information.

We also found that LWB did not develop cultural plans for the children in a consistent and timely fashion in accordance with the Care Act, which makes it a requirement to include a cultural plan in the care plans of all Aboriginal or Torres Strait Islander children or young people.

Based on the above, the Chief Deputy Ombudsman made findings under s 26 of the Ombudsman Act that the agency's conduct was unreasonable or otherwise wrong.

What did we recommend?

We recommended that LWB formally apologise to the complainant for:

- any omissions in facilitating contact with the children
- not providing adequate and regular updates about the children's progress and development
- not developing cultural plans in a timely fashion.

We also recommended that LWB give regular and comprehensive updates in relation to the child who is currently still in out-of-home care and seek to engage the child and the extended family in developing future cultural plans. In addition, we recommended LWB review its policies and procedures to clarify expectations about how much information about a child's progress and development should be given to parents.

LWB accepted all our recommendations, which we are monitoring.

Using body-worn cameras to record conversations during inspections:

The case of the National Heavy Vehicle Regulator

Public authority:	National Heavy Vehicle Regulator
Responsible minister:	Minister for Transport Minister for Roads Minister for Regional Transport and Roads
Investigation report issued:	3 June 2024
Findings:	Conduct that was contrary to law
Recommendations:	Changes to practice and policy

We investigated the practice of the National Heavy Vehicle Regulator in requiring its NSW-based Safety and Compliance Officers to use body-worn cameras to record conversations with heavy vehicle drivers, including those when they did not have a driver's consent to do so.

Background

Since 2014, the National Heavy Vehicle Regulator (NHVR) has been responsible for regulating heavy vehicles in most Australian jurisdictions. However, the state and territory authorities continued to carry out certain on-road enforcement and compliance activities on behalf of the NHVR under contract. Beginning in 2017, these contracted responsibilities progressively transitioned from the state and territory authorities to the NHVR.

Body-worn cameras had started being used from 2020 by NHVR compliance officers working in those jurisdictions where the previously contracted responsibilities had already transitioned to the NHVR.

The NHVR developed a work procedure, which required its compliance officers to use body-worn cameras to make both audio and video recordings. The procedure stated that they were to record 'all interactions, conversations and interviews' during certain regulatory activities such as heavy vehicle intercepts and searches. Compliance officers were also instructed that they did not require a driver's consent before recording a conversation unless they were at a private residence.

In NSW, responsibility for certain on-road enforcement and compliance activities transitioned from Transport for NSW to the NHVR on 1 August 2022. Shortly after that time, the NHVR's body-worn camera work procedure was also applied by its compliance officers in NSW.

We started an investigation into this practice as it appeared to contravene the NSW *Surveillance Devices Act 2007* (SDA).

What did we find?

The SDA prohibits, with some exceptions, the recording of certain conversations in circumstances where one of the parties to the conversation does not consent to the recording.

We found that the NHVR's requirement to record all interactions with drivers, regardless of whether their consent was obtained, established a routine practice that did not comply with the SDA.

The NHVR initially told us it relied on an exception in the SDA, which allows the principal party to a conversation (in this case, the compliance officer) to record a conversation in the absence of consent if it is 'reasonably necessary' to do so to protect their 'lawful interests'. A lawful interest could, for example, include the need to maintain personal safety.

In our view, the lawful interests exception cannot be relied on to authorise a routine practice with general application to all conversations by compliance officers. Rather, the particular circumstances of a conversation would need to be carefully considered to determine whether an exception applies.

It is different in that regard from the express exception in the SDA that allows NSW police officers to record conversations without the other party's consent when they are using body-worn video and Taser devices. The express exception included in the Act for police officers to routinely use body-worn cameras strongly suggests that such routine use by the NHVR would also require specific legislative approval.

The Ombudsman found that the routine recording of conversations between NSW-based NHVR compliance officers and drivers, without the driver's consent, is contrary to law within the meaning of s 26 of the Ombudsman Act.

What did we recommend?

We recommended that:

- In NSW, the NHVR's practice of recording conversations in the absence of a driver's consent should stop immediately.
- The work procedure should be amended to include legally accurate instruction and practice advice to ensure that NSW-based compliance officers act in accordance with the SDA when using body-worn cameras.

In response, the NHVR advised that:

- It issued a general advice instruction, effective 22 January 2024, clarifying the requirement for its compliance officers nationally to obtain driver consent when using body-worn cameras.
- It will approve an amended work procedure, incorporating changes suggested by the NSW Privacy Commissioner, which will supersede the general advice instruction.

Automating a garnishee order process:
The case of Revenue NSW

Public authority:	Revenue NSW
Responsible minister:	Minister for Finance
Investigation report issued:	24 April 2024
Findings:	Conduct that was contrary to law and conduct that was otherwise wrong
Recommendations:	System and process improvements

Revenue NSW has since 2016 used a system for issuing garnishee orders to recover debts directly from the bank accounts of debtors. We found that, until March 2022, the use of this system was either contrary to law (between 2016 and 2019) or otherwise wrong (from 2019 to 2022).

Background

Revenue NSW has the power, in certain circumstances, to recover overdue debts, including unpaid fines, directly from the bank accounts of debtors by issuing garnishee orders.

From 2016 Revenue NSW began using technology to filter and identify those debtors who would be the subject of garnishee order. Initially, the system was highly automated: once the system generated a report, garnishee orders would be automatically issued electronically to one or more of the four major banks, which were instructed to identify if it held a relevant bank account in the name of that person and, if it did, to pay from it to Revenue NSW an amount up to the amount of the outstanding debt.

We received complaints about the garnishee order system (GO system), that raised concerns about its fairness, and the extent to which it caused financial hardship, particularly to those already experiencing vulnerability. Over time Revenue NSW made numerous changes and improvements to the GO system, including:

- introducing a minimum protected balance (now around $580) which it would leave in accounts
- adopting and publishing a hardship policy
- developing a 'vulnerability model' within the system to exclude certain people from being subject to a garnishee order.

We were also concerned about whether the fully automated nature of the system was consistent with the legislation that gives Revenue NSW the power to make garnishee orders.

From March 2019, Revenue NSW moved away from full automation and introduced a human decision-maker who received the outputs of the automated report each day, before authorising the daily batch of garnishee orders to be electronically transmitted to the banks.

Despite this change, we remained concerned about the extent to which the system complied with the legislative requirements for issuing garnishee orders.

We obtained several expert opinions from administrative law counsel, which suggested that our concerns were warranted.

What did we find?

The Ombudsman found that Revenue NSW's conduct in using the garnishee order system was until March 2019 contrary to law within the meaning of s 26 of the Ombudsman Act. This was because no authorised (human) decision maker was engaging in the necessary mental reasoning process that is required for making a valid decision.

Revenue NSW's conduct during the periods that system was in use[9] after March 2019 until March 2022 was wrong. This was because, even if it was possible that lawful decisions were being made during this time (because a human decision maker was present), the GO system did not provide that decision-maker with a clear and complete basis for those decisions. Nor was the human's decision-making clearly evidenced or recorded.

Revenue NSW obtained legal advice from the NSW Solicitor General after we commenced the investigation. It advised that the version of the GO system now in place complies with the legislation in so far as it applies to fines debts.

What did we recommend?

Having regard to the Solicitor General's advice, it appears Revenue NSW will continue to use the current version of the GO system for the purpose of recovering fines debts. Revenue NSW ceased using the system to recover other state debts in 2020.

We made several recommendations that aim to:

- improve the information available to Revenue NSW's decision makers
- improve the detection of cases not suitable for inclusion in the GO system
- improve safeguards for vulnerable people, and
- provide more information for debtors.

We also noted that, both when it introduced the GO system in 2016 and when it modified the system in 2019, Revenue NSW did not obtain any legal advice, whether internally from its own departmental lawyers or external. In our report on this investigation, we have put on record that, if any government agency were to implement a similar system today without first seeking appropriate legal advice, the failure to seek such advice could of itself be considered maladministration under s 26 of the Ombudsman Act.

A comprehensive report of this investigation was tabled as a special report to Parliament in April 2024. A copy of that report is available here.

9. Noting the system was suspended several times e.g., due to COVID 19 pandemic.

Part 2:
Complaint-handling case studies

Part 2: Complaint-handling case studies

This Part provides summaries of some complaints we finalised during the period 1 October 2023 to 30 June 2024.

We receive complaints over the phone, in person or in writing, including through our online complaint form. Any person can complain to us about:

- the conduct of a public authority – including any action or inaction, or alleged action or inaction relating to a matter of administration (unless it is excluded conduct) under the *Ombudsman Act 1974* (Ombudsman Act).
- the conduct of service providers with respect to the provision, failure to provide, withdrawal, variation or administration of a community service under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA).

Between January and July 2024[10], we received 7,539 'actionable complaints' being those complaints about a public authority or community service provider that we are authorised to deal with.

How we handle complaints

We have a range of tools for managing and resolving complaints outside of conducting a formal investigation like the matters in Part 1 of this report. This section of the report demonstrates the kinds of outcomes the Ombudsman can achieve through the different means available to us.

Our aim is to resolve complaints as early and efficiently as possible, without the need for investigatory action. Many complaints are finalised by our staff providing information and advice to complainants – for example, guidance on how to navigate an agency's complaint handling process. With some larger agencies, complaints can be directly referred to them with the complainant's consent, allowing the agency a chance to resolve the matter before the Ombudsman.

We can make preliminary inquiries under s 13AA of the Ombudsman Act for the purpose of deciding whether the conduct of an agency should be the subject of an investigation. Most complaints that result in preliminary inquiries are finalised without proceeding to an investigation of maladministration. Inquiries can provide information that assist in resolving the complaint. Sometimes the information suggests that no further action is warranted, and we are in a better position to explain to the complainant why this is the case.

In other cases, our inquiries prompt agencies to take corrective action to resolve the complaint (for example, by reviewing a decision, providing an apology, taking action where there has been delay, or undertaking some other action), or to provide the complainant with (clearer) reasons or further information that addresses their concerns.

In the process of resolving a complaint, we may make formal comments or suggestions to an agency under s 31AC of the Ombudsman Act. These comments are generally aimed at assisting an agency to improve its service delivery or its own complaint-handling.

We can and do also make comments to suggest an agency take steps to address a complainant's concerns, such as issuing an apology or providing an undertaking to act in a way that will resolve the situation.

Another way we can manage a complaint is under s 12A of the Ombudsman Act, which enables us to refer a complaint to a public authority for it to conduct an investigation. In those cases, the public authority is required to report back to us on the outcome. Using similar powers under CS CRAMA, we can also refer a

10. We will be tabling a similar report biannually and as such this period reflects that subsequent reports will cover a 6-month period.

community services complaint to the relevant department or a provider to resolve a complaint at a local level and report back to us on the outcome.

Finally, we can conciliate a matter under s 13A of the Ombudsman Act. Conciliation is held on a voluntary basis and can be most helpful where there is an ongoing relationship between the complainant and the agency that needs to be repaired or restored. The case studies below provide a range of examples of how we use these powers.

Introduction to the case studies

When we finalise a complaint, there are almost always lessons to be learned. Often, we identify simple mistakes that the agency can learn from. Sometimes complaints reveal systemic issues that need to be addressed to prevent the same issue from impacting others.

For a number of the matters below, we have identified key learnings in administrative conduct that could apply to any public authority. They are provided here in support of broader sector improvement.

All complaints are an opportunity for an agency to reflect on its conduct, and complaints that are escalated to our office help give agencies insight into the operation of their complaint handling systems and practices from an outside perspective.

The *6 principles for effective complaint management* are included in the Appendix to this report – they are a guide for all public sector agencies on the essential requirements for effective complaint management.

One of the 6 principles is *communication*, and we note that communication is one of the most common issues people raise with the Ombudsman. Almost every case study below demonstrates an opportunity to communicate more proactively with members of the public. In 2 cases, the issues with communication prompted us to make comments to the agency about the need to do better.

Another of the 6 complaint handling principles is *timeliness* and administrative delay is a common issue people raise with us. A number of the case studies below demonstrate how delay can significantly impact members of the public – for example the case of Homes NSW, where the tenant found mould growing on their carpet due to an unrepaired water leak. Delay can also lead to escalation of complaints to our office, and we commonly intervene to facilitate communication (and subsequent action) between the agency and complaint. The case study involving Transport for NSW and Service NSW provides a reminder of the role we play in bridging the gap when functions are separated across agencies.

This report also provides greater transparency around the work we do and illustrates how our services make a difference for the people of NSW. The NSW Trustee and Guardian matter, for example, shows how our efforts significantly improved the financial circumstances for the person at the heart of that complaint.

We receive a high volume of complaints about custodial settings. Often it only takes a phone call for our staff with the lead agency or a particular centre to resolve those matters. There is 1 example below of a ‘quick win’ scenario, where our intervention promptly assisted an inmate to access prescription glasses following a delay. In contrast, the other examples from the custodial setting demonstrate how our intervention made an even bigger impact for the individuals, with investigations by the agency identifying the need to take action on officer conduct.

Assessing individual circumstances for fairer outcomes

Public authority: Revenue NSW

Complaint overview

We received an online complaint about the issuing of 2 penalty notices totalling over $1,500 for the complainant driving an unregistered and uninsured car.

The complainant told us that her car had been deemed unregistered because she had not paid her Compulsory Third Party (CTP) insurance, and had continued to use her car. What had happened is that the she accidentally paid $3.07 instead of the correct amount of $307 to the CTP insurer. She submitted bank records and CTP insurance details to demonstrate the mistake.

As an eligible pensioner, the only step required by the complainant to register her car was to pay CTP insurance. The CTP insurer had not advised her of her error, and she mistakenly thought she had paid the correct amount and so assumed her car was properly registered. The complainant explained to us that she had suffered a fall several months earlier, resulting in hospitalisation and 2 months bed rest. She believed the stress of this situation had affected her judgment and contributed to her confusion when making the payment.

With the assistance of their only family support – her granddaughter – she had already asked Revenue NSW to consider waiving the notices. Revenue NSW informed her that it declined to do so, and told her she could pursue the matter in court.

We made inquiries of Revenue NSW about whether and how they had taken into account the material the complainant had provided – including the bank record demonstrating a clear error and the fact she had received no indication from the CTP insurer that the amount she paid was incorrect. We asked Revenue NSW whether it could be lenient in this case, given the circumstances.

What was the outcome?

As a result of our inquiries, Revenue NSW informed us that it had decided to use its discretion to waive the penalty notices, and instead issue cautions.

What can we learn?

Agencies often deal with situations that fall outside the relevant policy and guidance materials, which cannot cover every possible scenario. This matter illustrates the value of compassion and agencies using their lawful discretion in circumstances where it will lead to a fairer outcome.

Removal of trees obstructing a road impeding access for service providers

Public authority: a regional council

Complaint overview

A complainant contacted our office about a regional council, after they had spent 3 years trying unsuccessfully to resolve concerns about trees that obstructed a road near their home and were at risk of falling.

The complainant is the carer of their unwell son. She reported that ambulance services, NDIS workers and doctors were refusing to drive down to their house due to concerns about the trees and the safety of the road. The complainant also reported that they feared they would be unable to evacuate in case of bushfire due to the road's narrowness.

Having investigated the complainant's persistent communications, in February 2020, Council advised them that there were limited grounds to remove the trees. Council also told the complainant that, having regard to their persistent complaints, it was considering taking action against her under its *Managing Unreasonable Conduct* policy.

The complainant interpreted the letter from Council as a threat to take legal action against her. In October 2023, she complained to us, as her concerns about the trees had not been resolved. We made inquiries of Council to better understand the matter.

What was the outcome?

Following our inquiries, the Council engaged an arborist to re-inspect the trees. As a result of the inspection, the arborist recommended the removal of several trees, which was completed just before Christmas 2023.

Maintenance issues in a public housing residence

Public authority: Homes NSW

Complaint overview

The granddaughter of an elderly resident contacted our office to complain about maintenance issues in a public housing residence not being addressed by the responsible agency.

Almost 2 years before she contacted us, the complainant's grandmother had reported a shower leak in her public housing apartment. A plumber had attended her home and applied silicone along the edges of the shower base. This did not fix the problem, and the leak recurred. A year later, a plumber attended to do more repairs.

The plumber advised the agency that waterproofing was necessary. However, no waterproofing work took place. The resident noticed that the carpet near the bathroom was becoming mouldy, which she attributed to the ongoing leak. She and her granddaughter were concerned that the mould could exacerbate her serious respiratory condition.

When the works had still not been completed almost 6 months later, the granddaughter contacted the Homes NSW maintenance line and was told there was no open work order for the shower leak. She then complained to our office.

We made inquiries of Homes NSW asking whether there were outstanding work orders and a timeline for completion – which there were not.

What was the outcome?

Following our intervention, Homes NSW issued a work order for the waterproofing to the shower, replacement of the damaged carpet and repairs to the walls due to the leak. The shower leak was rectified, and a further work order was issued to replace the mouldy carpet.

What can we learn?

This case is a good example of the importance of having a responsive complaint system that supports timely and effective resolution of concerns raised.

In 2022 we reported on our investigation into modification of public housing properties for tenants with disability.

The report can be accessed on our website here: Modifying public housing properties to meet the needs of tenants with disability – issues identified through complaints. (nsw.gov.au).

Removal of a foster child from their carer

Public authorities: Department of Communities and Justice and a community services provider

Complaint overview

A foster carer complained to us that a foster child had been removed from her care without notice, after an 18-month placement. She complained to the department and the community services provider but considered their response to be inadequate.

We made inquiries of the department and the community services provider. We found out that the intention was to transition the child to a permanent relative or kinship care placement with a maternal aunt who lived interstate. The department and the community services provider had planned and consulted in accordance with relevant policies and guidelines, and they had pursued the appropriate proceedings with the Children's Court to formalise the care arrangements. However, the arrangements made to transition the child to the interstate relative were hurried, and the foster carer's request to the community services provider to delay the transition so that she could take the child to the airport and say goodbye had gone unheeded.

We wrote to the department and the community services provider under s 31AC of the Ombudsman Act about the lack of effective communication between the department and the community services provider, and the lack of timely communication with the foster carer.

We also suggested that the department and the community services provider both apologise to the foster carer for the communication breakdown, and the manner in which the interstate transition occurred.

What was the outcome?

The department and the community services provider acknowledged the shortcomings in their communication processes. They apologised to the foster carer and undertook to work in a more cooperative manner and ensure timely communication to keep all parties informed.

What can we learn?

This case study illustrates the importance of compassion and effective communication.

In this case the impact of poor communication on the complainant and potentially the child who had been in their care was significant. Due to the breakdown in communication, the foster carer was not given the opportunity to say goodbye to the child in the manner they had wished, before the child transitioned to an interstate placement.

Agencies working together to resolve a car registration issue

Public authorities: Transport for NSW and Service NSW

Complaint overview

The complainant attended a Service NSW (SNSW) centre to transfer ownership to themselves of a vehicle that had been in their father's name for over 60 years. The vehicle bore personalised number plates. The complainant had completed paperwork to effect the ownership transfer.

The ownership transfer occurred in June 2021. The complainant's father passed away in July 2021, one month after the transfer of ownership of the car and personalised plates occurred.

Sometime later, the complainant realised they had, since the ownership transfer, been charged annual bills for the personalised number plate costs. When a vehicle bearing personalised plates is transferred between immediate family members and the right process is followed, no annual fee should be charged. The complainant had not been made aware of the existence of a form that would have enabled ownership of the personalised plates to be transferred as an immediate family member without incurring annual fees.

The complainant raised concerns with SNSW several times, and while SNSW liaised with Transport for NSW (TfNSW), the issue remained unresolved by the time a complaint was made to our office in March 2024. By that stage the complainant and their family had a high degree of frustration about the lack of resolution.

Our office has arrangements with a number of agencies to refer actionable complaints directly to the agency complained about for resolution. When we refer a matter for resolution, we ask the agency to liaise directly with the complainant within an agreed timeframe. We referred this matter to TfNSW for action in May 2024 and were pleased to receive an initial same-day response.

What was the outcome?

TfNSW subsequently advised that they had further liaised with SNSW to resolve the matter so that the recurring annual fee requirement was removed, and payment of a refund of past fees had been made.

What can we learn?

In this case, both SNSW and TfNSW had responsibilities for different parts of the overall administration of the process. SNSW processed the paperwork submitted by the complainant, and TfNSW is responsible for the issue and administration of number plates in NSW including the policy and procedure relating to plate fees.

The complainant expressed frustration that the issue had not been owned by an agency and that they were unable to resolve the matter despite months of actively pursuing an outcome.

Our office was able to facilitate a resolution for the complainant by engaging with TfNSW to work effectively with SNSW to identify what happened, and how to finalise the matter. This matter serves as a useful reminder that when services and functions are split across agencies, it can be difficult for complainants to navigate complaint handling processes.

Resolving poor communication at a registered training organisation

Public authority: a registered training organisation

Complaint overview

A student complained to us about issues including poor communication on the part of a registered training organisation which impacted their studies. They had enrolled in a diploma, then deferred 3 units of their course for health reasons. The registered training organisation sent an email to students about course commencement, which included a note that the email may be disregarded if the student had withdrawn or deferred.

The student did not receive further emails that were sent to students about the commencement of the course in semester 1. The reason emails were not sent to this particular student was not clear to the organisation, which took action to rectify the issue as soon as it became aware. However, by that time it was too late for the student to commence semester 1.

The organisation suggested options to assist the student to catch up however the student was not satisfied with the resolution offered. The student complained to us about the organisation's failure to adequately correspond about their course and its subsequent failure to support the student to make up missed coursework. The student also complained about the organisation's failure to adequately manage their complaint.

We made preliminary inquiries and wrote to the organisation under s 31AC of the Ombudsman Act. We suggested that a written apology be issued to the student for any confusion caused by the email about the commencement of the course, and for the failure to send the student subsequent emails about the commencement of the course. We suggested the registered training organisation provide an updated learning plan and tutor to assist the student with their missed coursework.

What was the outcome?

The registered training organisation sent a written apology to the student in line with our suggestions, and offered to connect the student with a teacher consultant to develop an updated learning plan and identify opportunities for individual support to help them achieve their personal learning goals.

Financial and emotional distress due to administrative delays

Public authority: NSW Trustee and Guardian

Complaint overview

We received a complaint about the circumstances of a person who is under a financial management order with NSW Trustee and Guardian (NSWTG). It was alleged that NSWTG's significant administrative delays had placed him under serious financial and emotional stress.

The complainant was an Aboriginal man who sustained a traumatic brain injury from a motor vehicle accident. Prior to the accident, he and his de facto partner had separated and were in the process of dividing their assets, including their home. His home was subsequently destroyed by fire, and he was residing in rental accommodation at the time the complaint was made.

In 2020, he was placed under a financial management order and NSWTG became responsible for finalising the family law court matter, including the transfer of the property title solely to him. The family law court proceedings concluded in May 2022, after which it was alleged there was a delay in transferring the case to NSWTG's property law team to finalise the removal of joint title of the property. We were told that throughout this time the complainant – whose only source of income was the disability support pension – was required to pay both mortgage and rent, was suffering severe financial hardship and was at risk of losing his property.

Despite multiple requests for the case to be actioned, the complainant alleged that no work was undertaken between May 2022 and March 2023, and that the case was only allocated following the receipt of a formal complaint.

We made several inquiries of NSWTG, who acknowledged the delays and advised us of strategies it was implementing to avoid similar situations occurring in future. We asked NSWTG what action they proposed to take in relation to the financial impact on the complainant.

What was the outcome?

NSWTG apologised to the complainant, and advised that they would reimburse the cost of rent (approximately $28,000) incurred because of delays.

What can we learn?

This case highlights how significantly administrative delay can impact a person. Further, it shows how complaints, if properly identified and dealt with, can draw attention to issues in routine administrative procedures and lead to improved practices.

Damage to property from a burst council water main

Public authority: a regional council

Complaint overview

We received a complaint from a property owner, who told us their garage had flooded after a council water main had burst, allegedly for the fourth time. The owner made an insurance claim with Council. When they received no response, the complainant used an online template to write to Council with a 'letter of demand'.

A Council officer responded by writing to the complainant, telling them that their making of unwarranted demands with the threat of legal action could constitute 'blackmail', which is a criminal offence[11].

We contacted Council to better understand the rationale behind its response.

Council explained that it considered the property owner's action in sending a letter of demand was disproportionate, given that the monetary amount in dispute was relatively small. It also considered that the complainant was showing early signs of unreasonable conduct.

We wrote to the Council under s 31AC of the Ombudsman Act suggesting that they review the way they deal with legal or insurance claims, provide training where appropriate and apologise to the complainant.

What was the outcome?

Council responded positively to the suggestions and wrote to the complainant to apologise.

What can we learn?

This case study demonstrates why it is important for agencies to maintain impartiality and objectivity.

Whether or not Council had a legally sound basis to decline payment in this instance, complainants should always be treated respectfully.

A complainant who states that, if their complaint is not resolved, they may exercise legal rights is not engaged in 'blackmail'. For an agency to respond by suggesting that they are committing a criminal offence may itself appear to be an implied threat, and is only likely to escalate tensions.

11. Under s 249K of the *Crimes Act 1900*.

Recognising a complaint as a public interest disclosure

Public authority: a NSW public university

Complaint overview

A PhD student who was also employed as a part-time lecturer at a NSW university had complained to the university that their PhD supervisor had engaged in academic misconduct.

The university handled the complaint under their standard academic misconduct process, without recognising it as a PID. The complainant was not satisfied with how the university handled their concerns, so they complained to us.

We made inquiries of the university to better understand the matter and to identify if it had followed the correct process. The university told us it did not consider that the complainant had made a PID. It also told us it had engaged an external investigator to complete a review of the concerns raised.

In our assessment, the complainant had taken all the steps required to make a PID and the university should have dealt with the matter under its PID policy. This was because:

- they were an employee of the university, and were therefore a 'public official'
- they had made an internal report alleging serious wrongdoing to a disclosure officer of the university
- they had raised allegations of serious maladministration
- there was no reason to doubt that the complainant honestly believed that they were making a report of serious wrongdoing
- there was information available to the university to indicate there were reasonable grounds for the complainant's belief that the disclosure showed or tended to show serious wrongdoing[12].

We wrote to the university under s 31AC of the Ombudsman Act suggesting steps it should take to ensure that all parties involved in the process of identifying PIDs are aware of the importance of identifying complaints where the protections offered by the new *Public Interest Disclosures Act 2022* may apply.

What was the outcome?

The university accepted our comments. It also agreed to provide us with a copy of the investigation report when completed.

12. The features of a voluntary PID are set out in Part 2 of the *Public Interest Disclosures Act 2022* (NSW).

What can we learn?

In this matter the complainant's internal report was not treated as a PID by their employer, when it should have been. This case illustrates the importance of agencies understanding and adhering to their obligations to ensure that PID-makers are properly identified and afforded the appropriate legislative protections.

Guidance for agencies on how to identify and deal with PIDs is provided on our website at The Public Interest Disclosures Act 2022 - NSW Ombudsman.

Securing new glasses for an inmate

Public Authority: Justice Health NSW

Complaint overview

In February 2024, an inmate in a correctional centre complained to us that he had not yet received his prescription glasses, after having met with an optometrist in November the previous year. He told us he had followed up with health staff at the correctional centre, but said nurses were giving him inconsistent reasons for the delay, and weren't telling him when he could expect to receive them.

We made inquiries and we were informed by the nurse unit manager at the correctional centre that the glasses had been ordered in November, shortly after the inmate's consultation, and that they were delivered to the correctional centre in December 2023. Unfortunately, it appeared the glasses had been lost before being delivered to the inmate. Justice Health staff had been liaising with custodial staff to try to locate the glasses, to no avail.

What was the outcome?

Within a week of our inquiries, new glasses had been ordered for the complainant, with a request for urgent fabrication and delivery.

Oversighting management of officer misconduct allegations

Public authority: Corrective Services NSW (CSNSW)

Complaint overview

We received a complaint from an inmate during one of our regular visits to a correctional centre. The complainant raised concerns about the way an officer had spoken to her. She told us the officer made disparaging comments about her parenting ability and also used offensive language toward her. The officer refuted the matter and claimed that their offensive language had been directed to another officer rather than the complainant.

We made preliminary inquiries of the centre governor following our visit and sought information about the steps that would be taken to review the matter. When we did not receive a response, we decided to refer the matter to CSNSW for investigation.

The complaint was referred to the Acting Commissioner of CSNSW under section 12A of the Ombudsman Act. Section 12A allows the Ombudsman to refer a complaint about the conduct of a public authority to the public authority for investigation. The public authority must report to the Ombudsman on the outcome of the referral.

What was the outcome?

CSNSW provided our office with a copy of a fact-finding enquiry report which concluded (in part) that the conduct complained about had occurred.

We were advised that the conduct was not consistent with the relevant *Code of Ethical Conduct* and that further action would be taken in respect of the officer. We assessed that the investigatory action taken, and the outcome, were appropriate.

What can we learn?

This case study illustrates the importance of public servants behaving appropriately, and in accordance with their agencies' conduct standards at all times.

The Ombudsman cannot investigate every matter that comes to our attention and 12A referrals are a useful complaint resolution tool in circumstances such as this matter.

Exposing officer misconduct after signatures were forged

Public authority: privately managed correctional centre

Complaint overview

We received separate complaints from 2 inmates at a privately managed correctional centre. Both inmates had been charged with several offences in custody: intimidation, failure to comply with correctional centre routine, and 'disobey direction', as a result of an incident where they had refused to remove a towel covering their cell window and were alleged to have become verbally aggressive.

Both inmates told us that they had not been afforded due process in relation to the charges. In particular, they said they were not given the opportunity to either enter a plea of guilty or to plead not guilty and contest the charges. Following the disciplinary process, they had asked to view relevant paperwork relating to the charges and saw that the documents had been 'signed' in their names, indicating that they had pleaded guilty to the charges. Both denied having signed the papers.

We made inquiries of the general manager of the correctional centre and requested copies of the misconduct packages.

What was the outcome?

Following our inquiries, the general manager commenced an investigation, which identified that an officer had forged the inmates' signatures. A disciplinary process for that officer was then commenced. The general manager told us they were liaising with the department to have records relating to the charges updated to reflect the findings were unsound.

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Appendix:
The 6 principles for effective complaint management

The 6 principles for effective complaint management

Treat complainants with respect

Respectful treatment

Your organisation will:

- treat complainants with courtesy and respect
- require staff to treat complainants with courtesy and respect in your complaint policy
- be responsive
- train your public contact staff in customer service, complaint handling and management of complex complaints and complaints from people in distress, who require additional support or have diverse needs
- take appropriate action when your organisation receives complaints about its staff
- review the type and number of complaints your organisation receives about its staff
- ensure that people can complain without fear of detrimental action.

Make it easy for people to complain

Information and Accessibility

Your organisation will:

- make it easy for customers to complain and help them to lodge their complaints
- provide easy-to-access information about the complaints process in different formats and mediums
- tell customers about:
  - how to complain, for example online, email, in person, in writing
  - what information you need from customers to assess their complaints
  - what to expect from the complaints process
  - who to contact for more information
  - how complaints have helped improve your organisation's service.

Keep complainants informed

Your organisation will:

- keep complainants informed about the status of their complaint
- acknowledge that you've received their complaint and tell the complainant:
  - who to contact for more information about their complaint
  - what the next steps will be in the complaint process
  - how long your organisation will likely need to finalise the complaint.
- use the most appropriate channel to communicate with the complainant and:
  - update them about their complaint's progress regularly (as specified in your procedure)
  - tell them the outcome of their complaint and explain the reason for it (for example, tell them what action was taken and how reached your decision)
  - explain and apologise when things go wrong.

Give complainants a contact person

Your organisation will:

- make sure that staff who manage complaints are suitably trained and skilled
- allocate a complaint to one person (or one team) and give complainants their contact details
- generally, have frontline staff resolve a complaint themselves and escalate serious or complex complaints to a more appropriate officer or team.

Deal with complaints as soon as possible

Your organisation will:

- do your best to deal with complaints as quickly as possible
- set and make public expected timeframes for finalising complaints
- set these timeframes to reflect the different levels of seriousness, urgency and complexity across the complaints you receive
- contact the complainant and explain why, if there are unavoidable delays when dealing with a complaint.

Tell complainants what you do with their information

Transparency

Your organisation will:

- let complainants know that you record and analyse information from your complaint management process. Explain that this includes the:
  - number of complaints received
  - number of complaints finalised
  - percentage of complaints finalised within your KPIs
  - issues raised by complaints
  - actions taken in response to complaints
  - systemic issues identified
  - number of requests received for internal or external review.

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