Casebook January 2025: Investigations and complaint-handling case studies

A special report under section 31 of the *Ombudsman Act 1974*

Pursuing fairness for the people of NSW.

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The Hon. Ben Franklin, MLC
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The Hon. Greg Piper, MP
Speaker
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Parliament House
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Dear Mr President and Mr Speaker

Pursuant to s 31 of the *Ombudsman Act 1974*, I am providing you with a report titled *Casebook January 2025: Investigations and complaint-handling case studies*. The report includes a summary of investigations finalised by the NSW Ombudsman in the period from 1 July 2024 to 31 December 2024, as well as a selection of case studies relating to complaint matters finalised over the same period.

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

Yours sincerely

Paul Miller
NSW Ombudsman

30 January 2025

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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 less formal investigatory actions like inquiries or conciliatory engagement with the agency and the complainant, we will take that action.

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[1] Under s 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 s 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.

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

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
- 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 report comprises 2 parts:

- Part 1 includes a summary of each of the formal investigations finalised between 1 July and 31 December 2024.
- Part 2 includes a selection of case studies relating to complaint matters finalised over the same period.

A summary of the *6 principles for effective complaint management* is appended to the report. 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 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 relevant 6-month 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.

Part 1: Investigations Summaries

Part 1: Investigations summaries

This part provides a summary of formal investigations we finalised during the period 1 July and 31 December 2024.

We finalised 8 investigations[5] in the 6 month reporting period. Most were started in response to individual complaints and also considered broader systemic issues.

Common issues – the importance of fairness

Our vision is that everyone receives the right services and fair treatment from those we oversight. Implementing fair decision-making processes is key to ensuring that public sector and community services organisations deliver programs and services in an accountable manner that meets public expectations.

The concept of fairness encompasses the decision-making process, the decision itself, and the way someone is treated.

A fair process ensures that those who are adversely impacted by a decision have an opportunity to understand and meaningfully participate in decision-making processes. Equally, the person making the decision must have an open mind and be unbiased and impartial.

Decisions that are fair are made on transparent criteria and reflect a genuine exercise of discretion where individual circumstances have been considered.

When someone is treated respectfully at all stages of the process, including when they are interacting with the decisionmaker, this improves their perception of fairness generally, and contributes to building trust in the fairness of the outcome.

In all the matters we have investigated in this period there has been a failure of one or more aspects of fairness.

In the drainage dispute between School Infrastructure NSW and a member of the public whose property was adjacent to a school, School Infrastructure failed to act in line with its stakeholder engagement guidelines or communication strategy. It gave the man unreasonably short deadlines (on 1 occasion only 1 day) to comply with various requirements that had a significant adverse impact on him. This meant he could not genuinely participate in the decision-making process.

The Department of Communities and Justice imposed a requirement on an authorised carer to live outside his family home to mitigate any risk to 2 children living in his and his wife's care while a historic reportable allegation against him was being investigated. The situation, which continued for over 3 years, was manifestly unfair because the requirement was not reviewed and some restrictions continued to apply without adequate justification – even after the investigation was concluded with no sustained findings.

Western Sydney University doubled the fees in a course for both new and continuing students. Although the university's policy put students on notice that tuition fees are reviewed annually and may increase and apply to all students irrespective of their date of enrolment in the calendar year, the policy did not give any indication of the amount of the increase. Wherever possible, people should be put on notice ahead of time of decisions that may adversely affect them. Generally, the greater the impact of a decision, the more notice and information about the decision and decision-making processes should be given.

[5] This total includes an investigation our office discontinued with a 31AC comment. That matter is included in this report in Part 2: Complaint-handling case studies.

The last 4 investigations all involved disciplinary processes in correctional settings, which has been an area of focus in this period. When prisoners break good conduct and behaviour rules, they can be charged with a correctional centre offence and, if proven guilty, penalised by losing privileges. Prison offending can also have longer term consequences, including adverse impacts on parole and classification.

All 4 cases demonstrate a failure to follow fair decision-making processes. In many cases the systemic failures led to unjust outcomes, and at times, unlawful decisions. The lack of fairness was compounded by the fact that inmates currently have no effective review rights on a disciplinary determination.

Our investigations during this period resulted in recommendations both for corrective action to remedy the immediate unfairness to affected complainants, as well as systemic reforms to improve decision-making processes for the future. These included our recommendation for a comprehensive reform to the inmate disciplinary system, a recommendation which we are pleased that Corrective Services NSW has accepted and already begun to implement.

Monitoring compliance with 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 by seeking regular updates.

For investigations finalised during the period 1 July 2024 to 31 December 2024, we made 52 recommendations. Of these, 40 have been fully accepted, 1 has been partially accepted, 10 have been accepted in principle and 1 recommendation was not accepted. 9 recommendations have already been implemented. We are monitoring the progress in implementing the rest of the accepted recommendations.

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.

Drainage dispute with a residential neighbour

The case of School Infrastructure NSW

Public authority:	School Infrastructure NSW (NSW Department of Education)
Responsible minister:	Minister for Education
Investigation report issued:	19 August 2024
Findings:	Conduct that was unreasonable
Recommendations:	Letter of apology; waive certain costs incurred by the complainant

We investigated School Infrastructure NSW's (SINSW) handling of a drainage dispute between a NSW public school and the owner of a residential property adjoining the school. The owner complained to us after SINSW insisted he take immediate action to redirect his stormwater drainage, which had flowed into Council's drainage infrastructure on the school property for the past 25 years. SINSW had told the complainant it would terminate the stormwater connection within days if he did not act.

Once we became involved, SINSW agreed to consider an easement for the residential property to access the stormwater drainage, but then insisted the complainant pay the first of 2 instalments totalling almost $20,000 within 10 calendar days to secure this arrangement. We found that SINSW had set unreasonably short deadlines for the complainant to act, and had failed to act in line with its own stakeholder engagement guidelines and communication strategy.

We recommended SINSW apologise to the owner, and waive or absorb particular costs that he incurred as a result of its actions.

Background

In 1997, the complainant submitted a building application to his local council to renovate his property, which adjoins a public school in metropolitan Sydney. The application included a stormwater management plan to discharge his stormwater into a council-owned drain approximately 50 centimetres within the boundary of the school. Council sought submissions from the Department of Education at the time. When no objections were received, it approved the development.

In its 2021/2022 budget the NSW Government announced an upgrade to the school, with minor works commencing late 2022.

On 14 November 2022 SINSW emailed the complainant, telling him that the area his stormwater discharged into would undergo works from 24 November 2022 and that he had to find an alternate way to discharge his stormwater before that date. SINSW told the complainant his property would risk flooding if he did not make alternate arrangements before 24 November.

SINSW did not terminate the connection on 24 November. It wrote to the complainant again on 7 December, this time stating it would terminate the connection by 16 December if he did not make a development application to the local council for the connection.

After receiving the complaint, we wrote to SINSW on 14 December seeking information.

After discussions with the complainant in December 2022, SINSW wrote to him again on 13 February 2023 telling him that it would grant an easement if he paid SINSW $18,579 in 2 instalments, with the first payment due in 10 days.

We issued an investigation notice in April 2023, as we had ongoing concerns about how SINSW was making decisions and communicating with the complainant about the matter.

What did we find?

In 3 instances, SINSW set unreasonably short deadlines for the complainant to act:

- In November 2022, it gave the complainant 10 days to modify his stormwater drainage
- In December 2022, it gave the complainant 1 day to submit a development application to his local council, and seemingly expected it to be approved within 9 days
- In February 2023, it expected the complainant to immediately pay the first of 2 instalments totalling $18,579.

We also found that SINSW failed to act in line with its own stakeholder engagement guidelines or communication strategy in its communications with the complainant.

What did we recommend?

We recommended that SINSW apologise to the complainant for its unreasonable actions. We also recommended that SINSW waive or absorb certain costs associated with an easement application (acknowledging SINSW had already absorbed some construction costs during the investigation period).

SINSW agreed to comply with our recommendations.

An onerous and ineffective child protection safety plan

The case of the Department of Communities and Justice

Public authority:	Department of Communities and Justice
Responsible minister:	Minister for Families and Communities
Investigation report issued:	2 July 2024
Findings:	Conduct that was unreasonable and unjust
Recommendations:	Apology; compensation

We investigated the Department of Communities and Justice's (DCJ) imposition of a safety plan concerning 2 children in out-of-home care that required the authorised carer to live outside of the family home for over 3 years and be supervised by his wife in the presence of the children.

We found that the plan was onerous, impractical, and ineffective in ensuring the safety of the children, and had not been reviewed either during or after an investigation into the carer's conduct. The plan was not replaced by a long-term safety plan as it should have been.

We recommended that DCJ apologise and compensate the complainant for expenses incurred in complying with the plan, and to acknowledge the stress caused by DCJ's conduct.

Background

An authorised kinship carer who (together with his wife) had 2 children in his care complained to us that he had been waiting for over 2 years to be allowed to move back into his family home after the Department of Communities and Justice discovered a historical child sexual allegation recorded against him on their system. The discovery of the allegation – which DCJ had apparently failed to take into account when it approved the couple as carers – prompted DCJ to impose a safety plan for the children, which required the man to sleep outside of the home and be supervised by his wife in the presence of the children during the day. DCJ's Reportable Conduct Unit (RCU) also commenced an investigation.

The man and his wife complained that despite requests from them, the safety plan had not been reviewed for the 2 years while the RCU investigation continued, and remained in place unchanged even after the RCU investigation concluded and found that the allegation was not sustained.

What did we find?

The safety plan was onerous and, in any event, would have been ineffective in ensuring the safety of the children. The requirement for the wife to supervise her husband at all times while he was with the children was impractical, and it was impossible to ensure that it was followed consistently. Exceptions to the requirements were allowed in response to ad-hoc requests by the couple on over 50 occasions. However, no substantive review occurred. The plan was not replaced by a long-term care plan as it should have been. The explanation for the lack of review was that it was awaiting or dependent on the finalisation of the RCU investigation.

The RCU investigation took 2 years to complete. Due to 'competing priorities' the RCU had no capacity to take any substantive action on the investigation for a year after it commenced. The man did not

receive any communication about the investigation for over 18 months. He was not told what the specific allegation against him was.

After the RCU investigation was finalised with no findings, DCJ continued to unreasonably set restrictions on the man's access to the family home by limiting the number of nights he could stay. This was despite the fact a risk assessment and a carer review both determined that the children were safe.

Ultimately the man was required to live outside the family home for 3 and a half years. During that time, he stayed overnight with friends or slept in his ute and from September 2021, he moved into a rented apartment. He told us that at the time they complained to us, he and his wife had spent over half their married life living separately, which caused financial and emotional strain for both.

What did we recommend?

We recommended that DCJ apologise to the couple for:

- failing to substantively review the safety plan between 14 February 2020 and March 2023
- the delay in finalising the RCU investigation
- the delay in completing a risk assessment after the RCU investigation
- continuing to unreasonably set limits on the man's access to the family home following the completion of the risk assessment and carer review.

We also recommended that DCJ pay an appropriate amount of compensation to the man to recompense him for the money expended maintaining 2 households from February 2020 until June 2023, and to acknowledge in part the stress caused.

Fee increases for a continuing student

The case of Western Sydney University

Public authority:	Western Sydney University
Responsible minister:	Minister for Skills, TAFE and Tertiary Education
Investigation report issued:	26 August 2024
Findings:	Conduct that was unreasonable
Recommendations:	Changes to fees and refunds to affected students; changes to policy

A continuing student at Western Sydney University complained that the subject fees for his postgraduate course had doubled in 2023 compared to the previous year.

We investigated, finding that it was unreasonable for the university to increase fees by 100% for students who had already enrolled in, and were part-way through, the course.

We recommended that the university reverse the fee increase, refund any amount of the increase that had already been paid, and revise its policy to clarify the basis on which fees may be raised and the expectations students should have around fee increases.

Background

We received a complaint from a student enrolled in the Graduate Certificate in Person-centred Diabetes Care and Education, a postgraduate full fee paying course, at Western Sydney University.

The student complained that the university had doubled the fee-per-subject for the course to $2,680 from $1,340 in 2023. The student had enrolled and commenced the course in 2022. He told us that he had chosen Western Sydney University over a similar course at another university because the course fees-per-subject were lower.

The university's student fees policy stated that tuition fees for all fee-paying programs are reviewed annually and may increase over the period of enrolment. It also specified that any increases will apply to all students irrespective of the date of enrolment.

The university explained to the complainant that it had increased the fees to bring them in line with fees charged by other universities and other courses in its School of Medicine.

What did we find?

We considered that it was unreasonable for the university to increase the fees by 100% for students who had already enrolled in, and were part-way through, the course.

Having enrolled and commenced their studies, continuing students are already in a relationship with the university. If they are subject to much higher than reasonably anticipated fee increases, they will be faced with the dilemma of either paying the fee or abandoning their studies. In the latter case, they will have wasted the time and financial investment in the subjects they had already completed, without obtaining a qualification. While transfer to another university might be a possibility, this is contingent on recognition of previous studies and the fees that may be charged by that university.

When making the decision to enrol in a particular multi-year course of study at a particular university, students require (and should be entitled to legitimately expect) some broad certainty of the price they will likely pay for their studies. They need to assess whether they will be able to afford to complete their course, and make an informed decision as to whether, for them, the value of undertaking the course and gaining the relevant qualification justifies the price.

We formed the view that students should be able to expect that any future annual adjustments to course fees will be relatively modest and generally reflective of changes in a university's costs of providing the course. In this case, the fee increase of 100% was far greater than what students could have reasonably anticipated, and was not justified on the basis of relevant changes to the university's cost of delivering the course.

What did we recommend?

We recommended that the university:

- reverse the 2023 fee increase for continuing students enrolled in the Graduate Certificate in Person-centred Diabetes Care and Education, and refund any amount of the increase that had already been paid
- review and revise its documented policy to make clear the basis on which fees may be subject to annual review for continuing students, and the expectations students should have regarding the potential quantum of annual fee increases.

The university advised us that it would accept our recommendations and was taking the following action in response:

- Refunding both the student who made the complaint, and other similarly affected continuing students in the Graduate Certificate in Person-centred Diabetes Care and Education the difference between the unit fee at enrolment and the increased fee.
- Amending the Student Fees Policy to:
    - outline the considerations attending fee adjustments, including sector pricing, CPI, and cost of delivery
    - provide that, for continuing students, fee increases over a stated amount/percentage will be grandfathered.
- Reviewing its notifications to students regarding potential fee increases at enrolment, including the likely amount of any such increases in a calendar year, and when fees are increased.
- Changing the fee setting process to establish 'guardrails' based on CPI for continuing students. Exceeding these guardrails will trigger consideration of grandfathering arrangements.

Inmate discipline in NSW correctional centres

The case of Corrective Services NSW

Public authority:	Corrective Services NSW
Responsible minister:	Minister for Corrections
Investigation report issued:	12 August 2024
Findings:	Conduct that was contrary to law, conduct that was unreasonable, unjust and/or otherwise wrong; and conduct that was in accordance with law and established practice but the law or practice is unreasonable and unjust
Recommendations:	Legislative amendment; amendment of policies and practices; improvements to offence charge selection and to the conduct of discipline inquiries and selection of penalties; improvements to recordkeeping, cell confinement practices, staff training, and information provided to inmates

A comprehensive report of this investigation was tabled as a special report to Parliament in August 2024. A copy of that report is available here: Investigation into inmate discipline in NSW correctional centres.

In this systemic investigation we analysed more than 57,000 inmate discipline charges determined between 2018 and 2022, and conducted an in-depth review of a sample of over 350 individual determinations. We found that there is a systemic failure to follow the requirements of the legislation and relevant policies relating to inmate discipline, which can lead to unjust and potentially unlawful decisions. We also found poor practices amounting to maladministration at all steps in the disciplinary process across centres and decision-makers.

We made 34 recommendations aimed at improving the fairness and effectiveness of the process.

Background

The inmate disciplinary system applies to inmates who are alleged to have committed a 'correctional centre offence' while in custody.[7] Correctional centre offences include various discipline and good order offences, such as 'disobey direction', 'fail to clean yards' and 'enter other cells' as well as more serious offences such as assaults, drug offences, theft and other property offences.

Penalties imposed, if an inmate is found guilty of an offence, range from reprimand and caution, deprivation of certain privileges, cell confinement, and cancellation of payments for work done in the centre. Inmates can also be charged compensation for property damage (up to $500).

Inmate disciplinary processes are administrative in nature, and do not result in criminal charges, convictions or sentences.[8] However, guilty findings can impact decisions made about an inmate's placement within the correctional system, their classification and parole.

[7] These offences are prescribed in Schedule 2 of the *Crimes (Administration of Sentences) Regulation 2014*

[8] There is one exception to this: if the inquiry into a correctional centre offence is conducted by a Visiting Magistrate (rather than by the governor or a delegate of the governor), the Visiting Magistrate can, as well as the usual administrative penalties, impose a sentence of imprisonment of up to 6 months: s 56 *Crimes (Administration of Sentences) Act 1999* ('CAS Act').

We regularly receive complaints from inmates about the process and decisions made in relation to correctional centre offences. In some complaints received in recent years, our inquiries led us to conclude that guilty findings made may have been unfair or even unlawful.

Given the concerns identified through individual complaints, and the potential impact of disciplinary decisions on inmates, we commenced a systemic investigation to examine the administration of inmate discipline across all NSW correctional centres.

We carried out a trend analysis of the more than 57,000 inmate discipline charges determined between 2018 and 2022 and conducted an in-depth review of a sample of over 350 individual determinations. We also reviewed relevant legislation and policies, staff training and education materials, and information contained in inmate handbooks.

What did we find?

Our overarching conclusion is that there has been a systemic failure to follow the requirements of the legislation and the relevant policies relating to inmate discipline. In some cases, this had led to unjust outcomes and potentially unlawful decisions.

We found poor practices amounting to maladministration at all steps in the disciplinary process across centres and decisionmakers. Issues that particularly concerned us included the following:

- Multiple inmates had been convicted of offences in circumstances where it was not open to the decisionmaker to have found the offence proven beyond reasonable doubt, as required by legislation.
- Inmates with intellectual disability or difficulty understanding English were not always given support to ensure a fair inquiry.
- Inmates charged with drug offences were not always receiving referrals to drug intervention programs.
- Inmates whose behaviour would have more appropriately warranted referral for mental health support were being dealt with through the disciplinary process.
- Inmates were being required to pay compensation for damage caused to property in excess of the maximum amount of compensation that can lawfully be imposed.
- In some cases, young Aboriginal inmates were penalised by being confined to a cell alone – despite policy stating this should not happen, and the practice being contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody.[9]
- Other vulnerable inmates were also being confined to a cell alone, where records suggested that risk factors for confinement were not appropriately assessed.
- Insufficient regard was being paid to the policy requirement that withdrawal of phone calls and contact visits should be considered as a penalty of last resort.

We made findings under s 26(1) of the Ombudsman Act that some aspects of the administration of inmate discipline across all custodial facilities in NSW are contrary to law, while others are unreasonable, unjust and otherwise wrong.

We also made a finding in relation to (the lack of) review and appeal rights that, although relevant aspects of the administration are in accordance with law or established practice, the law or practice itself is unreasonable and unjust.

[9] Royal Commission into Aboriginal Deaths in Custody, Recommendation 181 (Final Report, 9 May 1991) vol 5.

What did we recommend?

We recommended a comprehensive review of the inmate discipline system in NSW, including legislative change, to improve its fairness and effectiveness. We made a range of recommendations aimed at strengthening the current processes in relation to the conduct of inquiries, imposition of penalties, staff training and the information provided to inmates.

We also recommended that a comprehensive and continuous quality assurance program be developed to underpin correct and consistent decision-making and ongoing process improvement.

To address individual inmate discipline decisions and their lasting effects, we recommended that:

- CSNSW review all matters since 2018 where a compensation order was made against an inmate, to ascertain whether the order was imposed contrary to law or policy (for example by exceeding the prescribed maximum of $500) and, if so, reimburse inmates accordingly.
- subject to it obtaining legal advice as to what can be done, CSNSW amend its policies and practices so that decisions about an inmate's ongoing management (including parole decisions) should only take into account a disciplinary determination made since 2018 if a review of that determination is made which concludes that the relevant finding may be safely relied upon.

Investigation into actions taken against bystander inmates following an incident at Clarence Correctional Centre

The case of Serco Australia Pty Ltd

Public authority:	Serco Australia Pty Ltd (Serco)
Responsible minister:	Minister for Corrections
Investigation report issued:	13 August 2024
Findings:	Some conduct that was contrary to law, and some that was unreasonable and oppressive
Recommendations:	Apologies to inmates; review of procedures; staff training

A comprehensive report of this investigation was tabled as a special report to Parliament in August 2024. A copy of that report is available here: Investigation following incident at Clarence Correctional Centre.

We investigated Serco's management of inmates who witnessed an inmate assault an officer in September 2023. Bystander inmates were locked in cells for 5 days, placed on segregation orders, charged with correctional centre offences and placed on behaviour management contracts that restricted their time out of cell to 2 or 4 hours a day for 8 weeks.

Following complaints made by some of those inmates, we conducted an investigation and found that Serco's conduct when managing bystander inmates were in some aspects contrary to law, and otherwise unreasonable and oppressive.

Serco and Corrective Services NSW have implemented most of our recommendations, updating inmate records so that the inmates' correctional centre charges are disregarded in future decisions and implementing staff training to improve the fairness of disciplinary processes and effectiveness of inmate behaviour management at the centre.

Background

In September 2023 we received 11 complaints from inmates at Clarence Correctional Centre (**Clarence**) which is managed by Serco Australia Pty Ltd (**Serco**). The complainants alleged that, after another inmate had assaulted a staff member, they and approximately 20 other inmates who had observed the assault were:

- charged with failing to comply with correctional centre routine
- penalised by having access to television withdrawn for 2 weeks
- told they must sign an 8-week behaviour management contract, which restricted their time out of cell to either 2 or 4 hours a day.

They told us they felt these outcomes were unfair. We observed that:

- After the assault 175 inmates housed in the Neighbourhood[10] where the assault occurred were locked in cell for 5 days.
- 3 bystander inmates were placed on segregation orders for 14 days.
- 34 bystander inmates were charged with correctional centre offences – mainly fail to follow correctional centre routine, but also intimidation, obstruct correctional officer and participate or incite a riot.
- 33 inmates were placed on an 8-week behaviour management contract that limited their time out of cell to 2 or 4 hours a day.

What did we find?

We found that some aspects of Serco's conduct were contrary to law. In particular:

- The available evidence did not support the decision to segregate 3 of the inmates.
- The inquiry process for inmates charged with correctional centre offences was not conducted in accordance with legislation, specifically:
  - all relevant information was not considered when charges were laid, inquiries held and guilty pleas recorded
  - inmates were not provided with the opportunity to examine and cross examine witnesses
  - some inmates with disability were not assisted by a support person during the process
  - inmates were charged, found guilty and penalised for correctional centre offences when the available evidence for charges fell well short of what might be reasonably sufficient to establish the elements of the offences, let alone prove the charges.

We found that some aspects of Serco's conduct was unreasonable and oppressive, in particular:

- The decision to lock all inmates in Neighbourhood 1 in their cells for 5 days after the incident was not warranted.
- Relevant considerations were not considered when penalties for correctional centre offences were imposed.
- The decisions to confine 3 inmates as a penalty for correctional centre offences did not comply with relevant policy and procedural requirements.
- The behaviour management contracts were imposed for a purpose for which they were not intended and without consideration of relevant information. Conditions restricting inmates' out of cell hours were unreasonable and oppressive.
- The processes to review, extend and cease the behaviour management contracts and plans contravened relevant policies and procedures, resulting in inmates being treated in an unreasonable and oppressive manner.

[10] Most prisons call the area where inmates live a unit or wing. At Clarence these are called neighbourhoods.

What did we recommend?

We recommended that:

- Findings relating to the correctional centre charges be recorded as unsound and disregarded in future decisions.
- Serco apologise to all affected inmates.
- Corrective Services NSW review the Clarence Correctional Centre routine to ensure it complies with legal and contractual obligations; is documented and is being effectively communicated, including to inmates.
- Serco provide refresher training to staff, including management.
- Serco determine the factors leading to incomplete and erroneous information being recorded or relied upon when charging and segregating inmates and decide whether further remedial or other action is warranted.

Unlawful findings relating to disciplinary charges concerning the misuse of the offender telephone system

The case of Clarence Correctional Centre

Public authority:	Serco Australia Pty Ltd (Serco)
Responsible minister:	Minister for Corrections
Investigation report issued:	25 September 2024
Findings:	Conduct contrary to law and unreasonable
Recommendations:	Findings to be disregarded in future decisions; identification of inmates in similar circumstances; review and update procedures and information give to inmates

In June 2023, we received 2 similar complaints from 2 inmates who were incarcerated at Clarence Correctional Centre, which is privately operated by Serco under contract with Corrective Services NSW. Both inmates had been charged with and found guilty of correctional centre offences for misusing a telephone[11] and disobeying a direction.[12] They each told us they had lent their centre-issued tablets to another inmate, whose tablet was not working, so that inmate could make telephone calls. The 2 inmates claimed they had not been told that lending their tablets to another inmate was an offence.

We found that the offence of disobeying a direction could not be proven, and that Serco did not prove beyond reasonable doubt that the inmates misused the telephone system. We recommended that the guilty findings be disregarded, and that procedures and information given to inmates around use of tablets should be reviewed and updated.

Background

Inmates at Clarence Correctional Centre are issued with tablets that allow them to make telephone calls to approved numbers through the Offender Telephone System (OTS). When an inmate receives a tablet, he is required to sign an acknowledgement form that outlines the terms and conditions of tablet use. The general manager of the centre also publishes instructions for inmates on their tablets. These are known as the GM instruction.

The 2 inmates who complained to us were charged because, in Serco's view, when they allowed another inmate to use their tablets they had:`

- misused the OTS
- disobeyed direction because they failed to follow instructions about the use of tablets contained in the acknowledgement form and the GM instruction.

[11] A correctional centre offence under cl 119 of the *Crimes (Administration of Sentences) Regulation 2014* (CAS regs).

[12] An offence under cl 130 of the CAS regs.

What did we find?

The offences of disobeying a direction could not be proven because the GM instruction did not clearly state that inmates should not allow other inmates to use their tablets to log into their own phone accounts. Similarly, the acknowledgement form did not clearly state that an inmate could not lend their tablet to another inmate.

Serco did not prove beyond reasonable doubt[13] that the inmates misused the telephone system. To do so, it would have had to establish that the inmates had made an unauthorised telephone call. According to the records, there was no evidence the inmates had made unauthorised calls. For these reasons, we made a finding that Serco's conduct in finding the inmates guilty of the offences was contrary to law.

In addition, at the time the 2 inmates were charged, many inmates were experiencing issues with their tablets, some of which were failing to reboot once the battery was exhausted. Given that Serco's management team was aware of the exceptional circumstances, we also concluded that it was unreasonable to have laid charges in the first place.

What did we recommend?

We recommended that Serco:

- note on the affected inmates' discipline records that the guilty findings for misusing a telephone and disobeying a direction were unsound, and should be disregarded in future decision making (such as placement and parole decisions)
- make it explicit in the tablet acknowledgement form that inmates are not allowed to lend their tablets to other inmates, if this is the case
- consider issuing a plain English version of the GM instruction
- identify any other inmates found guilty of similar offences in the same period when it was known that inmates were experiencing issues with their tablets, and refer these charges to the CSNSW General Manager, State-wide Operations to review.[14]

Serco accepted all of our recommendations.

[13] The standard of proof required under s 53(1) of the *Crimes (Administration of Sentences) Act 1999*.

[14] In line with Corrective Services NSW, *Custodial Operations Policy and Procedures 14.1.6.2*, December 2017.

Inmate charged for providing false or misleading information

The case of Corrective Services NSW

Public authority:	Corrective Services NSW
Responsible minister:	Minister for Corrections
Investigation report issued:	14 August 2024
Findings:	Conduct that was contrary to law
Recommendations:	Apology and notation on inmate record

In June 2023, an inmate complained that he was unfairly charged and found guilty of the correctional centre offence of giving false or misleading information. We investigated, finding that the charge could not be established beyond a reasonable doubt.

We recommended that CSNSW apologise to the inmate and note on his disciplinary record that a guilty finding was unsound and should be disregarded in future decisions. CSNSW agreed to comply with our recommendation.

Background

In August 2023, an inmate complained to us that he had been unfairly charged and found guilty of a correctional centre offence for giving false or misleading information. He was penalised by not being able to buy items from the inmate shop (known as buy-ups) for 56 days, which is the maximum allowable length for this penalty type.

While inmate disciplinary processes are administrative in nature, findings can also have ramifications for an inmate beyond the immediate penalty. For example, they can impact decisions made about an inmate's placement, classification and parole. We decided to investigate.

What did we find?

The records we reviewed documented that the inmate approached 2 correctional officers to discuss an incident that happened earlier that day when he was alleged to have stolen items from the buy-up shop. The record indicated that the inmate told the officers that staff were bringing contraband into the centre. The officers responded by saying that his comments would not be tolerated, and a disciplinary charge was then made against him.

The inmate pleaded not guilty to the charge and stated during the hearing that his comment had been taken out of context and he had in fact been referring to past events. The hearing form recorded that he was found guilty because his account of the conversation had changed several times.

The inmate was charged and found guilty of contravening clause 184 of the *Crimes (Administration of Sentences) Regulation 2014 False and Misleading Information,* which states that 'an inmate must not, in or in connection with a notice or application under Parts 2–9 of this Regulation or under

Part 2 of the Act, make any statement (whether orally or in writing) knowing that it is false or misleading in a material particular'.[15]

The inmate's comments were made in an incidental conversation. The question of whether or not the comments were false in any material particular did not arise as they were not made in connection with a 'notice' or an 'application' under the CAS Act or the Regulation.

The CAS Act requires correctional centre offences to be established beyond reasonable doubt. As the alleged conduct of the inmate was not capable of constituting the elements of the offence, it was not open to the decision-make to find, beyond reasonable doubt, that he was guilty of the offence. We therefore found that the conduct of Corrective Services NSW was contrary to law.

What did we recommend?

We recommended that CSNSW apologise to the inmate and include a note on his disciplinary record that the finding of guilty was unsound and should be disregarded in future decisions.

CSNSW accepted the finding and confirmed that it would comply with our recommendation.

[15] 'The Act' refers to the CAS Act.

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 July to 31 December 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 **July 2024 and December 2024**, we received 8,313 'actionable complaints' – that is, 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 ways that we manage and resolve complaints outside of conducting a formal investigation like the matters in part 1 of this report. This part 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. 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 without the need for our office to intervene.

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. Inquiries can provide information that assists 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 unwarranted 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 practices.

We can and do also make comments to suggest an agency take steps to address a complainant's particular concerns, such as issuing an apology or taking some other action to resolve the situation.

Alternatively we can manage a complaint 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 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 either under s 13A of the Ombudsman Act or under s 74 of the *Public Interest Disclosures Act 2022* (NSW) (**PID 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

For a number of the matters highlighted in this report we have identified key learnings in administrative conduct that could apply to any public authority or service provider. 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.

This report also provides greater transparency around the work we do, and illustrates how our services make a difference for the people of NSW.

Even the act of making inquiries of an agency to better understand the nature of the complaint and the issues to be addressed can result in a resolution of the complaint, by virtue of us bringing these issues to the agency's attention. This was the case in relation to the matter concerning long-term maintenance concerns of a social housing tenant, and the matter concerning a First Nations person seeking access to the medical records of deceased relatives.

In a correctional centre context where people rely on their declared allergies being appropriately managed by others, a failure to do so could have dire consequences. As described below, our suggestions resulted in process improvements at the centre in question and an apology to the affected inmate.

During the latter part of 2024, we reinvigorated our voluntary conciliation function under s 13A of the Ombudsman Act. In the July-December period we commenced the conciliation of 15 complaints. Of those completed in the period, all resulted in robust, comprehensive agreements. In that context, we have featured a number of our conciliated matters below. The 4 examples provided show how effective conciliation can be in bringing parties together to resolve complaints efficiently and effectively with independent facilitation. The conciliation function is proving particularly effective in matters where communication or trust has been impacted, and there is a need to restore or reset a relationship in order for the parties to move forward on a more constructive footing.

In November 2024, we issued a refreshed version of our guidance to agencies – the *Effective Complaint Management Guidelines*.[16] It is 20 years since this office first released guidance to public sector agencies on handling complaints. This updated version incorporates contemporary practice and terminology and reflects the latest Australian Standard released in March 2022. The new guide is accompanied by 6 information sheets that each address the 6 principles for effective complaint management (**the principles**).

The principles are appended to this report. One of the 6 principles is communication. 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. The case involving the Point to Point Commission demonstrates how frustration from an initial service delivery problem can be compounded by a lack of responsiveness when bringing it to an agency's attention.

Another principle is Information and Accessibility. The case study concerning the NSW Trustee & Guardian demonstrates the importance of having measures in place to assist those needing additional supports.

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[16] Accessible on our website: NSW Ombudsman | Effective complaint management.

A social housing tenant’s long-term maintenance issues

Public authority: Homes NSW

Complaint overview

A tenant who had been in social housing properties for many years contacted us to complain about Homes NSW’s response to a leaking roof and water ingress into parts of their home, as well as several less urgent repair requests they had submitted. The complainant stated they had raised several maintenance requests since 2022. Contractors had attended to inspect the property, but the leak was not fixed and the other repairs were not conducted. The complainant told us they had called the ‘maintenance line’ and were told the repairs would be classed as urgent. However, far from addressing the tenant’s concerns, when contractors attended the property they said it was the responsibility of the tenant to clean the gutters, and the problems were essentially of the tenant’s own making.

What was the outcome?

We made inquiries with Homes NSW to better understand the position and to seek clarity for the tenant, who was increasingly concerned about the protracted nature of the issues and the resultantly significant safety concerns. Staff attended the property, made safe the ceiling that was about to collapse, and attended again a week later to make the roof watertight. Further work orders were raised to:

- Patch, paint and replace impacted floor and ceiling areas.
- Replace an exhaust fan.
- Repair a vanity and benchtop.
- Clean gutters and trim vegetation in the common area.

Homes NSW clarified for the tenant that the agency has the responsibility to clean gutters, and not the tenant. A staff member attended the property to reassure the tenant.

What can we learn?

This complaint highlights the importance of treating complainants with respect and agencies being timely in managing issues. Our inquiries assisted the tenant to receive a resolution to their longstanding concerns, and ensured they were able to be provided with correct information about who was responsible for maintenance.

Delays in permanency planning for children in care

Public authority: Community services provider and Department of Communities and Justice

Complaint overview

Foster carers complained to us about a delay on the part of the relevant out-of-home care (**OOHC**) agency in facilitating their adoption of the 2 children who had been in their care for around 10 years. The carers raised concern about a high turnover of caseworkers assigned to their family, and the impact this had on achieving a permanent placement for the children. The carers also raised concern about the care allowance not meeting the needs of one of the children.

Before a carer can adopt a child in their care, the case management agency is responsible for consulting with the children's birth family members. The case management agency had difficulty locating the children's family members, who had therefore not participated in regular family time with the children. The children had indicated to both the carers and their case workers that they would like to be adopted by their long-term carers. Importantly, the carers said they were not getting enough clear and consistent information to help move the adoption forward.

We conciliated the complaint.

What was the outcome?

As a result of the conciliation, an agreement was reached between the carers and the OOHC agency regarding permanency planning, communication between the OOHC agency and its funding body, and communication between the OOHC agency and the carers. The agreement was comprehensive in its contents and purpose, and the carers felt that the detail in the agreement would keep the OOHC agency accountable.

Specific areas of contention that the parties agreed to included:

- Family time – how it will be scheduled, barriers to contact with family members.
- The children's needs – supports currently in place and supports likely need into the future.
- Cultural planning – better supporting the children's awareness and knowledge of their heritage and life stories and embedding cultural identity in the children's home and daily lives.

What can we learn?

This matter illustrates the importance of clear communication between carers and case management agencies. It was especially valuable for staff of both the case management agency and its funding body to hear the experience of carers and how issues with service delivery can affect foster carers and the children in their care.

Lack of progress to guardianship for a young person

Public authority: Department of Communities and Justice

Complaint overview

A young person had lost both parents some years earlier. When care was required, the young person's extended family members stepped in to provide them with the care and support they needed. During this time, the family had requested that they be granted guardianship for the young person. Unfortunately, this had never been progressed by the responsible department, the Department of Communities and Justice (**DCJ**).

The family members had requested assistance to reestablish contact with other members of the young person's family. However, this had not progressed either. The family advised DCJ that they were not able to fund the young person's travel expenses to visit their other family members. The family were also concerned that DCJ had not discussed the requirement for them to consent to a guardianship order with the young person, nor what the making of a guardianship order would mean for them.

We brought the parties together to conciliate the complaint.

What was the outcome?

DCJ agreed to progress guardianship as a matter of urgency, and agreed that progressing guardianship gave recognition to the importance of guardianship for the young person and his carers. Alongside the young person's guardianship application, DCJ agreed to implement a financial plan which set out expenses to pay for a range of important practical and supportive actions, including gaining life skills, strengthening familiar connections, supporting educational opportunities and emotional support.

A key outcome was that DCJ undertook to reunite family time between the young person and their sibling, whom they had not seen in many years.

What can we learn?

The conciliation was a means for DCJ to hear about the experiences of the family, and was a way for DCJ to take ownership of the complaint in order to resolve the family's concerns.

Correctional centre response to mismanagement of inmate's seafood allergy

Public authority: Corrective Services NSW

Complaint overview

An inmate in a correctional centre told us he was concerned that staff were not taking sufficient care to appropriately manage his seafood allergy. In particular, he said he had been provided seafood despite staff knowing of his allergy and was subsequently taken to hospital due to an anaphylactic reaction.

We made inquiries and correctional centre staff confirmed the man had been provided with seafood, as food services staff were not aware of the allergy. Other information we received suggested they should have been aware.

As a result, we made suggestions that the centre's governor:

- conduct a review of the circumstances in which the man's health alert regarding an allergy was not conveyed to food services staff
- explain to the inmate the reasons why his allergy had not been identified, and apologise to him for this oversight which appeared to have resulted in his hospitalisation
- conduct a review of local processes to ensure allergy alerts are being managed appropriately.

What was the outcome?

In response to the suggestions we made to the centre's governor, reviews were conducted both in relation to the individual circumstances of the affected inmate and local processes more generally. As a result, a new local operating procedure was developed and communicated to staff. In addition, the affected inmate received an apology from centre staff and a summary of the review findings.

What can we learn?

This matter highlights the vulnerability of people in custody when alerts relating to their health are not appropriately managed.

New property owners charged development fees attributed to previous owner

Public authority: a regional Council

Complaint overview

The complainant purchased property in 2022 in regional NSW. After submitting an amendment to a development application and subsequent construction certificate, Council told the complainant there was an outstanding debt of over $7,000 relating to 2017 development applications and construction certificates attributed to the previous owner. The complainant questioned the debt, including why Council had not collected all the required contributions prior to issuing the construction certificate and why it was not disclosed in the relevant property searches.

We made inquiries with Council, which told us the construction certificate was issued without the previous owner paying the required contributions – which is not the standard process. Council confirmed that the construction certificate was issued in error due to incorrect information in its systems, and the relevant checks were not completed to confirm the contributions had been paid. The complainant paid the contributions so Council would issue an amended construction certificate. Council advised it did not consider the debt was required to be disclosed on the section 603 certificate prior to the complainant's purchase of the property.

We wrote to Council about:

- Council requiring the complainant to pay contributions that should have been obtained from the previous owner prior to the property changing ownership.
- Council not disclosing the contributions in the certificate 603 issued to the complainant, as required by s 603(3) of the *Local Government Act* (**LG Act**).

Under s 31AC of the Ombudsman Act we can make suggestions where we believe there is the opportunity for the agency to improve its administrative practices.

Using this provision, we suggested to Council that it:

1. refund contributions to the complainant that were owed by the previous owner
2. apologise to the complainant for the inconvenience it caused in failing to collect the contributions from the previous owner
3. review whether it is appropriately disclosing all charges or other amounts owned on a property in accordance with s 603 of the LG Act.

What was the outcome?

Council agreed to all of our suggestions.

The complainant emailed our office and confirmed that they had received a letter of apology and a cheque reimbursing them in full for the contributions paid.

Lack of progress towards guardianship for children in care

Public authority: Community services provider

Complaint overview

Foster carers complained to us about the actions of a community services provider delivering out-of-home care services. The carers were concerned that this agency was not progressing guardianship for the children in their care (of which they had 6). Concern was also raised about the agency's communication with the carers and the case management of children.

The eldest of the children had been living with the carers for many years. One of the children had a significant medical diagnosis and the carers had to prioritise their treatment. The carers were experiencing difficulties in working with the agency in progressing their respective case plan goals because they were attending to the unwell child's medical needs.

We conciliated the complaint.

What was the outcome?

The conciliation allowed agency case management staff to gain a much better understanding of the challenges that the carers faced, and the supports they needed to care for the children.

The case management agency agreed to:

- implement the recommendations of the guardianship assessment reports for each of the children, including any outstanding tasks or issues that needed to be completed by the case management agency
- specify a timeframe for completion of each task
- ensure family time for each of the children – including current and future planned contact – and deal with any barriers to successful and sustainable contact
- clarify the roles and responsibilities of its staff
- provide cultural support for the children who identified as Aboriginal, including:
  - facilitating family meetings and/or a Family Group Conference to obtain family members' views about guardianship
  - referring to the relevant Department for an Aboriginal consultation as needed.

What can we learn?

The NSW community relies heavily on authorised carers to care for and support children that cannot live at home. When a carer takes responsibility for a number of children, as was the case here, it is critical that the case management agency is proactive and responsive in providing supports for all of those children. If agencies do not have accessible mechanisms in place for carers to escalate issues, the relationship between the parties can be adversely affected, which can make it harder to meet the needs of children in care.

Foster carer’s claim for repairs to damaged property unresolved

Public authority: Department of Communities and Justice

Complaint overview

A foster carer complained to us about repairs that had remained outstanding following property damage caused by a young person living with a disability who had been in their care. Repairs required included replacement of broken structural materials and some communication items in the home. The complainant and their spouse were retiring from foster care and had been unable to resolve the issue for some time, causing them considerable stress.

The complaint remained unresolved due to miscommunication between the parties and an inability to move the matter forward.

We conciliated the complaint.

What was the outcome?

An agreement was reached between the department (**DCJ**) and the complainant, with DCJ agreeing to cover the full cost of all repairs and replacement of electronic equipment.

The Manager, Client Services agreed to report back to DCJ’s leadership team about the themes that had emerged when the carer was given the opportunity to describe their experiences, providing valuable insight that could lead to service improvements. Issues that arose during the course of the conciliation included:

- the importance of handovers when matters are in progress and staff change
- the need to manage the impact of staff changes more effectively
- the importance of clear and accurate communication between the DCJ staff and carers
- the importance of committing to timeframes
- the need to clarify the advice that DCJ’s staff provide to carers about managing damage to property.

We ensured that the attending DCJ staff member had the appropriate financial delegation to approve the carer’s claim. That staff member was able to hear directly about the carer's experience and brief senior leadership at DCJ to provide insight into the impact of service delivery concerns.

What can we learn?

This matter demonstrates the importance of agencies:

- taking ownership of complaints and promptly resolving matters that are clearly the responsibility of that agency
- ensuring that someone with appropriate delegation and authority is in a position to resolve concerns.

Lack of action on a complaint about the conduct of a taxi driver

Public authority: NSW Point to Point Transport Commission

Complaint overview

The Point to Point Transport Commission is the regulator for taxis, hire vehicles and rideshares in NSW. The Commission has a Taxi Fare Hotline to receive consumer complaints.

The hotline had been set up by the Commission, with the support of the taxi industry, to help passengers report issues. The Hotline team collects information to ensure the report can be passed onto the appropriate Taxi Service Provider. The provider then looks into the matter and takes any necessary action including providing a passenger with a refund or reprimanding a driver.

We received a complaint from a taxi passenger about how the Commission had dealt with a complaint about the conduct of a taxi driver received via the hotline.

The complainant had provided the taxi details to the Commission twice via its hotline, and had been told that, although it had passed on details to the taxi service provider, the provider was unable to identify the involved vehicle or the taxi driver. The complainant was dissatisfied with the response, and with what they considered to be a failure to adequately investigate. The complainant requested a review, but did not receive a response.

We made preliminary inquiries with the Commission, asking for a summary of the complainant's matter, including what steps the Commission had taken following the complaint. We also asked for expected timeframes for resolution of the complaint, the options available to complainants in circumstances where the taxi driver identity could not be established, and for the complaint-handling policy to be provided to us for our reference.

What was the outcome?

The Commission responded promptly to our inquiries.

Following our inquiries, the complainant received an email from the taxi service provider to advise that it had completed an investigation, and the taxi driver had since been identified. The taxi driver in question had received a caution, and the matter was placed on the driver's record with the provider. A partial refund of the fare was also offered to the complainant.

What can we learn?

One of the key concerns for this complainant was the perceived lack of action by the agency in facilitating steps to identify the taxi service provider and the driver. The matter highlights the importance of a complaint handling agency being responsive and giving complainants clear and timely updates.

Long-standing issues with the maintenance of a disused rail corridor

Public authority: the Transport Asset Holding Entity

Complaint overview

The Transport Asset Holding Entity (**TAHE**) is the owner of railway networks across NSW, including tracks, trains, stations, and land holdings around stations. We received a complaint from an elderly person who lived alone, beside a rural rail corridor which was no longer in use. The complainant told us the grass was very high within the corridor, and as a result snakes were entering their property from the unmaintained area. This was causing the complainant distress, and they did not feel safe in their own home. The complainant had been in touch with their local Council but was told it was not responsible for the area.

We made inquiries with TAHE to establish whether it was in fact responsible for the unmaintained area and, if so, what could be done to resolve the issue. An agency representative contacted our office. We explained the issues, and the agency confirmed that they were in fact responsible for this kind of issue. Their representative asked us to refer the complaint directly to them.

What was the outcome?

We contacted the complainant and explained the direct referral process. In essence, this involves us providing a 'warm' handover, by which we can (with a complainant's consent) refer their complaint to the agency in question. This provides the responsible agency with the opportunity to address the issues directly. TAHE explained to the complainant that it would be able to deal with the matter. The complainant told us they were greatly relieved that the area would be properly maintained, and that their safety concerns regarding the presence of snakes were now alleviated. They were also appreciative that they had been given a contact point within the responsible agency for future reference in the event the situation was to arise again.

What can we learn?

Navigating the web of government agencies can be difficult for members of the public, and our office can assist in matching appropriate services to issues. To the degree possible, agencies should aim to take a 'no wrong door' approach to help a complainant find the appropriate body to deal with their concerns.

A young person was admitted to their preferred university course following our suggestions

Public authority: a university

Complaint overview

We received a complaint from a student-applicant who had submitted several applications to a particular course at a university, including evidence of previous tertiary study. The student's applications were declined, because they were under the minimum age of admission nominated in the university's policies.

What was the outcome?

We made inquiries of the university. The university confirmed that there was a policy regarding the minimum age of admission. The university had discretion to consider an application from an underage student, but it had not exercised this discretion in favour of the student in this instance.

After considering the university's response, which focused on the student's age, we suggested (under s 31AC of the Ombudsman Act) that the university reconsider the grounds put forward by the student warranting admission, including having completed prior tertiary study, and to consider exercising its discretion in the student's favour. The university agreed with the suggestion – its reconsideration of the matter was informed by a new policy regarding the admission of underage students. The university offered the student a place in the coming enrolment period in their preferred course. The university advised that its new policy is aimed at ensuring consistency in decision making across the university in relation to applications for the admission of underage students.

What can we learn?

In this case, the university showed a willingness to be open and learn from the circumstances surrounding the complaint, leading to a positive outcome for the individual student and informing broader improvements, with a revised policy aimed at achieving fair and consistent outcomes for others.

Concerns about uses of force at 2 youth justice centres

Public authority: Youth Justice NSW

Complaint overview

During a visit to a youth justice centre in May 2024, we spoke to a young person who raised concerns about 2 separate incidents where force had been used on him. We reviewed a range of information about the incidents, including CCTV footage. We identified a number of issues, including questions about the adequacy of risk assessments, recordkeeping and the confinement of the young person following one of the incidents.

As a result, in accordance with s 31AC of the Ombudsman Act we suggested that Youth Justice NSW (**YJNSW**) conduct a further review of the uses of force against the young person to determine whether the incidents had been managed in accordance with relevant legislative and policy provisions, and to assess whether the oversight of these incidents was sufficiently rigorous.

What was the outcome?

YJNSW accepted our suggestions. It conducted a further review of the incidents where force had been used, with reference to the issues we identified. This review process determined that the uses of force were necessary, reasonable and proportionate. However, while that was the case, arising from the review YJNSW also made several recommendations to improve practice and governance in incidents where force is used, including in relation to the use of body worn cameras, training for officers and enhanced review mechanisms when confinement is used as a punishment.

YJNSW has since provided us with an update on the implementation of these recommendations.

What can we learn?

This case illustrates the value of an agency being willing to learn from complaints. Complaints can provide the opportunity to consider broader systems issues, to improve services and to prevent similar complaints in the future.

Unclear accountability for the operations of a retirement village

Public authority: a rural Council

Complaint overview

A complainant joined a volunteer group in their community in 2022, under the understanding that the group (known as the volunteer committee) had been created to provide gardening and simple maintenance support to a local retirement village that was owned and operated by their local council.

The complainant had concerns about how Council was operating the village. In particular, they had concerns that Council was expecting the volunteer committee to take on more and more administration tasks beyond gardening and maintenance. Council expected the volunteer committee to be signatories to tenancy agreements and to collect rents. The complainant argued Council was unduly pressuring this group of volunteers to take on various risks associated with the retirement village when the volunteer committee had no power or expertise to carry out these functions. The complainant also disagreed with Council charging village residents rates for a vacant block of land Council itself purchased to extend the retirement village.

Our inquiries uncovered that at the core of this complaint was a disagreement over whether the volunteer committee was:

- an unincorporated association of volunteers with no ties to Council, or
- a committee set up by Council under s 355 of the *Local Government Act 1993* (**LG Act**).

Under the above section of the LG Act, councils can delegate functions to a committee of council, including a committee comprised of volunteers. There was a lack of clear records to support Council's position that the volunteer committee for the retirement village was a 'section 355' committee, and if so, what functions the volunteer committee was delegated to perform on behalf of Council.

We wrote to Council to suggest that it take action to obtain access to the bank account for the village, which the committee had sole access to.

What was the outcome?

Council accepted our suggestions. It acknowledged that it needed to improve its financial management practices, have stronger control measures and to improve oversight of its section 355 committees. As a result, it drafted a new instrument of delegation outlining the responsibilities of this volunteer committee. It also commenced a project to enhance governance and risk management of these types of committees throughout its local government area.

Council also agreed to prioritise action to obtain appropriate access to council funds in the bank account managed by the village committee.

What can we learn?

This case study illustrates the importance of having strong governance of volunteers that work alongside or perform functions of public authorities. If there had been robust governance and recordkeeping processes been in place during the history of this committee, the ambiguity of whether this particular volunteer committee was a section 355 committee could likely have been avoided.

It also demonstrates good practice – Council's decision to commence a project to review its current section 355 committees is an example other councils may wish to follow, to identify possible areas for improvements.

Delayed response to carer relocation

Public authority: Department of Communities and Justice and community services provider

Complaint overview

In late 2024, we received a complaint from an authorised foster carer about a child who had been in their care for just over 12 months. The case manager was a non-government community service provider. The case was still before the Children's Court and the Department of Communities and Justice (**DCJ**) held parental responsibility. The child's case plan goal was under review, as the child's mother was seeking restoration and DCJ was reconsidering the case plan goal.

The carers had been consistently clear with the community service provider about the fact that they planned to relocate to another state when their current accommodation changed in late 2024. The carers complained they had been in frequent contact with that provider since mid-2024 in an attempt to resolve issues related to their relocation – however there had been no progress.

The complainant sought parallel planning for a contingency arrangement whereby they could continue to provide care (and ensure minimal disruption) for the child. The carers committed to returning to NSW, and if appropriate, advised that they would seek to be the child's long-term carers. The relationship with the NGO agency had broken down.

We referred the matter to DCJ for local resolution under s 25(3) of CS CRAMA.

What was the outcome?

DCJ contacted the carers and met with them to discuss their complaint and their forthcoming move interstate. Time limited authorisation was granted for the child to travel with the carers. DCJ also met with the community service provider and the carers with their advocate to resolve concerns about the provider's case management. DCJ advised that, considering the irretrievable breakdown between the agency and carers, case management would return to the Department for future casework. The carers were very happy with this outcome.

What can we learn?

This complaint was time critical due to the imminent move of the carers and the need for travel to be authorised to minimise disruption to the child. The relationship between the agency and the carers had broken down, and this was preventing any progress in resolving the issue. Complaints are often unnecessarily escalated due to lack of timeliness, communication and responsiveness. In this case, local resolution provided a circuit breaker to the situation, and offered the carers an opportunity to discuss their concerns directly with the funding agency.

Financial hardship caused by delay in settling deceased estate

Public authority: NSW Trustee and Guardian

Complaint overview

We received a complaint from a widow raising concerns that it had taken NSW Trustee & Guardian (**NSWTG**), in its role as executor, nearly 3 years to finalise the estate of her late husband. The complainant told us that this delay had caused her financial hardship. Further, as English was her second language she had struggled to give NSWTG the information it required. She did not have any family able to assist her with providing documents to the agency.

We wrote to NSWTG on 2 occasions to make inquiries about the delay. NSWTG acknowledged there were some issues with their processes and staffing levels that had contributed to the time taken to finalise the estate.

NSWTG had already agreed to waive fees and other costs. We acknowledged this and suggested to NSWTG (under s 31AC of the Ombudsman Act) that it take further steps, including apologising to the complainant and reviewing its policies and procedures around how it provides support to people who require additional assistance.

What was the outcome?

NSWTG wrote to the complainant to apologise for the delay in finalising the estate, and noted that it was committed to making its processes more streamlined. NSWTG advised us that while it did have measures in place for people requiring additional supports, it believed its processes could be enhanced. To that end, it intends to have its processes made the subject of a 'sludge audit' by the Department of Customer Service in order to identify where further improvement could be made.

What can we learn?

While agencies experiencing staffing shortages can see their service delivery adversely impacted, it is important to keep people informed and provide honest explanations for any lack of timeliness. Learning from a complainant's experience to use it to help drive process improvements can help prevent the recurrence of similar situations in future and improve service delivery longer term.

Refund request for retained tuition fees declined

Public authority: a university

Complaint overview

The complainant, an international student, emailed our office seeking a refund for tuition fees totalling almost $20,000 paid in advance to the university. Shortly after making the payment, their visa application had been declined. They subsequently applied for a tuition refund, but this was declined on the basis that they had previously failed to disclose to the university a visa refusal to another country several years earlier.

We made inquiries of the university. On receiving its response the position was:

- The complainant had accepted they were at fault in misunderstanding and failing to accurately fill out the university intake form asking them to declare all previous visa refusals, believing that they only needed to disclose student and study-related visa refusals.
- The university had acted in line with its policy to retain the fees paid on the basis that the application had been inaccurate or 'fraudulent'.

Nevertheless, we asked whether the university considered that the outcome of an almost $20,000 loss without receiving tuition in return could be considered disproportionately harsh. We also noted that the complainant had included the earlier visa refusal in their Australian visa application, which supported their argument that they were not seeking to conceal that episode, but rather made an honest mistake in their interpretation of the question from the university specifically.

What was the outcome?

Following inquiries by our office, the university advised that prior to this complaint, they had commenced the process of reviewing the relevant policy so that a student in similar circumstances would qualify for a full refund, minus a $500 administrative fee. Noting that it was unlikely that this policy would be applied retrospectively, we made a suggestion under s 31AC of the Ombudsman Act that a full or partial refund be granted to the complainant on the basis of the disproportionate impact of the amount and the fact that the policy was being changed, which indicated a tacit acknowledgement that it was too harsh.

The university accepted the suggestion and granted a full refund to the student, as well as waiving the relevant $500 administrative fee.

What can we learn?

Discretion and fairness are important considerations in administrative decisions. An agency's decision may be technically correct but nonetheless have a disproportionate or unfair impact. In this case, the university recognised the disproportionality and took appropriate steps to adjust its policy.

Difficulty in accessing medical records of deceased First Nation relatives

Public authority: a local health district

Complaint overview

The complainant, a First Nations person, emailed our office in June 2024 seeking assistance in obtaining medical records from a hospital for themselves and several deceased relatives, as they were the last remaining survivor of their bloodline. The complainant stated that they believed the hospital's response to their requests demonstrated a lack of cultural understanding and they were also concerned with what was being asked to be provided to support release of their relatives' documents, as well as how long the process was taking.

We made inquiries of the relevant local health district. We asked if the records could be provided to the complainant and asked for the reasons for the process being so protracted. We also asked whether, in circumstances where someone advises that they are a First Nations person, the hospital would involve an Aboriginal Liaison Officer. We asked what avenues existed for accessing deceased relatives' records where there was an absence of a will or death certificate.

The local health district responded, informing our office that the complainant's own records had been released after receipt of our inquiries, but 2 of their relatives' records had already been destroyed in accordance with NSW General Retention and Disposal Authority Public Health Services. The hospital had written to the complainant to confirm the destruction of the records and explain why another relative's records could not be released.

What was the outcome?

Following our inquiries, the hospital acknowledged the need to be flexible in relation to requests for information from First Nations people. Therefore, it provided to the complainant a summary of their relative's encounters with the hospital in line with disclosures allowed by the NSW Health Privacy Manual under compassionate grounds. The local health district apologised for the delay in the process, noting by way of explanation that waiting times had increased due to the volume of requests, records were stored offsite, required clinical review and checks had to be made to confirm the complainant's standing as next-of-kin.

In addition, the local health district acknowledged that it was not current practice to involve an Aboriginal Liaison Officer in such requests. However, based on the feedback from the complainant, it has been recognised as a benefit and is now being incorporated in departmental workflows across all Patient Information Services Departments within the local health district.

What can we learn?

This matter demonstrates the importance of agencies building cultural competence and ensuring that practices and policies are informed by the needs of First Nations people. This matter also demonstrates the benefits of considering complaints from a systems perspective, and introducing changes to address systemic issues.

Unfair inmate disciplinary process

Public authority: Corrective Services NSW

Complaint overview

Two inmates in a correctional centre contacted us stating they had each been charged and found guilty of 2 correctional centre offences: stealing and failing to comply with correctional centre routine.

These charges related to an incident that occurred where both inmates were observed to be wearing different shoes than they had been wearing earlier. The inmates complained the inmate discipline process was unfair – despite pleading not guilty, there was no clear inquiry process. One of the inmates also complained that he had to pay $500 in compensation as part of his penalty.

We made preliminary inquiries with CSNSW and requested further information. The information received raised questions about:

- the fairness of the inquiry process
- whether the elements for a 'stealing' offence had been proven beyond reasonable doubt
- whether not wearing the correct shoes constituted a breach of 'correctional centre routine'
- the appropriateness of requiring an inmate to pay $500 as compensation when compensation can only be ordered for property damage
- the fairness of requiring one inmate to pay compensation when the other was issued with a reprimand and caution.

As a result, we wrote to the governor of the correctional centre and made the following suggestions under s 31AC of the Ombudsman Act:

1. the disciplinary decisions relating to the correctional centre charges be referred to the General Manager of Statewide Operations for review
2. the inmate be reimbursed the $500 compensation he had paid
3. staff be reminded of their responsibilities during inmate disciplinary proceedings and determinations.

What was the outcome?

After we made the above suggestions, CSNSW advised us that:

- the charges were reviewed and the guilty determinations found to be unsound
- records have been updated to reflect that the charges are to be disregarded in future decisions
- the inmate who paid the compensation has been reimbursed
- staff will undertake refresher training on inmate discipline processes.

What can we learn?

This matter demonstrates the need for agencies to have sound administrative practices whereby decisions are evidence-based and rational.[17]

[17] See further 'Inmate discipline in NSW correctional centres' in Part 1 of this report.

Appendix: The 6 principles for effective complaint management

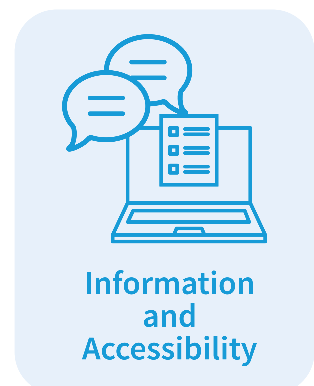
The 6 principles for effective complaint management

Treat complainants with respect

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



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:

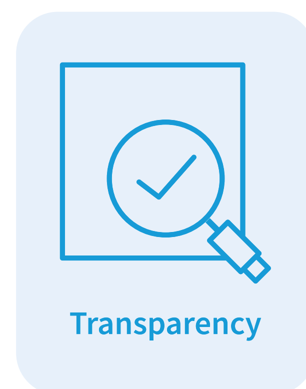
- make sure that staff who manage complaints are suitably trained and skilled
- allocate a complaint to one person (or one team) and give complainants their contact details
- generally, have frontline staff resolve a complaint themselves and escalate serious or complex complaints to a more appropriate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



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.

Pursuing fairness for the people of NSW.

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