Casebook January 2026: Investigations and complaint-handling case studies

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

Pursuing fairness for the people of NSW.

Ombudsman New South Wales

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Ombudsman
New South Wales

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

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

Dear Mr President and Mr Speaker

Pursuant to s 31 of the Ombudsman Act 1974, I am providing you with a report titled *Casebook January 2026: Investigations and complaint-handling case studies*. The report includes a selection of case studies relating to complaint matters finalised in the period from 1 July 2025 to 31 December 2025, as well as summaries of investigations completed in that period.

I draw your attention to section 31AA of the Act 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 2026

Table of Contents

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* (**PID Act**).

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

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

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

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

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

[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

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 formal investigations finalised between 1 July 2025 and 31 December 2025.
- Part 2 includes a selection of case studies relating to complaint matters finalised during that 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.

The biannual casebook reports include a summary of some of the investigations concluded in the relevant 6-month period, regardless of whether a special report has also been tabled in respect of the 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: Investigation summaries

Part 1: Investigation summaries

This part provides a summary of some formal investigations finalised between 1 July and 31 December 2025.

When and how we conduct investigations

Investigations are an essential tool for holding agencies to account. We can investigate when we suspect serious maladministration, whether as a result of complaints or reports we have received, or on our own motion. Maladministration is when administrative conduct is unlawful, unjust, unreasonable, improperly discriminatory or otherwise wrong.

Investigations can be resource-intensive, both for our office and for the agency under scrutiny. Generally, we give priority to investigating only the most serious of matters.

When we undertake an investigation, we have similar powers to a royal commission. For example, we can require an agency to provide us with a statement of information or documents relating to the conduct we are investigating.

Our investigations examine the conduct of agencies (and in some cases individuals) and enable us to make findings where we believe the evidence is sufficient to show that wrong conduct has occurred.

When we finish the investigation, we will report what we found and what we consider should happen next. Any agency or individual subject of potential findings by us are given an opportunity to respond to our report before it is made final. Examples of recommendations we may make include that the agency or service provider:

- reconsiders or changes an action or decision
- changes a rule, procedure or law
- pays compensation, and
- takes some action to prevent a recurrence of the conduct we investigated.

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.

In total, we made 14 recommendations in respect of the investigations reported in this casebook. Of these, 6 have been fully accepted and we are waiting for agency responses on 8 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.[5]

Introduction to the investigations

Four investigations finalised in the above 6-month period have been included in this casebook. Three investigations resulted in findings, with one being discontinued without findings of wrongdoing. None of the investigations have resulted in a report under s 31 of the Ombudsman Act.

All 4 investigations related to how agencies responded to significant concerns or allegations, whether relating to backlogs, misconduct, fitness for work, or the legitimacy of licences. In each of these investigations, staff had made reports under the PID Act. These cases demonstrate how the effectiveness of the PID scheme depends not only on a good speak-up culture, but on agencies identifying public interest disclosures and taking timely and appropriate action in response to those reports.

Utilising our investigation powers, we scrutinised whether agency processes were adequate, fair, and transparent, and whether authorities took timely, appropriate remedial action to the issues at hand. In 3 of the matters we investigated, we identified deficiencies, made findings of wrong conduct and several recommendations for improvement.

[5] Section 28 CS CRAMA.

A backlog of radiology studies

The case of Sydney Local Health District

Public authority:	Sydney Local Health District
Responsible minister:	Minister for Health
Investigation report issued:	22 September 2025
Findings:	Conduct that was unreasonable and wrong
Recommendations:	Development of an action plan

We investigated Sydney Local Health District's (**SLHD**'s) response to, and management of, a backlog of unreported radiology images that had progressively accumulated between 2019 and 2024 at Concord Repatriation General Hospital (**Concord Hospital**). At its peak, the backlog consisted of approximately 50,000 unreported images, which were mostly x-rays.

We found that SLHD's conduct in responding to and managing the backlog was wrong, as it had failed to address ongoing and unreasonable delays in reporting radiology images at Concord Hospital over a protracted period of several years.

We recommended that SLHD consult with the radiology department to develop a forward-looking action plan to ensure existing resources and processes were fit for purpose to meet future radiology demand.

Background

We began this investigation after receiving a public interest disclosure (**PID**) from a doctor. Among a range of other allegations, the doctor raised concerns about a significant backlog of unreported radiology images at Concord Hospital's radiology department, which also serves Canterbury and Sydney Dental Hospitals. He told us that the backlog had been accumulating since about 2019, and at the time of the PID it had reached approximately 50,000 unreported images. The doctor raised concerns about adverse impacts on patient safety and the wellbeing of the staff radiologists.

What did we find?

Multiple parties had raised concerns with SLHD management about under-resourcing for radiology services, including the emergence of a burgeoning backlog, since around 2019.

SLHD did not take steps to fully understand the drivers of the problem or closely monitor the growing backlog until January 2022. It did not set key performance indicators for reporting turnaround timeframes until 2023. By October 2023, the backlog comprised approximately 40 per cent of the total annual volume of scans. Some unreported x-rays dated back years.

Despite suggestions from various parties about how to manage the increasing workload of radiologists and the growing backlog, SLHD did not work collaboratively with the radiology department to address the issues. While it made repeated attempts to recruit radiologists, these efforts did not always find

suitable applicants. It put some other limited strategies in place at various times, but they were ineffective. Successful backlog management began after private teleradiology providers were engaged in April 2023, an arrangement that has remained in place since then.

Whilst the number of actual adverse incidents attributed to the backlog was relatively low and the radiology department had implemented certain strategies to manage potential risks from delayed reporting as early as 2020, SLHD only began systematically identifying and addressing potential patient safety risks after external intervention in 2023.

The causes of the backlog were complex. They included increased demand for medical imaging and higher workloads alongside challenges in recruiting and retaining radiologists. Overall, we concluded that stronger intervention was required at an earlier point. SLHD had ample warning from as early as 2019 that the reporting backlog had been accumulating, would worsen if not addressed, and that strategic intervention was required to manage the situation. For this reason, we found that the conduct of SLHD was unreasonable and wrong.

What did we recommend?

SLHD has materially resolved the backlog by engagement of private radiology providers. In the event that this arrangement is terminated in the future, we recommended that it:

- develop a forward-looking action plan to ensure existing resources and processes are fit for purpose to meet future radiology demand, regardless of the availability of private providers, and
- consult with Concord Hospital's radiology department on the development of the forward-looking action plan.

The management of misconduct investigations

The case of the Ministry of Health

Public authority:	Ministry of Health
Responsible minister:	Minister for Health
Investigation report issued:	22 September 2025
Findings:	Conduct that was unreasonable
Recommendations:	Apology; policy review

We investigated the Ministry of Health's (the **Ministry**'s) management of misconduct investigations against 3 doctors. The misconduct investigations commenced after the doctors made public interest disclosures (**PID**s) alleging that a Local Health District (**LHD**) had not adequately responded to concerns they had raised about another doctor. The doctors believed that the misconduct investigations against them were commenced in reprisal for making PIDs.

We found that the Ministry's conduct in managing the misconduct investigations was unreasonable because it did not give the doctors the specific allegations against them until over 8 months after they were notified that they were under investigation. However, we did not find that the misconduct investigations were commenced in reprisal for making PIDs.

We recommended that the Ministry consider whether to progress or discontinue the misconduct investigations, apologise to all involved parties and review its misconduct policy.

Background

Several doctors had raised concerns with various parties alleging that another doctor was engaging in conduct that was causing potentially avoidable injuries and deaths.

Three of the doctors who reported concerns subsequently became the subject of misconduct investigations undertaken by the Ministry for alleged bullying and harassment. They complained to us that the misconduct investigations had been commenced in reprisal for their reported concerns, which were or should have been assessed as PIDs.

The *Public Interest Disclosures Act 2022* makes it a criminal offence to take detrimental action against a person based on a suspicion, belief or awareness that a person has made, may have made or may make a PID.

As the misconduct investigations progressed, the doctors also became increasingly concerned that they had not been told what the specific allegations against them were and that this undermined the fairness of the process.

The Ministry began investigating after it received complaints about the doctors that alleged bullying and harassment. The Ministry conducted fact-finding inquiries to clarify the allegations, then engaged an external investigator to formally investigate. The 3 doctors received letters telling them they were being investigated for alleged bullying and harassment. They were also told that they would receive specific allegations within approximately a month.

The investigation proceeded with witness interviews. The 3 doctors received several apologies for the continuing delays but still did not receive the allegations as undertaken. By the time we started our investigation they had been waiting 8 months to be told the case against them.

What did we find?

There was no evidence that the Ministry commenced the misconduct investigations in reprisal for the PIDs made, or the concerns raised by the doctors. The Ministry was obliged to assess and respond to the complaints it received about the doctors, but some aspects of its investigation were not in line with good practice and led to an unfair process. Consequently, we found that the Ministry's conduct was unreasonable.

It is standard practice to conduct preliminary fact-finding inquiries without advising the subject of the allegations made about them. This enables agencies to clarify and test the credibility of the allegations and decide whether a formal investigation (or another process) is viable and necessary.

However, once a formal investigation starts and the subject of the investigation has been put on notice, unless exceptional circumstances exist, they should also be told the specific allegations against them. This is important because it enables the person to respond meaningfully, seek advice and provide relevant information at an early stage. It also puts them on notice to refrain from conduct that may exacerbate the situation or interfere with evidence or witnesses.

Providing specific allegations ensures the process is fair and transparent. Clarity and transparency improves trust in the process, reduces any claims of bias or predetermined outcomes and prevents unnecessary disputes or procedural challenges. Importantly, knowing the specific allegations reduces the inevitable stress people feel when under investigation.

The Ministry's *Managing Misconduct Policy* acknowledges the importance of providing advice about the allegations at an early stage, although it leaves room to withhold the full details to avoid compromising the investigation and to minimise any risk of harm to potential victims and witnesses. In such cases, it requires that the reasons be documented for any decision to withhold or delay advising the staff member of the allegations against them.

In this case, at least a high-level summary of the allegations should have been given to the doctors at an early stage. Not being provided with any information about the nature and seriousness of the allegations against them for over 8 months was unfair. This was particularly so given the possible serious repercussions under the misconduct policy.

What did we recommend?

We recommended that the Ministry:

- consider whether it should progress or discontinue the misconduct investigations
- consider additional or other strategies to deal with the workplace issues
- apologise to the doctors for the failure to provide them the allegations and apologise to other involved parties for the delays in finalising the investigations, and
- review the relevant policies in light of the learnings from this investigation.

The response to a report of an impaired practitioner

The case of a Local Health District

Public authority:	A Local Health District
Responsible minister:	Minister for Health
Investigation report issued:	22 December 2025
Findings:	Conduct that was unreasonable
Recommendations:	Additional training for managers and development of local complaint-handling and return to work policies

We investigated a Local Health District's (**LHD**'s) response to a report it received about a doctor suspected of having an impairment. We looked at the LHD's management of the doctor's return to work and its handling of complaints made against the doctor along with a related public interest disclosure (**PID**).

We found that the LHD had managed the issues largely in accordance with relevant policy, but its processes and procedures were poorly documented. We also identified deficiencies in the training of managers about their obligations in the management of complaints and PIDs.

We recommended the LHD develop local policies and procedures to assist managers in handling complaints and non-work-related illnesses and injuries. We also suggested provision of further training for managers in the handling of complaints and PIDs, and the importance of documentation.

Background

We received a PID alleging that an LHD had allowed a doctor to return to work after an incident in circumstances where:

- an assessment by the Medical Council of NSW to determine whether the doctor was impaired and/or fit to practice had not been concluded, and
- the LHD had not conducted a risk assessment or imposed any work plan or restriction on the doctor's practice.

The PID-maker also alleged that complaints about the doctor were not handled appropriately.

Health conditions may impact an employee's ability to carry out the inherent requirements of their position. Under current policies that apply to all government agencies, including NSW Health, when such circumstances are identified, an initial consultation with the employee should occur and may include consideration of medical advice from the employee's treating medical practitioner. Depending on the severity of the impact, adjustments may be made to the employee's work. If the situation is not resolved through discussion and adjustments, the policy provides for further escalating steps.

What did we find?

The LHD followed the appropriate steps when returning the doctor to work, and it was not required to restrict the doctor's practice in the absence of any interim conditions being imposed by the Medical Council. However, understanding of applicable policies and recordkeeping requirements among staff with management responsibilities was poor. The LHD dealt with complaints informally and did not make records as required.

Similarly, we found that the understanding of PID obligations, including the training provided to staff, was inadequate.

What did we recommend?

We recommended that the LHD:

- provide additional training for managers around complaint-handling and handling of PIDs
- develop local policies and procedures to assist managers to deal with non-work-related injuries and illnesses, and
- develop local policies and procedures around the handling of complaints and concerns about clinicians, and adequately document such processes.

Reports of illegitimate qualifications used to obtain building licences

The case of Building Commission NSW

Public authority:	Building Commission NSW
Responsible minister:	Minister for Building
Investigation report issued:	Discontinued on 13 November 2025
Findings:	Nil
Recommendations:	Suggestions made to consider seeking legal advice to clarify the appropriateness of imposing conditions on licences to confirm whether its approach of sometimes imposing conditions on licences (to prohibit licensees conducting certain trades otherwise authorised by the licence), rather than cancelling the licence, is permissible under the legislation.

We received several public interest disclosures (**PID**s) raising concerns that Building Commission NSW (**BCNSW**) executives may have stopped an investigation into the use of illegitimate qualifications to obtain building licences. The complainants also raised concerns that BCNSW executives may have prevented staff from cancelling such falsely obtained building licenses, despite legislation requiring them to do so.

We found that the concerns were not substantiated and discontinued the investigation without findings of wrong conduct.

Background

The *Home Building Act 1989* (the **Home Building Act**) sets out the requirements for obtaining building licences in NSW. Section 43 of the Home Building Act gives BCNSW the power to cancel building licences if they were issued, renewed or restored through a 'misrepresentation (whether fraudulent or not)'. Section 22 of the Home Building Act separately sets out some circumstances in which BCNSW must cancel a licence.

In December 2023 the NSW Police Force provided information to BCNSW about individuals offering to sell illegitimate building industry qualifications, which were then used to apply for and subsequently grant licences under the Act.

BCNSW investigated. It determined that as many as 750 individuals may have obtained 930 building licences using illegitimate qualifications.

BCNSW investigators reviewed and cancelled an initial batch of licences. The initial cancellations were then paused for 8 months while legal advice was obtained from the Crown Solicitor's Office. During the pause, BCNSW implemented several risk mitigation strategies to protect the public.

BCNSW created a specialist taskforce to consider the evidence collected in relation to each of the 750 licence holders and determine if their licence should be cancelled, have conditions imposed or be allowed to stand. Over a further period of 10 months the taskforce reviewed all 930 licences, cancelling

231 and imposing conditions on 68. It took no further action on 630 of the licences on the basis that there was insufficient evidence that fraudulent qualifications had been used.

What did we find?

After considering the actions taken by BCNSW, we made no findings of maladministration and discontinued the investigation.

We did, however, suggest that BCNSW obtain legal advice to clarify one aspect of its practices. In some cases where a licensee held a licence for various types of works, BCNSW discovered that improper qualifications impacted some, but not all, of the types of works listed in the licence. In some cases, BCSW allowed the licensee to keep the licence, but imposed a condition prohibiting them from undertaking the affected types of work. We suggested that BCNSW obtain legal advice as to whether this is permissible, and the circumstances when the Home Building Act requires that the entire licence be cancelled.

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 2025.

The NSW Ombudsman manages complaints relating to unfair treatment by most NSW Government agencies, local councils, or NSW Government funded community service providers. 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**), and
- 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 2025, we received 8,492 '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. 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*. Conciliation is held on a voluntary basis and can be most helpful where there is an ongoing relationship between the complainant and the agency that needs to be repaired or restored.

The case studies below provide a range of examples of how we use these powers.

Introduction to the case studies

When we finalise a complaint, there are almost always lessons to be learned. The case studies in this report include key learnings that could apply to any public authority or service provider. They are provided here to support continuous improvement in public administration including complaint-handling.

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

In this casebook we have included case studies that illustrate the various ways we can resolve complaints using early resolution powers, including conciliation, preliminary inquiries, direct referrals, liaison with agencies and issuing suggestions and comments under s 31AC of the Ombudsman Act.

A recurring theme in the casebook is that the Ombudsman's early intervention can resolve complaints, even where issues have been in dispute for a considerable period. Examples in this casebook include fee waiver by the NSW Trustee and Guardian, granting an inmate access to a wheelchair by Corrective Services NSW, refunds of up to $10,000 by Local Health Districts and a refund of excessive water charges by Homes NSW.

They also demonstrate how the resolution of an individual complaint can result in the identification and resolution of systemic issues, to the benefit of the wider community. For example, a lost invoice caused by a technical issue in a Local Health District resulted in process improvements for other people who were similarly affected. Several complaints resulted in improvements to policy or additional training for staff, for example the case studies involving Corrective Services NSW, Homes NSW and TAFE NSW.

The use of artificial intelligence in seatbelt detection cameras

Public authority: Transport for NSW and Revenue NSW

Complaint overview

On 1 July 2024, the existing mobile phone camera network and other established Transport for NSW (**TfNSW**) cameras were activated as seatbelt detection cameras (**SDC**s) to detect seatbelt offences. According to TfNSW, in the first 10 months of operation, the SDCs photographed 117 million vehicles and within the first 21 days detected over 11,400 seatbelt offences.

We received several complaints about SDCs, including concerns about the use of artificial intelligence (**AI**) and the quality of some images captured by SDCs. In most cases we advised the complainants of their right to dispute the fine in court. We also conducted preliminary inquiries with TfNSW and Revenue NSW (**RNSW**) to understand how the system operated.

What was the outcome?

AI is only used in the initial analysis of photos taken by SDCs in the same way it has been used in mobile phone detection cameras since 2019 in NSW. This process involves AI determining the likelihood of a seatbelt offence by either the driver or front passenger by analysing the 3 photographs taken by the SDC. If a certain confidence is reached, the images are referred for review by a TfNSW authorised officer.

If the TfNSW authorised officer considers an offence has likely occurred, the photographs are referred to a RNSW officer for additional review. If the RNSW officer also agrees, a penalty is issued to the registered owner of the vehicle.

Through our inquiries we found that concerns about image quality generating 'false positives' was not in fact a common feature in requests for internal reviews. The rate of internal reviews requested for SDC offences was also comparable to other camera detected offences such as speeding and mobile phone use.

What can we learn?

This matter highlights the importance of fair and transparent processes and human oversight in the use of AI.

Upgrade to the Western Harbour Tunnel/Warringah Freeway

Public authority: Transport for NSW

Complaint overview

The complainant, a member of the public who lived near the Warringah Freeway, requested a meeting with the Customer Complaint Mediator (**CCM**) for the Western Harbour Tunnel/Warringah Freeway upgrade. Transport for NSW (**TfNSW**) initially told him that he could not have the meeting and subsequently advised the member of the public that it would assess his request for a meeting. TfNSW did not advise who the CCM was or provide the complainant their contact details.

The *Western Harbour Tunnel Complaint Procedure* states that 'any member of the public who has lodged a complaint which is registered in the Project's Complaints Management System… may submit a written request to the CCM to review the project team's response to their complaint. The CCM must respond within 28 days of the request being made or a specified timeframe agreed between the CCM and the complainant. The CCM may only address the complaint on completion of the reviews by Transport…'

We contacted TfNSW to obtain the identity and contact details for the CCM.

What was the outcome?

TfNSW provided the CCM details to our office and to the member of the public. The complainant told us he was satisfied with the outcome, as he was now able to direct concerns about the Western Harbour Tunnel/Warringah Freeway Upgrade to the CCM directly.

What can we learn?

Alternative dispute resolution, including mediation, is often an effective way to resolve complaints. Where NSW public authorities advise that members of the public will have direct access to dispute resolution mechanisms, it is important that it is facilitated.

Delays issuing a death certificate

Public authority: NSW Registry of Births, Deaths and Marriages

Complaint overview

A complainant told us she had applied and paid for the priority processing of her late husband's death certificate in September 2025. She submitted the necessary documents and information to the NSW Registry of Births, Deaths and Marriages (**BDM**), which told her she would receive the death certificate in 1 week. The complainant and her daughter were homeless and urgently required the certificate for a house and title settlement.

BDM subsequently told the complainant that it would take 6 weeks to issue the certificate. The complainant contacted our office because the delay would have had a significant impact on her and her daughter.

We made inquiries with BDM, asking about the reasons for the delay. BDM told us that it had requested further information from the complainant about her application as she was not recorded as a spouse on the death record and therefore was not entitled to the certificate. BDM also told us that, through the application process, BDM advised the complainant of the documents required to prove entitlement.

We asked BDM which specific documents it required and contacted the complainant to explain the documentation that BDM needed.

What was the outcome?

The complainant provided the outstanding documents and BDM issued the certificate. BDM sent the death certificate by express post, and it was delivered to the complainant the next day. It took us 6 days to resolve the complaint. The complainant did not have to wait 6 weeks for the death certificate to be issued.

What can we learn?

This is an example of action our staff can take to ensure an early resolution of an issue that may otherwise become protracted. A complaint may be resolved by clear communication with members of the public.

Excessive water usage fees charged for business

Public authority: Port Macquarie Hastings Council

Complaint overview

A complainant told us about excessive water usage charges that had been attributed to their business. They said that they had complained to Port Macquarie Hastings Council (**Council**), suggesting that the fees and charges were not consistent with its 2024/25 report on fees and charges, but told us they did not receive a clear explanation.

We made inquiries with Council, seeking an explanation regarding the charges attributed to the complainant's account and whether they were accurate.

What was the outcome?

In response to our inquiries, Council undertook further investigations of the complainant's account with reference to the fees and charges report. It was uncovered that the fees and charges report did not cover 'major water users' methodology, which is a practice that provides relief to users with high water consumption.

The previous owner of the property (not the complainant) had requested the major water users option be set up on the account. Council reset the complainant's account. Council also applied an adjustment to the water account, which resulted in a $8,405.96 credit being applied.

We requested that Council provide a clear explanation to the complainant about the credit made to their water usage account and what led to those charges.

What can we learn?

This complaint highlights the importance of ensuring fees and charges in government agency policies are clear and transparent and the importance of providing a clear explanation to a complainant.

Same public housing property offered to 2 families

Public authority: Homes NSW

Complaint overview

A complainant told us that in March 2025 she had collected keys and attempted to move into a house allocated by Homes NSW. However, she found that someone else was already occupying the property and the keys provided did not work in the locks. The complainant contacted Homes NSW, which told her it would investigate her concerns and get back to her. After she had not heard from Homes NSW despite making contact to follow up, the complainant was eventually told that the property had been offered to another family because she had rejected it.

She complained to Homes NSW. She did not get a response to her complaint, but was told by a staff member that the property had been allocated to 2 families simultaneously. She was asked to contact another housing office to escalate her concerns. At this point the complainant brought her complaint to us.

We made inquiries with Homes NSW.

What was the outcome?

Homes NSW acknowledged that there had been a communication breakdown following the housing allocation of the property to the complainant. It had made an out-of-guidelines decision in an urgent allocation of this property to another family. Homes NSW was unable to disclose this information to the complainant, and it appears that she was given conflicting explanations by different Homes NSW staff.

Homes NSW told us it had identified several opportunities for staff training, including using this case as an example for all staff around the importance of following effective communication practices and adhering to relevant complaint-handling processes.

Our inquiries also resulted in Homes NSW identifying and offering another suitable vacant property to the complainant. Homes NSW acknowledged the stress experienced by the complainant and her children as a result of the situation.

The complainant thanked us for our intervention and told us that she and her daughters may not have been housed without our involvement.

What can we learn?

This complaint shows the importance of clear and consistent communication on the part of agencies, and particularly the timely communication of decisions made about customers. It also highlights the important role of escalated complaint processes in putting things right when unfairness occurs, and how one complaint can lead to broader systemic improvement.

Lost invoice delay remedied

Public authority: a Local Health District

Complaint overview

A complainant told us a Local Health District (**LHD**) had issued him overdue invoices for an emergency hospital stay which occurred over 2 years ago. The complainant had provided his overseas student health cover insurance details to the hospital at the time of his stay. Two years later, the LHD had told him that it had sent the invoices to his insurance company, but the claims had been rejected, so it had forwarded the invoices to him.

The complainant paid the total of nearly $2,500 in good faith. However, when he tried to claim the amount back from his insurance company, his claim was denied as the services had been rendered over 2 years ago. Furthermore, the insurance company advised that they had never received these invoices from the hospital. The complainant tried to contact the LHD again multiple times but did not receive a reply.

We made inquiries with the LHD.

What was the outcome?

After reviewing the case the LHD acknowledged that an error had occurred. These invoices had been discovered in a departmental review of unpaid invoices and, due to a technological issue in early 2023, the invoices were raised but were never actually sent to either the complainant or the insurance company until they were issued to the complainant in mid-2025. Other invoices for the complainant's same hospital stay had been successfully claimed through the insurance company at the time.

As a result of our inquiries, the LHD committed to refunding the complainant for the fees paid. It did so acknowledging that the period for him to make a claim through his private health insurer had, through no fault of his own, expired. The LHD advised that staff are aware of the 2-year timeframe associated for private health fund claims and acknowledged that the staff had not undertaken satisfactory checks in relation to this complainant's account.

What can we learn?

This case highlights that even with adequate staff training, knowledge, and documented processes, things can be missed and sometimes processes are not undertaken as diligently as they should be. It is important to pay attention to what complainants are telling us and look into the reason for delays, to ensure any unfair administration can be addressed.

Excessive water charges for a public housing tenant

Public authority: Homes NSW

Complaint overview

A public housing tenant contacted our office after being charged an unusually high water bill for a 3-month period by Homes NSW. During this time, Homes NSW deducted additional payments from the complainant's rent to recover the cost. The complainant experienced inconsistent communication from staff, who provided conflicting advice suggesting the charges may have been caused by an error or a water leak. He sought our assistance to clarify the charges and obtain a clear outcome.

Our office made inquiries with Homes NSW.

What was the outcome?

Homes NSW told us that a water pressure test at the property had identified a leak in the garden tap area. The tenant's water charges were adjusted to reflect their usual average amount prior to the leak. Homes NSW acknowledged its delay in resolving the complaint, and issued a refund for the overcharging.

What can we learn?

This complaint highlights the importance of agencies promptly responding to complaints about unusually high charges and taking corrective action when an error or fault is identified. It also reinforces the need for clear, timely, and consistent communication with tenants throughout the process. Explaining outcomes in plain language helps ensure transparency, maintain trust, and support positive tenant–agency relationships.

The complaint also demonstrates the important role our office plays in facilitating fair outcomes by seeking clarification from agencies and ensuring that tenant concerns are properly addressed.

Ten-thousand-dollar refund secured within 14 days

Public authority: a Local Health District

Complaint overview

A complainant told us about a delay in the reimbursement of a $10,000 by a Local Health District (**LHD**) following his mother's discharge from hospital. The complainant paid the sum out of his own pocket in July 2024, as the LHD had been unable to process insurance claims due to a system issue at the time.

In January 2025, the complainant saw that his insurance company had made the relevant payment to the LHD. Despite following up with the LHD frequently over the next 6 months, the complainant felt he had not received an adequate response.

We made inquiries to the LHD about the reasons for the alleged inaction.

What was the outcome?

As a result of our inquiries, the LHD processed the refund amounting to a sum of $10,000 within 14 days from the date of our letter.

The LHD told us that the lengthy delays had occurred because that hospital had previously been in a public/private partnership and had not had a billing system that could support the required process until December 2024. It also told us that its revenue team were working to address the subsequent backlog, and once it had been addressed the normal processes followed by the LHD would apply at the hospital in question, helping ensure timely reimbursements.

A further outcome of our inquiries was that the revenue team were reviewing the pre-payments accepted by patients and had prioritised contacting patients expecting a refund within 6 to 8 weeks of discharge.

Following the outcome, the complainant contacted us to thank us for our intervention and involvement. He felt he had made the right decision by raising a complaint with us, without which he felt he could not have secured his monies.

What can we learn?

This complaint is an example of the impact that the breakdown of public agency systems can have on members of the public. It also shows how one complaint can result in remedial action for other people affected by the same process.

Visa status discrepancies on enrolment

Public authority: TAFE NSW

Complaint overview

A complainant told us that TAFE NSW would not release their course testamur (graduation certificate) due to conflicting information about their enrolment.

During the course, the complainant had attempted to change their enrolment from a temporary visa status to a permanent visa holder to be eligible for fee-free training. The complainant successfully completed the course. TAFE NSW did not issue the complainant the testamur until the course fees were paid.

The complainant contacted our office 2 years after they had completed the course, after receiving conflicting advice from TAFE NSW teachers about whether the course fees should be waived.

We wrote to TAFE NSW to understand both the eligibility criteria for fee-free training and what had occurred in this matter. TAFE NSW advised us the complainant had unenrolled during the course, and continued to undertake the course whilst unenrolled. TAFE NSW said that it could not provide further advice as to why this occurred, due to staff changes. It told us that the complainant was not enrolled in its system until 2 years after they completed the course.

What was the outcome?

TAFE NSW determined that the complainant was not eligible for fee-free training. However, it agreed to investigate opportunities to adjust their course fees. It issued the complainant their testamur.

TAFE NSW identified opportunities for improvements in ensuring students are correctly enrolled, and in maintaining accurate class records. It used this case example in a team workshop to emphasise the importance of following TAFE NSW policies and procedures.

What can we learn?

This case highlights the need for government agencies to comply with policies and procedures, and ensure staff are trained and maintain proper records. It also highlights how acknowledging errors can lead to organisational improvements – in this case, improved staff training.

An inmate's access to an electric wheelchair

Public authority: Corrective Services NSW

Complaint overview

A man in custody who has partial paraplegia complained to us about delays by Corrective Services NSW (**CSNSW**) in approving access to his electric wheelchair. The man advised us that his National Disability Insurance Scheme (**NDIS**) support worker and his family had been communicating with CSNSW for several months, attempting to seek approval for his NDIS-funded electric wheelchair to be provided to him in custody.

The man told us that he had been using an older style manual wheelchair, which was meant for short term use and was not intended to be sat in for longer periods. He had been sitting in it for up to 14 hours at a time.

We made inquiries with the Governor of the centre to better understand the communication and decisions that had occurred regarding the access request. The Governor referred our inquiries to Statewide Disability Services (**SDS**).

What was the outcome?

We were aware from reviewing the relevant policies and procedures that easily portable mobility equipment purchased by an inmate may be brought into the correctional centre, subject to security inspection.

SDS told us its records reflected that wheelchair access had already been approved and the complainant was already in receipt of this. Our inquiries prompted SDS to further investigate the situation, including communicating with the complainant and the centre.

SDS concluded that there had been some miscommunication. It had understood that the man was already using his own wheelchair (the manual one), had recorded that he was satisfied using it, and were unaware of further requests to access an electric wheelchair.

SDS then promptly arranged to have the man's electric wheelchair delivered to him.

What can we learn?

This case highlights the importance of clear communication across CSNSW teams (and other agencies) when it comes to sharing and recording information about the welfare of a person in custody, especially when they have a disability.

While SDS has a responsibility to assess and action referrals made to it about a person in custody with a disability, it is also the responsibility of CSNSW staff, and that of Justice Health, to inform SDS of any concerns raised to them about a person with a disability.

Improving support for foster carers

Public authority: Department of Communities and Justice

Complaint overview

Foster carers complained to us about a lack of support received from the Department of Communities and Justice (**DCJ**) since December 2024. They told us DCJ's communication had been poor, including providing unclear reasons as to why case management for the children had not been transferred to a local Community Services Centre (**CSC**) or Aboriginal Community Controlled Organisation (**ACCO**) closer to where they and the children lived. Case management had up until then remained at a CSC over an hour away, despite the complainant repeatedly requesting a transfer to a local CSC or a more culturally appropriate ACCO. The complainants also told us about a lack of access to respite options and their concerns about DCJ's poor response to the formal complaint they made in July 2025 about these issues.

We conducted a thorough review of DCJ records. The review showed last-minute cancellation of home visits by case workers and no reference to DCJ working towards a transfer of case management to another office or agency. There was also no record of any communication with the complainants following the formal complaint they had made.

We made preliminary inquiries of DCJ to determine why transfer of case management had not yet occurred, and which respite options had been explored and discussed with the foster carers. We also sought further information about its response to the formal complaint that had been made to it.

What was the outcome?

DCJ arranged for the complainants to meet with 3 senior DCJ staff to discuss their concerns in detail and resolve the issues. DCJ apologised to the complainants and advised that it had since taken steps to ensure that they and the children receive the services and supports that are considered appropriate at this time (including regular respite). DCJ acknowledged that a transfer of case management should have occurred and committed to doing so. The complainants told us that since we had contacted DCJ the situation had greatly improved, and that they now felt heard.

What can we learn?

This matter demonstrates the importance of agencies listening to the needs and concerns of foster carers in service delivery and case management. In situations where there is a lack of support received, there is a risk that authorised carers could decide to relinquish care. In this case, the foster carers were struggling and tried to raise their concerns in an appropriate way, but they were not being heard. We were able to prompt the agency to think about what changes needed to be made. The agency was then able to resolve the issues at the local level.

Strip searches in NSW correctional centres

Public authority: Corrective Services NSW

(Warning: graphic content)

Complaint overview

We received multiple complaints from inmates across several different correctional centres raising concerns about being directed to retract their foreskin as part of a strip search. The complainants were concerned that this direction was unlawful.

We made inquiries with Corrective Services NSW (**CSNSW**).

What was the outcome?

We found that relevant policy, guidance and training materials were unclear and inconsistent. The relevant policy did not make clear that officers were not to request an inmate to retract their foreskin, stating only that officers may 'instruct the inmate to:

- Lift the penis then the scrotum and
- Abdomen or skin folds, if applicable.'

Custodial training unit guidance included that, in the event an officer believes an inmate is secreting contraband, they must not direct an inmate to roll back their foreskin. However, the same training also identified that inmates may secrete contraband in 'skin fold/crevice', including the foreskin and stated that 'if an officer suspects that an inmate has contraband concealed in their scrotum, breast or other skin folds, they may direct an inmate to lift those areas.' The training also contained a note that officers can use force to retrieve contraband secreted on an inmate except when it is secreted within a skin fold.

CSNSW acknowledged that its policy and the training provided to officers were at odds with one another regarding whether it could direct an inmate to retract their foreskin during a search.

It told us it has now reviewed and updated its Custodial Operations Policy and Procedures and training to ensure they align and clearly state that officers are prohibited from directing an inmate to retract their foreskin.

What can we learn?

This case highlights the importance of clear and consistent policy and training guidance, particularly where practices intersect with human rights, privacy and bodily integrity.

Child placement principles met for an Aboriginal child in care through local resolution referral

Public authority: Department of Communities and Justice

Complaint overview

A family member of an Aboriginal child (who was under the care of the Minister for Families and Communities) contacted us, telling us that despite attempts by family members to place the child in their community of belonging and with family, the child was still placed with foster carers about 3 hours away from their family.

We referred the complaint for local resolution between the complainant and the Department of Communities and Justice (**DCJ**).

What was the outcome?

DCJ completed further family finding, and finalised kinship carer assessments for the child's maternal uncle and aunty. The child was moved into their new placement with their family within their community of belonging, meeting Aboriginal child placement principles. Additionally, DCJ progressed with assessing the family member who contacted our office as a potential respite carer for weekends. This would ensure that the child grows up surrounded by family, culture and their connection to Country.

After the referral for local resolution, DCJ caseworkers acted promptly and enrolled the child in daycare for the remainder of 2025, and in their new primary school for 2026 close to their new placement. As the child is closer to their family and community of belonging, quality family time can now occur with less time spent on travelling.

What can we learn?

This case shows how an agency (in this case, DCJ) can include family in decision-making processes, and the importance of family finding for Aboriginal children so they can be surrounded by culture and family while in care. This also provides an opportunity to improve service delivery to vulnerable communities that may experience distrust with agencies due to historical experiences.

Taking action on young people's complaints

Public authority: Youth Justice NSW

Complaint overview

In August 2025, while routinely reviewing youth justice notifications (which we receive whenever a child in detention is segregated or separated from other children for a period exceeding 24 hours), we noticed that a young person had told their case worker that they felt that force recently used on them in the centre was excessive.

From the information available, it was not clear whether the youth justice centre in question had registered the complaint made by the young person and whether appropriate action had been taken regarding their concerns.

We made preliminary inquiries with the youth justice centre, which advised that the complaint raised by the young person had not been formally registered as a complaint. We were also advised that a case manager had raised the matter with a unit manager, and the young person was spoken to about the incident. The young person declined to proceed with the complaint and requested that no further action be taken.

What was the outcome?

The centre advised that contact had been made with the young person, their complaint had now been formally registered, and a summary of the allegations had been submitted to the Conduct and Professional Standards Unit for review of the alleged excessive use of force.

The centre issued a reminder to the involved staff about their responsibility to immediately report complaint matters to management, to ensure transparency when allegations such as these are made. It also reminded staff of the requirement to formally register complaints raised by young people.

What can we learn?

It is important to listen to young people in custody when they are raising concerns relating to their treatment. Agencies, including Youth Justice NSW should register the complaints of young people and take appropriate action. Any allegation of staff misconduct should be appropriately referred so that an assessment can be undertaken to determine what action, if any, should be taken.

Fees waived due to administrative delay and staffing issues

Public authority: NSW Trustee and Guardian

Complaint overview

We received a complaint about a woman in her 90s who was subject to a financial management order that was managed by NSW Trustee and Guardian (**NSWTG**). The complainant, the son of the woman, told us that she had been living with less than $50 a fortnight for living expenses, even though she owned a 50 per cent share of a $3 million house along with another family member. There were conflicting views in the family about whether the house should be sold.

After making preliminary inquiries with NSWTG, we identified that the home should have been put to market more than 12 months prior. However, due to administration delays and staffing issues, this had not progressed, leaving the client with limited funds for a prolonged time. We made suggestions to NSWTG that it refund 12 months of management fees and consider covering a higher daily cost that the client had been paying for her aged care, given she did not have the ability to put down a refundable deposit without the sale of the home.

What was the outcome?

NSWTG agreed to waive management fees – not just for the 12 months we suggested, but for the full period it had been managing the client's finances to the sum of $21,300. It also agreed to pay the additional costs that the client had been paying for higher fees while living in an aged care facility. NSWTG also met with the family to discuss ways to resolve the issues and agreed to cover any costs the son would incur to provide his mother with a higher quality of life, which would be taken out of the proceeds of the sale of the house.

What can we learn?

This matter illustrates the value of agencies using their lawful discretion in circumstances where it will lead to a fairer outcome. It is also a good example of the impacts that can arise from delays and the importance of responsive organisational and complaint systems that support timely and effective resolution of concerns raised.

Improving casework delivery to support young people

Public authority: Department of Communities and Justice

Complaint overview

A mother complained to our office after her child was removed from her care. She raised concerns that the Department of Communities and Justice (**DCJ**) were restoring the child to their father, who has a significant history of perpetrating domestic violence towards the complainant.

Our inquiries indicated that DCJ had not adequately assessed, understood, recorded or responded to the violence used by the father. The child had also been exposed to the father's use of violence on multiple occasions.

What was the outcome?

We made suggestions to DCJ for the DCJ's Office of the Senior Practitioner (**OSP**) to review the child's case – taking into account the father's history of domestic violence against the complainant, DCJ's assessment of the father's use of violence, and the child's ongoing safety.

We also requested:

- that DCJ provide our office with a copy of the OSP review and any recommendations made to the casework team, and
- an update about the child's care in 6 months' time.

DCJ accepted all of our suggestions. The OSP completed a review of the child's case, which included recommendations for urgent casework to ensure that the child's needs are met and their best interests considered. The casework team sought feedback from the coordinator of the men's behaviour change program (which the father was undertaking) and sought the father's understanding and learnings following completion of the program.

The review was shared with the district and leadership team to form basis of reflective discussion. The concerns of our office and DCJ's response were provided to the Children's Court as part of the s 82 report of the *Children and Young Persons (Care and Protection) Act 1998*. The leadership team accepted the review and its recommendations, and immediate action was taken to better understand the child's current and future safety. DCJ also sought to pause the child's return to their father until these recommendations were actioned.

What can we learn?

This case provides a good example of the importance of agency's internal review functions, and the importance of holistic casework for children and young people, particularly in situations where the safety of a child or young person is potentially at risk. It is also an example of how our office assisted with drawing attention and focus of individual case management decisions to the experiences of the individual.

CCTV confirms damaged number plates

Public authority: Service NSW

Complaint overview

A complainant told us that he had retrieved number plates that had been in storage at a Service NSW centre. He paid the $64 fee and the number plates were reissued to him in plastic wrap, then after walking out of the service centre he inspected the plates and noticed that they were dented in several places. He re-entered the service centre to request a refund. Service NSW staff refused to provide a refund because the complainant had left the service centre carpark and had therefore 'used' the plates. The complainant denied having left the carpark with the plates.

We made preliminary inquiries with Service NSW, asking it to review the CCTV footage.

What was the outcome?

Service NSW agreed that the complainant did not leave the centre. It offered the complainant a full refund and an apology.

What can we learn?

This case highlights the importance of government agencies being open to reviewing available information and rectifying mistakes or otherwise changing their position. It also identifies the importance of agencies being willing to exercise reasonable discretion when making decisions. It was open to the staff at the Service NSW centre to resolve the complaint on the same day by using their discretion to exchange the number plates or provide a refund, but in this case that did not occur. It also provides an example of how our office's inquiries can open up opportunities to better understand agencies' processes and identify how mistakes can be made in the handling of complaints.

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

Communication

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

Taking ownership

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

Timeliness

Your organisation will:

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

Tell complainants what you do with their information

Transparency

Your organisation will:

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

Pursuing fairness for the people of NSW.

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