

Casebook July 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

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 July 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 January 2026 to 30 June 2026, 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

31 July 2026



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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 (PID Act)*.

Under the *Ombudsman Act 1974 (Ombudsman Act)* the Ombudsman may conduct an investigation into the conduct of a public authority¹ or a community service provider² 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 January 2026 and 30 June 2026.
- 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 formal investigations finalised between 1 January and 30 June 2026.

When and how we conduct investigations

Investigations are an essential tool for holding agencies to account. We can start an investigation of our own motion, or following complaints and public interest disclosures that indicate serious maladministration by an agency may have occurred. Maladministration is a term used to describe administrative conduct that is unlawful, unjust, unreasonable, improperly discriminatory or otherwise wrong. 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.

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 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. We can also undertake inspections and conduct hearings under oath.

When we finish an investigation, we will report what we found and what we consider should happen next. Any agency or individual subject of proposed findings by us are given an opportunity to respond before we make a final report.

Examples of recommendations we may make include that an 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 42 recommendations in respect of the investigations reported in this casebook. Of these, 13 have been fully accepted, 1 accepted in principle and we are waiting for agency responses on 28 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. We made 1 report of this nature during the reporting period. On 2 March 2026, we tabled a report titled, *The progress of NSW's inmate discipline system reform*⁵ where we raised concerns that insufficient action had been taken to reform the inmate discipline system in response to our 2024 investigation.⁶

⁵ Available at www.ombo.nsw.gov.au: [The progress of NSW inmate discipline system reform](#).

⁶ Available at www.ombo.nsw.gov.au: [Investigation into inmate discipline in NSW correctional centres](#).

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.⁷

Introduction to the investigations

Six investigations finalised in the above 6-month period have been included in this casebook.

The investigations examined how public authorities discharged their statutory role across a diverse spectrum of services and responsibilities in areas with significant impacts on individuals and the NSW community.

The summaries include investigations about the handling of reports concerning children at risk of significant harm; a local council's lack of enforcement of fire safety obligations at a residential building; audit processes and debt recovery of government grants; delays in adjusting workers compensation premiums; the treatment of a public housing tenant's personal property, and inmates in protective custody not having access to daily exercise.

While each investigation focused on a different area of public administration, all identified shortcomings relating to delay, inaction and poor communication with affected people – often exacerbating harm or distress. Another theme across many of the matters was failures in governance, including inconsistent application of policy, gaps in policy and lack of guidance for staff, which undermine the fair and effective performance of statutory functions.

All 6 investigations resulted in findings of wrongdoing and several recommendations for improvements. Five of the investigations were tabled separately in Parliament as special reports under s 31 of the Ombudsman Act.

⁷ Section 28 CS CRAMA.

No capacity to allocate

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:	6 February 2026
Findings:	Conduct that was unreasonable (including by reason of being inconsistent with statutory responsibilities)
Recommendations:	Policy review and reform; legislative review; staff training. 4 recommendations were made, all 4 recommendations were accepted by DCJ.

A full report of this investigation was tabled as a special report to Parliament in February 2026. A copy of that report is available here: [“No capacity to allocate” – The Department of Communities and Justice’s practice of closing ROSH \(Risk of Significant Harm\) reports](#)

We commenced an own motion investigation into the Department of Communities and Justice’s (DCJ’s) practice of closing a large proportion of reports it receives about risks of significant harm (ROSH) to children and young persons without a face-to-face assessment, and without being assured that the child is not at ROSH.

In 2024-25, DCJ received 244,710 ROSH reports. Based on a stated reason of lack of capacity or competing priorities, DCJ closed 64% of these reports without allocating them to a caseworker for further assessment.

We made findings of maladministration and made recommendations that include legislative and policy review, as well as immediate improvements to practices while a longer-term reform is finalised.

Background

Determining whether a child or a young person is at risk of significant harm is typically the first step in considering any child protection intervention in respect of that child. It is one of DCJ’s core responsibilities under the *Children and Young Persons (Care and Protection) Act 1998* (the **Care Act**). Our investigation sought to examine DCJ’s practices involved in triaging and assessing the ROSH reports it receives and assess whether they are aligned with the requirements of the Care Act.

What did we find?

We made comprehensive observations and findings in our [report](#) tabled in Parliament.

We found that:

- The closure problem is significant: the closing of cases based on resource limitations has become ‘business as usual’ and a tolerated cultural norm within DCJ.
- DCJ’s triage policy, which generally provides (with some exceptions) that where a ROSH report is not allocated to a caseworker for a face-to-face assessment within 28 days, it is to be closed, is not consistent with DCJ’s statutory responsibilities under the Care Act.
- DCJ has tolerated confusion and delayed clarifying its legislative responsibilities with staff. It failed to provide guidance or tools to staff to enable them to accurately and comprehensively document any substantive assessments they had made before deciding to close ROSH reports.
- There are concerning practices when deciding which ROSH reports receive a response: our staff survey results confirmed anecdotal evidence that performance targets had created an incentive for some staff to preference or avoid allocating certain ROSH reports.
- Similarly, ROSH reports with less immediate but longer-term risks to the child – such as chronic neglect, whether medical or educational – tended to be de-prioritised. In cases involving children or carers with disability, the involvement of other services was too often treated as a reason not to allocate a ROSH report to a caseworker.
- Even when reports were allocated for a face-to-face assessment, DCJ has struggled to meet the response timeframes specified during the initial triage of the ROSH report. This means that allocation does not always result in timely and adequate support.
- DCJ under-utilises desktop investigation and does not always collect reasonably available information when triaging ROSH reports or fails to follow up requests issued to third parties. We observed cases where multiple reports (that indicated escalating risk) were repeatedly closed based on a lack of capacity to allocate to a caseworker. This occurred even in cases where earlier closure decisions had recommended that any further reports received should be allocated.

We also made additional observations and findings about DCJ’s over-reliance on, and failure to review, its structured decision-making tools.

What did we recommend?

We recommended that:

- DCJ undertake a comprehensive review and reform of its ROSH and related policies, practices and tools.
- The Government consider whether the relevant provisions of the Care Act should be reviewed and improved.
- DCJ should then roll out comprehensive training to all relevant DCJ staff in the revised policies and on the principles and practices of good decision-making, aligned with the Care Act.
- In the meantime, DCJ should make changes to its practices, including stopping the practice of closing unallocated reports after 28 days, addressing the over-reliance on the involvement of other services when making allocation decisions and improving its recording of decisions.
- DCJ should also review its use of structured decision-making tools and provide better guidance to staff making decisions about whether a child is not at risk of significant harm.

All recommendations were accepted by DCJ, with an action plan developed to address each of the recommendations. Implementation of the action plan is underway and we will continue to monitor DCJ’s progress.

Enforcement of fire safety obligations at a residential building in Lane Cove

The case of Lane Cove Council

Public authority:	Lane Cove Council
Responsible minister:	Minister for Local Government
Investigation report issued:	25 May 2026
Findings:	Conduct that was unreasonable and contrary to law
Recommendations:	Apology; confirmation of actions to rectify outstanding fire safety issues; provide annual fire safety statements; provide progress update of implementation of recommendations from external auditors; audit the fire safety register and advise us of outcome of audit. There were 6 recommendations made, all 6 were accepted by Lane Cove Council. 2 have been fully implemented and the remaining in progress.

A full report of this investigation was tabled as a special report to Parliament in May 2026. A copy of that report is available here: [Investigation into enforcement of fire safety obligations at a residential building in Lane Cove](#)

We investigated Lane Cove Council's (**Council**) actions in regulating and enforcing fire safety requirements at a mixed-use strata premises in Lane Cove following a complaint from the chair of the owner's corporation for the residential part of the building. Council had developed (and continues to partially own) the premises.

Council failed to rectify known fire safety defects, including at a multi-storey residential building on the premises. Council failed to comply with applicable legislation by failing to obtain annual fire safety statements for the premises. It took no enforcement action for continued non-compliance against the building owners, including Council itself as a part-owner of the premises.

Council also had inadequate systems to manage the inherent conflicts of interest that may arise when councils hold multiple potentially conflicting roles, such as when they are the landowner, developer, and regulator for the same development.

We made several recommendations to ensure that compliance is achieved, and Council improves its processes for managing conflicts and complying with fire safety requirements.

Background

Council had developed one of its existing sites in Lane Cove to provide additional parking and a connection to other facilities. Part of the development included the construction of a multi-storey residential building on top of Council's car park and commercial office spaces.

Following subdivision, Council had retained ownership of 5 lots. The newly constructed residential building, consisting of approximately 107 apartments, became lot 6.

Now, a number of years later, the chair of the owners corporation for the residential building complained to us that Council had not taken appropriate action to fix multiple defects in the building, including fire safety issues, and had failed to enforce regulations requiring building owners to provide annual fire safety statements. A separate investigation by the NSW Building Commissioner confirmed there were serious fire safety defects in the building.

What did we find?

We found that Council's conduct was unreasonable because it:

- failed to address fire safety non-compliance at the premises for 7 years
- failed to exercise its discretion to take enforcement action against the building owners, including itself, and this was contrary to its usual approach to enforcement.

Council also acted contrary to law. As the owner of 5 lots, it was required to provide annual fire safety statements for the buildings it owned. As the majority owner and a member of the building management committee, it should have taken the lead role in arranging annual fire safety statements for the entire premises, but it failed to do so for 7 years.

What did we recommend?

We recommended that Council:

- apologise to the owners corporation, and provide written confirmation of actions it has taken or intends to take to rectify any fire safety issues that may still be outstanding
- provide the Ombudsman with a copy of the annual fire safety statements for the premises, and provide updates of the progress made in implementing recommendations made by an external audit of building compliance and fire safety
- audit Council's fire safety register for all buildings required to submit annual fire safety statements, and advise us of the outcome.

Lane Cove Council accepted all recommendations. Apologies and written confirmation of actions to address fire safety issues have been sent to the owners. We will continue to monitor implementation of the remaining recommendations.

Covid grants audit program

The case of Service NSW and Revenue NSW

Public authorities:	Service NSW and Revenue NSW
Responsible ministers:	Minister for Customer Service and Digital Government and Minister for Finance
Investigation report issued:	28 April 2026
Findings:	Conduct that was wrong
Recommendations:	Improvements to grant audit processes and policy documents; provide better information to grant applicants; conduct a review of auditees found ineligible at audit, to see if their debt should be refunded. There were 7 recommendations made, all are awaiting response by Service NSW and Revenue NSW.

A full report of this investigation was tabled as a special report to Parliament in April 2026. A copy of that report is available here: [Investigation into the compliance audit program for COVID grants](#)

We investigated how Service NSW and Revenue NSW audited certain businesses that had received grants during the COVID-19 pandemic following a series of complaints from affected businesses. We also looked at how any debts raised following audits were recovered.

We found that the audit program was not supported by a consistent framework. The approaches taken by both Service NSW and Revenue NSW changed over time, resulting in inconsistent treatment of applicants and in some cases leading to financial stress.

To prevent similar issues arising in future, we recommended that both agencies make improvements to their grant audit processes and supporting policy documents. We recommended that clear information should be provided to applicants for any future grants about the nature and extent of automated approvals. We also recommended that certain groups of audited applicants should be reviewed to confirm whether their debts should be refunded.

Background

During the COVID-19 pandemic, part of the NSW Government's response included financial support to businesses. This included 3 grants: the Business Grant (a one-off cash payment to businesses), the JobSaver Payment (fortnightly cash payments to help businesses maintain employee headcount) and the Micro-Business Grant (weekly cash payments to small businesses). The 3 grants were open between July and October 2021 and cost a combined total of \$10.7 billion. They provided payments to almost 300,000 businesses in New South Wales.

In many cases an automated system was used to process the grant applications. Rather than evaluating applications against the eligibility criteria, it relied on applicant's self-declaration of their eligibility. Not all applications were reviewed by staff from Service NSW or Revenue NSW to confirm eligibility. This meant that some businesses that did not meet eligibility criteria were approved by the automated system and received grant payments to which they were not entitled.

After the audit program began in late 2021, we began receiving complaints from affected businesses that claimed they applied for grants in good faith, honestly believing they were eligible. Some even told us they received advice from agency staff that had encouraged them to apply as they appeared to meet the criteria. Many reported experiencing financial and psychological stress.

What did we find?

The audits were implemented as essentially an ‘after-the-fact’ eligibility assessment by the agencies.

The errors made during the application period – including system errors and incorrect advice given by staff on eligibility criteria – were not consistently taken into account when deciding whether to take steps to recover a debt or otherwise exclude a grant recipient from the debt recovery process.

Some applicants were exempted from audits due to system errors, while others were not. Policies on exemptions, hardship, and alternatives to enforcement were introduced iteratively and late in the compliance program. While basic procedures and work instructions existed, the lack of a comprehensive audit framework from the outset of the audits meant similar cases were treated differently, leading to inequitable outcomes.

Discretionary measures – including allowing applicants an ‘offset’ if they were assessed to be ineligible for the grant they received but would have been eligible for a different, lesser grant, had they applied for it – were also inconsistently applied.

Audited applicants were sometimes assessed against interpretations of guidelines that had not been communicated at the time they applied. The imposition of the debts following the audits led to financial stress for many small businesses, something the Covid-19 grants had been intended to prevent.

Early audit communications were perceived as harsh and threatening. Over time, the tone of communication improved, but issues remained, including unreasonably short and inconsistent timeframes for responding to audits, including requests for further information, and inadequate explanations for audit outcomes.

What did we recommend?

We made recommendations aimed at improving future compliance programs by:

- increasing transparency about grant approval processes
- establishing comprehensive audit methodologies from the outset
- ensuring consistent application of policies and
- providing clear communication about eligibility, audits, and hardship provisions.

We also recommended that outcomes for particular cohorts of grant auditees should be reviewed with a view to rectifying inequitable outcomes.

We are awaiting a response from Service NSW and Revenue NSW regarding our recommendations.

Delays processing hindsight adjustments

The case of Insurance and Care NSW

Public authority:	Insurance and Care NSW
Responsible minister:	Minister for Industrial Relations and Minister for Work Health and Safety
Investigation report issued:	29 May 2026
Findings:	Conduct that was unreasonable
Recommendations:	Apology; offer appropriate payment plans to complainants; provide a written report on the outcomes of a remediation plan. There were 4 recommendations made, all 4 were accepted by Icare, 2 have been fully implemented and the remaining in progress.

A full report of this investigation was tabled as a special report to Parliament in May 2026. A copy of that report is available here: [Investigation-into-icare-processing-of-actual-wage-declarations-and-hindsight-adjustments-to-workers-compensation-premiums-report](#)

One of the functions of Insurance and Care NSW (icare) is to provide workers compensation insurance to employers in NSW and their employees.

We began an investigation after receiving complaints from 6 employers suggesting that icare had been significantly delayed in adjusting their workers compensation premiums based on the actual wages they paid to their employees, which they had declared to icare as required. We looked at the systems, processes and procedures icare uses in processing actual wage declarations and making the consequent premium adjustments, known as 'hindsight adjustments'.

We found that icare's conduct was unreasonable as, although it knew from 2017 that it had a substantial number of unprocessed hindsight adjustments and that there were problems with its software that impacted on timely processing, it did not fix the issues until 2025. The delays impacted individual employers and also risked undermining the integrity of the workers compensation scheme.

We recommended that icare formally apologise to the complainants and negotiate appropriate payment plans relative to their financial circumstances. We also asked icare to provide us with a written report about the outcome of its remediation plan.

Background

The purpose of a hindsight adjustment to a workers compensation premium is to ensure that an employer pays a fair, accurate, and transparent premium that reflects the wages they actually paid, rather than the wages they estimated they would pay at the start of the insurance year (and on which their premium is originally calculated). Hindsight adjustment is an important mechanism that ensures that employers maintain appropriate levels of workers compensation insurance and allows icare to maintain the financial viability of the workers compensation scheme.

The 6 insured employers who complained to us told us that delays in adjusting their premiums resulted in substantial unexpected invoices and caused them financial hardship.

In each case, the employers had lodged their actual wage declarations with icare in accordance with the legislative timeframe – that is, within 4 months following the close of the insurance year. The employers received invoices for hindsight adjustments much later than this, ranging between 12 months and 3 years later. Two employers received substantial invoices for multiple years, with only 3 months given to pay the debts.

What did we find?

Between 2017 and 2023 there were systemic failures that caused unreasonable delays in processing hindsight adjustments.

In 2017, icare inherited a backlog of 55,000 unprocessed hindsight adjustments when it took over policy and billing functions from scheme agents across the workers compensation scheme. Although the legislation does not impose processing timeframes on icare, as a general principle all statutory functions must be exercised reasonably – including in respect of timeframes.

icare's software was not adequately configured to process hindsight adjustments automatically until 2023. Administrative oversights – including the erroneous closure of files – further worsened delays. icare only implemented internal timeliness metrics for processing hindsight adjustments in 2023.

icare implemented a remediation plan in 2025 and has now identified and processed all outstanding actual wage declarations for active policies it received between 2019 and 2024.

We made findings of unreasonable conduct because of icare's failure to:

- process all actual wage declarations between 2017 and 2023 within a reasonable timeframe
- implement software fixes within a reasonable timeframe once it knew there were problems with its software that impacted on timely processing and incorrectly closed files
- ascertain the extent of the unprocessed actual wage declarations until June 2025
- implement a sufficiently rigorous remediation plan to identify and process incorrectly indexed actual wage declarations until June 2025.

What did we recommend?

We recommended that icare:

- apologise to the employers with active policies who complained to us for the delays in processing their actual wage declarations and negotiate appropriate payment plans with any that had outstanding debts
- provide us with a written report that details the outcomes of the remediation plan, including any apologies and payment plans offered to any other affected employers
- provide us with copies of any further internal or external audits conducted as assurance that hindsight adjustments are being processed in accordance with the timeliness metrics and controls identified in icare's remediation plan.

icare accepted all recommendations and has apologised to the affected employees and negotiated payment plans. We will monitor icare's implementation of the outstanding recommendations.

The disposal of a tenant’s property after sewage overflows

The case of Homes NSW

Public authority:	Homes NSW ⁸
Responsible minister:	Minister for Housing
Investigation report issued:	11 June 2026
Findings:	Conduct that was unreasonable
Recommendations:	Compensate and apologise to the complainant; develop procedures for disposing of tenants’ contaminated property, and review how insurance claims are responded to. There were 5 recommendations made, all 5 were accepted by Homes NSW.

We investigated Homes NSW’s conduct in disposing of an elderly tenant’s household contents after several sewage leaks at her unit, which contaminated and damaged her property. We also looked at how Homes NSW communicated with the tenant and her advocates, and how it handled her subsequent insurance claim, which was rejected.

We found that Homes NSW’s conduct was unreasonable, and that the disposal of the tenant’s property happened without her consent and contrary to what she was initially told. The insurance company handling the claim was not provided with full and accurate information about the claim.

To remedy the impact on the tenant, we recommended that Homes NSW apologise to her and pay full compensation for the value of her destroyed property, including for the distress she suffered in pursuing her complaint over 5 years. In addition, we recommended development of property disposal procedures and a review of how insurance claims are handled.

Background

An elderly woman who lived in a public housing unit for over 15 years complained to us that 3 successive sewage overflows had occurred at her unit within 3 months, resulting in raw sewage entering her unit. After the last and worst sewage overflow, the tenant was relocated but her property remained at the contaminated unit for a further 2 months until it was boxed up and moved into a vacant unit. The property – which included furniture, household items, an extensive book collection and family heirlooms – was not cleaned.

Homes NSW told the tenant that she would have an opportunity to go through her belongings with Homes NSW and contractors and decide which items could be cleaned and returned to her. Any items deemed non-salvageable were to be disposed of, and the tenant compensated after lodging an insurance claim. Homes NSW staff assured her that she would be actively involved in the decision to keep or dispose of any items.

⁸ Homes NSW was established in February 2024 as a central unit within the Department of Communities and Justice that coordinates the tenancy, asset, and Aboriginal Housing functions. Many of the events in this investigation predate the establishment of Homes NSW.

Despite these assurances, the contractor engaged by Homes NSW disposed of all of the tenant's contaminated property without her consent. The tenant was then assured that she would be adequately compensated through an insurance claim. However, Homes NSW failed to provide full and accurate information to the insurer. When the tenant submitted the claim, Homes NSW's insurer denied liability and offered her a small amount of the value claimed as a 'goodwill' gesture.

What did we find?

Homes NSW's conduct was unreasonable because it:

- failed to take active steps to mitigate further damage to the tenant's property after her unit was contaminated by sewage. Her property was not protected as it was left in the unit for over 2 months and not cleaned
- did not follow the process it outlined to the tenant and disposed of her property without obtaining her consent.

Homes NSW also failed to provide full and accurate information to the insurer to inform its decision on whether to accept liability. It did not inform the insurer that the disposal of the tenant's property was not in accordance with any agreement, documented procedure or the tenant's consent.

What did we recommend?

We recommended that Homes NSW:

- apologise and compensate the tenant in full in accordance with her itemised compensation claim, and provide an additional amount for the distress and suffering she experienced while trying to resolve her claim for over 5 years
- develop procedures and guidelines for disposing of tenants' contaminated property
- review its procedures for responding to insurance claims to ensure all relevant information is gathered and disclosed.

Homes NSW has accepted all the recommendations and advised that the tenant will receive an apology and will be fully compensated for the disposal of her property by the end of August 2026.

Treatment of protective custody inmates

The case of Corrective Services NSW

Public authority:	Corrective Services NSW
Responsible minister:	Minister for Corrections
Investigation report issued:	16 June 2026
Findings:	Conduct that was oppressive, unlawful, and wrong
Recommendations:	Conduct review of policies and procedures, provide training and ensure compliance with relevant legislation. There were 16 recommendations, all which are awaiting an agency response from South Coast Corrective Services.
A full report of this investigation was tabled as a special report to Parliament in May 2026. A copy of that report is available here: Investigation into the management and treatment of inmates at South Coast Correctional Centre	

The investigation examined the treatment of inmates held in protective custody at South Coast Correctional Centre (**South Coast CC**) and several other centres following a number of complaints from inmates. It found that inmates were effectively locked in their cells 24 hours 7 days a week without access to daily outdoor exercise and no access to contact visits or other meaningful human contact. The conditions they were held in resembled solitary confinement, which in some cases extended over a period of weeks.

We recommended Corrective Service NSW (**CSNSW**) conduct regular reviews of inmates in protective custody, reinstate the ability of those inmates to associate with one another where appropriate, review its protective custody procedures and provide training to staff on recordkeeping. We further recommended that correctional centres should notify assistant commissioners whenever any inmates were unable to access their daily exercise entitlements for 3 continuous days or more.

Background

We started the investigation after receiving complaints in April 2025 from a number of inmates who were held in protective custody at South Coast CC. Inmates in protective custody are kept separated from the mainstream population because of a threat to their safety, rather than as a punishment. The inmates told us that they had been locked in their cells for 24 hours a day for periods ranging from 2 weeks to 3 months.

The law requires that all inmates be offered access to daily exercise in the open air for a minimum of 2 hours.⁹ Inmates who are in protective custody retain the same legal entitlements as inmates in the general population.

Prolonged confinement to a cell without access to exercise can lead to significant physical deterioration and psychological harm and can compound the challenges inmates face when reintegrating into society upon release.

⁹ Clause 53, *Crimes (Administration of Sentences) Regulation 2014* (the only exception is inmates being confined as a punishment, who are entitled to 1 hour).

What did we find?

Since 2020, inmates who needed protection were either held in isolation from all other inmates under 'protective custody orders' or under another mechanism known as 's 78A orders', which allowed them limited association with other similar inmates.

In July 2024, CSNSW received legal advice that s 78A orders did not provide a separate head of power to separate inmates from the general prison population. Six months after receiving that advice, all centres were directed to cease using s 78A orders. Inmates who were separated under such orders were to be transitioned to another placement or order. This resulted in a large increase in the number of inmates being placed on protective custody orders. Inmates moved from a situation where they were being held together as a cohort, to one where they were required to be fully isolated from every other inmate.

The sudden increase in protective custody inmates quickly exhausted the facilities that are available at centres for such inmates. The 'overflows' of protective custody inmates were placed in other areas within centres, where providing access to yards (in isolation from all other inmates) was more challenging. Staffing shortages exacerbated the problems, particularly given that more protective custody inmates require increased staffing to facilitate and supervise time out of cells.

At South Coast CC, overflow inmates were placed in a reception area (with no dedicated yards attached) intended to house inmates only for a short period of time pending their transition to the general prison population. The inmates were effectively confined to their individual cells and denied access to exercise in the open air for prolonged periods. They were also restricted to non-contact visits with family or friends.

The increase of protective custody inmates following receipt of the legal advice and the directive to centres to cease using s 78A orders to separate inmates were clearly foreseeable and should have been planned for. In the six months between the legal advice and the directive no action was taken to prepare for the influx.

We found that CSNSW failed to identify and manage foreseeable risks that came from the change.

We also made findings that keeping protective custody inmates, both at South Coast CC and other centres, for prolonged periods of time without access to daily open-air exercise unlawful and oppressive.

The denial of contact visits for inmates at South Coast CC was also unlawful. The housing of those inmates was also not properly authorised or recorded, and was unlawful and otherwise wrong as a breach of policy.

What did we recommend?

We made 13 recommendations, including that CSNSW:

- conduct regular reviews of protective custody inmates' placement
- re-instate the placement option to allow cohorts of protective custody inmates to associate with one another where appropriate
- review and update the relevant policy to reflect legislation, and improve record keeping and review processes for protective custody inmates
- require correctional centres to notify the relevant assistant commissioner if any inmate is not able to access the required 2 hours of daily exercise for 3 continuous days or more
- review the decision made by South Coast CC to restrict protective custody inmates to non-contact visits
- conduct training for all senior staff in recordkeeping.

We are awaiting a response from Corrective Services NSW regarding our recommendations.

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 January to 30 June 2026.

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 portal. 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 January 2026 and June 2026, we received 8913 ‘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 the 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.

The case studies 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.

There are several recurring themes in this casebook:

- A prominent theme is the importance of taking steps to understand the needs of people with disability and responding in a way that ensures that services, and complaint handling processes, accommodate those needs in a way that preserves the dignity of the individual.

Examples in this casebook include the need to avoid assumptions that supports are not required without consulting the person who disclosed a disability in a health complaint, Corrective Services NSW allowing an inmate in a wheelchair a sufficient period to shower effectively, and in another, taking an inmate's mental health into account prior to applying penalties where it was a mitigating factor.

Treating inmates with dignity is also a theme in case studies in which young people regained access to photos taken with visiting football players, and improvements to strip search policies.

In Community Services, a complaint from a parent about poor communication by a service provider responsible for the case management of their child highlights the importance of recognising a person's individual circumstances, including their disability and mental health and responding in a trauma-informed way.

- Another recurring theme is the importance of utilising discretionary powers to remedy unfairness caused by administrative errors.

Examples in this casebook included waiver of a \$44,990 TAFE debt for a student who had not been informed she was not eligible for a VET loan and was not able to withdraw or make an informed decision about the financial impact of proceeding with the course.

The importance of clear communication and, where appropriate, complaint escalation were also evident in complaints restoring a Homes NSW tenant to the housing waitlist that she had been removed from without notice, and another family whose financial and health circumstances were affected by delays in handling their complaint about repairs and other issues.

- The importance of effective complaint handling is another theme in this casebook.

The role of agency heads and senior leaders in fostering a culture where complaints are valued is evident in the case study about Central Coast Council.

Clear communication as the basis for service delivery

Public authority: NSW Trustee and Guardian

Complaint overview

A family member complained that the NSW Trustee and Guardian (**NSWTG**) took 6 years to finalise a deceased estate and distribute funds to the beneficiaries. They also complained about unclear communication regarding the NSWTG's procedures for withholding funds in reserve for tax, and the distribution of the deceased's personal items to the beneficiaries of the estate.

We made inquiries with the NSWTG.

What was the outcome?

We found that the NSWTG could have communicated with the beneficiaries more effectively, including providing advice regarding tax reserve and the distribution of the deceased's personal possessions. We found there was an opportunity for the NSWTG to apologise to the beneficiaries and refund any estate management fees that could have been avoided. We also identified that the NSWTG's *Easy to Read Guide for Beneficiaries* and the general *Guide to Beneficiaries*, available on its website, did not clearly outline some procedures regarding a deceased estate.

We made 6 suggestions under s 31AC of the Ombudsman Act with a focus on improving service delivery and communication with the beneficiaries of an estate.

The NSWTG accepted all 6 of our suggestions, including apologising in writing to the complainant for its unclear communication and to all of the beneficiaries for the delays in finalising the estate. NSWTG also updated information in its *Easy to Read Guide for Beneficiaries* regarding reserve tax and the distribution of personal possessions. NSWTG collaborated with the Council for Intellectual Disability to update the *Easy to Read Guide for Beneficiaries* and the general *Guide to Beneficiaries*, which are both now available on its website, with printed copies available in its Parramatta, Broken Hill and Newcastle offices.

What can we learn?

Clear, timely communication is particularly important when administering complex and sensitive services, including around deceased estates.

Delays may sometimes be unavoidable, but those affected should be kept informed about the reasons for those delays. Clear information – supported by accurate and accessible guidance materials – can reduce confusion and help maintain confidence in the process.

Improving communication and restoring relationships

Service provider: CareSouth

Complaint overview

We received a complaint from a parent of a young person about poor communication by a service provider responsible for the case management of their child who was in out-of-home care. The parent felt the service provider had not appropriately recognised their disability and mental health circumstances, and that this had impacted on their understanding of what was happening with their child. They told us this had affected their sense of self-respect.

Our inquiries found that final orders had been made by the Children's Court and case management had recently been transferred, which had led to a reduction in family time.

We made a referral for local resolution¹⁰ under s 25 of the *Community Services (Complaints, Monitoring and Reviews) Act 1993*. We asked that the service provider meet with the parent to better understand her experience and explore ways to improve communication.

What was the outcome?

The service provider met with the parent and their support workers and listened to the parent's experience, including the parent's own time living in out-of-home care. The service provider heard that the parent had felt discriminated against, and that this had triggered a trauma-related response that in turn led to a further deterioration of the relationship.

The service provider acknowledged the parent's experience and apologised. It acknowledged that a large volume of documentation contained inconsistent information about the complainant's disability, and that this had since been updated.

The parent and the service provider agreed that improvements to communication were necessary. The service provider scheduled regular updates with more detailed and appropriate information. In addition, they agreed that future family time visits would be held in environments that would better meet the family's needs. The service provider also proposed a clinical consultation to support the parent's ongoing relationship with the service provider to assist the complainant's understanding of their child's needs.

What can we learn?

This complaint highlights the importance of recognising a person's individual circumstances, including their disability and mental health circumstances and responding in a trauma-informed way. Agencies should listen to people's experiences and adapt their communication and service delivery wherever possible to meet individual needs, particularly where the relationship is ongoing and where – as in this case – doing so supports a child's ongoing care.

¹⁰ Local resolution is a process in which our office asks an agency to meet directly with the complainant to resolve the concerns raised, and report any outcomes back to us.

Local resolution as a mechanism to empower complainants

Public authority: Department of Communities and Justice

Complaint overview

A young person complained to us about the Department of Communities and Justice's (DCJ's) decision to place them and their siblings to live with a family member. They told us that DCJ had already placed some of their younger siblings with the family member, and the plan was for the complainant to be moved there later.

The young person felt that they weren't being heard by DCJ. They raised concerns about the family member's behaviour, which they thought might destabilise their siblings. They were particularly concerned for the mental health of one of their siblings. DCJ's decisions had left them feeling very upset and confused. They described feeling alone, disempowered and let down by the system.

We made a referral for local resolution¹¹ under s 25 of the *Community Services (Complaints, Monitoring and Reviews) Act 1993*. We summarised the complainant's concerns as part of our referral, including those relating to how decisions were made and how concerns could be raised.

What was the outcome?

DCJ met with the complainant and agreed that the placement decision was made without proper consultation with the young person. They provided an apology and expedited a plan for the young person to reside with their siblings. DCJ acknowledged the young person's experience, and a communication strategy was agreed upon.

While they had raised the issues with DCJ before, the structured local resolution meeting empowered the young person to discuss their concerns directly, allowing them to articulate their concerns and work towards a resolution. It also gave the agency an opportunity to understand the experience of the young person.

The young person later confirmed they had moved to live with the family member and siblings. They told us that they felt supported by DCJ and that the situation had 'improved a lot'.

What can we learn?

It is important that agencies meaningfully consult with children and young people about decisions that affect them and provide opportunities for them to explain their concerns and properly understand decisions that are made. Agencies should then listen carefully to those concerns and respond appropriately.

¹¹ Local resolution is a process in which our office asks an agency to meet directly with the complainant to resolve the concerns raised, and report any outcomes back to us.

Preserving inmate dignity in NSW correctional centres

Public authority: Corrective Services NSW

Complaint overview

An inmate told us that strip searches of maximum-security inmates following visits were being conducted in a common area in the presence of other inmates and officers. The inmate also told us that there were no cubicles or privacy screens available, contrary to relevant policies.

We made inquiries with the Governor, who confirmed that strip searches were being conducted in a common space without cubicles or partitions available for the privacy of inmates.

What was the outcome?

Corrective Services NSW advised that partitions had been ordered and have since been installed in the maximum-security visits area to provide a suitable level of privacy for inmates undergoing a strip search.

The *Custodial Operations Policy and Procedures* states that strip searches are to be conducted with due regard to inmate dignity, privacy and respect. Additionally, the Inspector of Custodial Services had previously observed the lack of privacy screens on a visit to the centre in May 2024, and raised the issue in her report in December 2025.

The Governor advised that the local policy relating to the visits process was under review to incorporate more efficient visitor processing and inmate searching procedures.

What can we learn?

This case highlights how strip search processes can impact the dignity and privacy of inmates in custody, and how complaints can result in practical improvements and policy changes that promote more respectful treatment and protect dignity.

Incorrect advice given about park land status

Public authority: City of Coffs Harbour Council

Complaint overview

A complainant was unhappy with City of Coffs Harbour Council's (**Council**) handling of their complaint. They had complained to Council that in responding to concerns about proposed construction occurring at a local beach park, it had incorrectly referred to the land as 'Crown land'. Council's response appeared to conflict with public planning information that indicated that the land was part of Coffs Coast Regional Park.

Crown land is managed under the *Crown Lands Management Act 2016*, and regional parks are managed under the *National Parks and Wildlife Act 1974*. Both Acts can allow a local council to be appointed as a land manager to make decisions or undertake work on the land. However, each Act confers different obligations and processes for land management.

The complainant was concerned that Council was acting based on a mistake, meaning that its decisions in the management of the park were not following the processes required by the relevant law.

We made preliminary inquiries with Council, requesting information on its understanding of the status of the park land in question.

What was the outcome?

Council acknowledged that its previous responses to the complainant had incorrectly characterised the land in question as Crown land when it was in fact a regional park. Consultation with NSW National Parks and Wildlife Service confirmed that Council's proposed actions for the land were within its lawful authority to both propose and carry out.

In response to our feedback, Council was able to improve its complaint handling processes. It changed its processes to ensure information provided to complainants is verified and that complaints are triaged correctly – so it can seek information from the relevant subject matter experts before responding.

What can we learn?

Agencies should verify accuracy of information they provide in response to complaints, particularly in circumstances where a complainant has raised concerns about the reliability of information given.

Young people in custody regain access to photos

Public authority: Youth Justice NSW

Complaint overview

In February 2026, while on a visit to a youth justice centre, a young person told us he was no longer allowed access to photographs taken of him within the centre.

He said a sporting team had recently visited the centre, and several young people had photographs taken with the players. He was told by staff that he was not allowed to have the photos in his room, nor would they be placed in his personal property for when he exited detention.

We made preliminary inquiries with the youth justice centre.

What was the outcome?

The youth justice centre advised that, while photographs could no longer be displayed around the centre due to privacy concerns, young people could have access to their individual photographs with invited guests (including the sporting team) and the photographs could also be placed in their property as long as the photo did not contain any other young person.

The Centre Manager acknowledged that there appeared to be a miscommunication with staff about the issue, after a recent internal communication had been sent out to staff providing guidelines about the taking and sharing of photographs of young people.

Following our inquiries, the centre also sought clarification through Youth Justice NSW to confirm that photographs taken with external facilitators and the young person could be kept if consent was obtained and no security features were visible.

The centre advised that all individual photos of young people taken with the sporting team had been given to the young people.

What can we learn?

Agencies should ensure staff receive clear guidance on operational policies and understand how to apply them correctly. When policies are misunderstood, people in custody (including young people) may be unnecessarily denied possessions or opportunities – in this case, photographs of a significant and potentially rehabilitative moment in their lives.

Procedural fairness must be applied in decision making

Public authority: Department of Communities and Justice

Complaint overview

A grandparent told us that the Department of Communities and Justice (DCJ) had removed their grandchild from their care and placed them with foster carers. The grandparent told us that they did not understand the reasoning for this decision, as case workers had previously told them that they were doing well in supporting the child in their care. They told us that they wanted their grandchild returned to their care and not 'placed with strangers.'

We made inquiries of DCJ to understand the circumstances of this complaint, including the processes that were followed and relied on, in deciding to relocate the child.

What was the outcome?

In response to our inquiries, the relevant DCJ district office referred the matter to the Office of the Senior Practitioner within DCJ for a review of the decision-making process for the relocation of the child and the supports that had been provided to the complainant as carer before the decision was made. The review also considered whether appropriate procedures had been followed, and if any further action was required.

The review found that the grandparent had not been afforded procedural fairness and had not been told that they had the right to request a review of the decision to relocate the child. The grandparent subsequently requested a review of the decision, which was assigned to another district office to complete.

What can we learn?

This complaint highlights the importance of following process and procedural fairness in making decisions. The agency initially viewed the grandparent's concerns as disagreement with the decision, however after our involvement the agency provided opportunity for a review, including consideration of support and planning for the child.

Parent reconnects with children after 3 years through local resolution referral

Service provider: Life Without Barriers

Complaint overview

A parent complained that they had not seen their 2 children for almost 3 years, despite their attempts to contact the out-of-home care service provider. Both children are under care of the Minister of Department of Communities and Justice and reside in an out-of-home care setting.

The parent told us that they have disability and have difficulty advocating for themselves. They told us that communication had broken down with the service provider and that they felt unheard.

We made a referral for local resolution¹² under s 25 of the *Community Services (Complaints, Monitoring and Reviews) Act 1993*. We asked that the service provider to meet with the parent to discuss the concerns. When making the referral, we told the service provider that the parent wished to attend any meeting held with their NDIS Support Worker.

What was the outcome?

The service provider met with the parent and their NDIS Support Worker. To ensure the parent felt comfortable to discuss their concerns, the meeting was held at a location of their choosing. At the meeting, the service provider scheduled contact between the parent and their children and provided guidance and support to help them reconnect. They were able to pass on gifts and record a video message for their children. The meeting gave them the opportunity to establish communication and a working relationship with the service provider and begin rebuilding their relationship with their children.

The process helped the service provider learn about the parent's experience and to engage more effectively with them, gaining a better understanding of their disability and communication support needs. It was agreed that future contact between the service provider and the parent would be supported by their NDIS Support Worker to ensure they are adequately supported during discussions about the children.

What can we learn?

This case illustrates the importance of identifying and addressing barriers to participation and communication, and adapting engagement to meet a person's individual needs. Practical adjustments – for example involving a support person or changing where meetings are conducted – can improve communication and relationships and can assist in resolving issues.

¹² Local resolution is a process in which our office helps agencies and complainants resolve concerns directly, with the agency reporting outcomes back to us.

Policy considerations for inmates during mental health episodes

Public authority: Corrective Services NSW

Complaint overview

An inmate told us that he was found guilty of the correctional centre offence of ‘destruction and damage of property’ and ordered to pay \$245 in compensation after he used a ripped blanket to attempt self-harm. He was being managed under the Risk Intervention Team at the time and had a significant history of mental health concerns.

We made inquiries with the Compensation Order Review Team at Corrective Services NSW (**CSNSW**). Information from CSNSW confirmed the circumstances and charge as described by the inmate. The information also suggested that the inmate may have been confined to his cell for more than 48 hours pending adjudication of the offence (although this could not be confirmed due to a lack of recordkeeping).

CSNSW policy states that when guilt is determined for a correctional centre offence, the adjudicating officer should consider a range of factors before imposing a penalty, including recent behaviour and any mitigating circumstances. It appeared that in this case, mitigating circumstances – namely, that the property damage occurred during a self-harming incident, and that the inmate was being managed for complex mental health needs – had not been considered.

What was the outcome?

We made suggestions to CSNSW under s 31AC of the Ombudsman Act that it review:

- the reasonableness of the decision to find the inmate guilty of destruction and damage of property and the associated compensation order
- the appropriateness of the cell confinement and the lack of related records
- current policies and procedures, to ensure they address circumstances when an inmate engages in conduct that may amount to a correctional centre offence during a mental health episode or self-harming attempt.

CSNSW accepted our suggestions and told us it was reviewing current policies and procedures. It also provided information indicating that the inmate’s charge and compensation order had been revoked and refunded shortly after we raised our concerns with the compensation order review team.¹³

What can we learn?

Decision makers should consider an individual’s circumstances before imposing penalties for correctional centre offences and it is vital that clear, transparent records are kept. In particular, relevant mitigating circumstances should be identified and weighed to ensure decisions are fair and reasonable.

¹³ In August 2024 we issued a special report, *Investigation into inmate discipline in NSW correctional centres*, which also included concerns about inappropriate use of inmate discipline charges to respond to inmates with self-harming behaviours: see pp 25 – 26.

TAFE waives fees due to administrative errors

Public authority/service provider: TAFE NSW

Complaint overview

A TAFE NSW student enrolled in a course believing she would be able to complete it fee-free. She was allowed to continue studying without paying any fees but was then pursued by debt collectors for approximately 3 years of outstanding fees.

TAFE NSW had sent her the standard *VET Student Loan Fee Notice – Statement of Covered Fees*, which stated that her enrolment had been accepted on the basis that either: some or all of her fees would be covered by Vocational Education and Training (VET) Loan, or that she would pay with an upfront self payment.

Although she did not obtain a VET loan or pay upfront, no blocks were placed on her study, and she was allowed to attend classes and continue the course. The subsequent notices she received had indicated there were no fees owing.

We made inquiries with TAFE NSW.

What was the outcome?

TAFE NSW confirmed that the student was not eligible for a fee-free place, and should have been made aware of the fees owing and been blocked from study if she had not paid them. TAFE NSW acknowledged a number of errors in the enrolment process, including:

- the student being incorrectly recorded as an international student
- no fees being applied to her enrolment
- inconsistent or unclear fee notices and invoicing
- insufficient follow-up with the student or her employer regarding payment obligations.

The error went undetected until an internal fee review, at which time the full fee was first applied. Prior to this, errors in the fee records resulted in the system generating and sending fee notices showing no fees owing, which meant no system blocks were triggered on her studies.

Ultimately TAFE NSW elected to waive the entire outstanding fee of \$44,990 due to the administrative errors that occurred.

After the fee was waived, the student was sent her diploma.

What can we learn?

This complaint highlights the importance of discretionary debt waiver processes in preventing unfair financial detriment that can arise from flawed administrative processes.

Unreported use of force referred for investigation

Public authority: Corrective Services NSW

Complaint overview

An inmate complained to us about the level of force used on him. He was being held in a clinic cell for management of his complex mental health needs when officers allegedly attended his cell, dragged him along the ground and physically assaulted him. He told us he had sustained visible injuries as a consequence of the force used.

We made inquiries with the Governor of the correctional centre to better understand what had occurred, including requesting a copy of the use of force package and any available video footage (correctional officers who use force on an inmate are legally required to immediately report the use of force incident to the Governor under cl 133 of the *Crimes (Administration of Sentences) Regulation 2014*.)

What was the outcome?

Although there was no record of the use of force, the Governor reviewed video footage and confirmed that an unreported use of force had in fact occurred.

The Governor identified that the force used was, in part, unnecessary and unreasonable and subsequently referred the matter to an internal integrity committee, and a formal investigation was commenced. The Governor also immediately referred the inmate to the health clinic for review.

What can we learn?

This complaint highlights the value of secondary sources of evidence, such as CCTV, in ensuring fairness where recordkeeping systems fail. It also underscores the importance of both internal and external complaint systems in scrutinising the use of administrative power, including use of force, particularly in closed environments such as correctional centres.

Applicant unknowingly removed from housing wait list

Public authority: Homes NSW

Complaint overview

A public housing applicant told us that when she contacted Homes NSW to update her housing application, she was told her name had been removed from the waitlist around 3 years ago.

She told us that Homes NSW had not previously told her that she had been removed, despite the fact she had been placed on the list 5 years ago. She appealed the decision, but Homes NSW declined her appeal request because she hadn't lodged the appeal within 3 months of the decision to remove her from the list.

She asserted to Homes NSW that she would have met that 3 month timeframe if she had been informed of or received Homes NSW's decision. However, Homes NSW upheld its decision not to accept her appeal request.

We made inquiries with Homes NSW.

What was the outcome?

Homes NSW reviewed the applicant's eligibility and status on the NSW Housing Register and confirmed that it had incorrectly closed her application.

Homes NSW then reactivated her housing application with full retrospective effect and confirmed her and her daughter's eligibility for a 2-bedroom property. It also apologised for its oversight.

What can we learn?

Care should be taken, before rejecting an appeal on the basis of an exceeded time limit, to check that the person was properly informed of the decision they are seeking to appeal. It is generally unfair and unreasonable for an agency to rely on a time limit for appealing a decision if the agency's own administrative failings meant that the person had not been made aware of that decision.

Improperly restricting a person's right to complain

Public authority: Waverley Council

Complaint overview

A complainant told us that Waverley Council had revoked a fine and 'menacing dog' order, subject to several conditions. Conditions that were imposed related appropriately to the control of the dog – however the agreement also required the complainant to agree not to disparage Council in any way. When the complainant refused to sign the agreement, Council reinstated the fine and the order.

We made preliminary inquiries with Council and raised concerns about the appropriateness and fairness of the actions taken by Council staff.

What was the outcome?

Council reviewed the matter and agreed that the process did not appear to adhere to their established protocols.¹⁴ Council apologised to the complainant and undertook to review and communicate their procedures to staff to avoid a recurrence of the issue.

What can we learn?

Conditions attached to regulatory decisions should relate to the purpose of the decision itself. While enforcement action was appropriate in these circumstances, public authorities should not use their regulatory powers to restrain a person's right to complain, disagree or express criticism.

¹⁴ It is also important to note that, in terms of dog behaviour, standards under the Companion Animals Act still needed to be met.

A review to be heard

Public authority: Health Care Complaints Commission

Complaint overview

A complainant contacted us after the Health Care Complaints Commission (**HCCC**) declined their request for a review of the outcome of their complaint. They believed their concerns had not been properly addressed and their disabilities had not been accommodated during the complaints process.

The complainant had multiple disabilities which affected their communication. They told us they understood that the HCCC required complaints to be in writing, so they had used AI to draft their concerns, disclosed their disabilities in the complaint form, and indicated they wanted to speak with someone about their complaint. As the HCCC did not contact them until after they had issued the complaint outcome in writing, the complainant did not feel they had the opportunity to fully explain their concerns.

They also said they never received correspondence explaining the HCCC's decision to decline their review request. The request for review had been made within 28 days of the complainant receiving the outcome of their complaint, and the HCCC's legislation requires them to undertake a review if it is requested in this timeframe.

We made inquiries with the HCCC about its handling of the matter.

What was the outcome?

The HCCC advised that as the written complaint was clearly articulated and complete – noting the form completed by the complainant indicated 'full information' was attached – no adjustments for verbal contact were identified as being necessary.

It acknowledged that contacting the complainant prior to sending the original outcome letter would likely have led to a better result for the complainant.

As a result of our inquiries, it undertook to carry out the review and contacted the complainant.

We noted that asking an individual if they require supports for their disability, rather than assuming they do not, is generally accepted as the best way to determine if support is required.

What can we learn?

This complaint highlights the importance of communicating with complainants to ensure clear, mutual understanding of the issues, especially with the rise of AI-assisted communication. Agencies should be aware that AI generated language in complaints may mask accessibility needs, and make appropriate accommodations to ensure people with disability are heard and understood.

Accommodation considerations for inmate living with a disability

Public authority: Corrective Services NSW

Complaint overview

An inmate with partial paraplegia complained about being housed in a correctional centre that could not adequately accommodate his disability.

He said that, until recently, he had not been provided a shower chair to use and had been partially disassembling his wheelchair, removing its more absorbent elements, so that he could use it as a makeshift shower chair. He also complained that he was limited to the standard 6-minute shower time allotted to all inmates in the centre, which was not enough time for him to properly clean himself.

We made inquiries with the Governor of the centre to understand what had occurred, including asking whether the State-wide Disability Service (**SDS**) had been consulted regarding accommodations for the man.

What was the outcome?

Following our inquiries, we were advised that centre staff had not consulted with the SDS since the inmate's reception to the centre. Staff subsequently increased his allotted shower time from 6 minutes to 15 minutes to provide him with sufficient time to clean himself. Staff also checked to see if any further accommodation assistance was required.

We reminded the centre that, in future, they should proactively engage with SDS upon reception of an inmate with disabilities. This is to ensure appropriate arrangements are made to accommodate incarcerated persons living with disabilities, prior to a person reaching the point of complaint.

What can we learn?

This complaint highlights the need for agencies to proactively consider how they can accommodate individuals' differing needs, particularly in situations of known disability. When warranted, agencies should seek specialist advice early in these cases – doing so can help identify appropriate supports before problems arise and ensure the safe and equitable treatment of people with disability.

Maintenance delays resolved with brand-new bathroom

Public Authority: The Aboriginal Housing Office

Complaint overview

A housing tenant complained about non-responsiveness and prolonged inaction by the Aboriginal Housing Office (AHO) relating to maintenance requests to address a severe mould outbreak and structural damage in the bathroom of their residence. The tenant had reported ongoing water leaks from the shower, which had caused increased water bills.

Before complaining to us, the tenant had raised multiple maintenance requests via the MyHousing app and by telephone to the Maintenance Response Centre over a 3-month period. They had also raised a number of additional concerns relating to the lack of a complaint response to complaints they had made relating to rental payments and health concerns related to mould exposure.

We made inquiries with the AHO.

What was the outcome?

The AHO conducted a full review of the complainant's file and acknowledged that it had not acted adequately on the tenant's maintenance requests at the time. It told us this was because the requests had been lodged via the app and via telephone in a way that did not convey the severity of the issues, and the supporting photos the tenant provided also did not adequately reflect the extent of the issues.

The AHO apologised to the tenant for the administrative oversight. It raised work orders to scope each of the reported repairs and completed a full bathroom renovation. The tenant and their family were placed in temporary accommodation while the repairs and renovation were being completed.

The AHO clarified its complaint handling actions and rental calculations, confirming that the complainant was not overcharged. It also reviewed the water charges, escalating them to Homes NSW's water management unit for review. The AHO undertook to oversee this process and keep the complainant informed of the outcome.

What can we learn?

Agencies should ensure their processes identify and escalate issues that remain unresolved over time, particularly where delays caused by administrative oversight can significantly impact the people involved – including, as in this case, a family's financial and health circumstances.

Inadequate complaint handling by a private certifier

Service provider: Private certifier

Complaint overview

A complainant told us a private certifier had failed to respond to their complaint and follow-up correspondence about the building design of a neighbouring development, which they believed affected the privacy of their property. The private certifier had not responded to the complainant because it believed that the issues raised were better addressed by the local council as the consent authority.

We made inquiries with the private certifier.¹⁵

What was the outcome?

Following our inquiries, the private certifier responded to the complainant to address their concerns. It explained the roles of the private certifier and council when it comes to development concerns, so they could direct their concerns to the appropriate authority.

To prevent the recurrence of similar communication failures, the private certifier reviewed its internal correspondence management procedures and strengthened its administrative processes supporting the timely allocation of (and response to) incoming communications – including adopting measures to monitor response timeframes.

What can we learn?

It is important to respond to complaints – even when it appears they might be misdirected. Rather than ignoring the complaint, clarifying information can be provided to help the complainant to direct their concerns to the relevant authority.

This case also shows how complaints can provide an opportunity to review and improve complaint handling and communication processes.

¹⁵ A private certifier (registered certifier within the meaning of the Building and Development Certifiers Act 2018) included in the definition of a public authority under s 5(1) of the the Ombudsman Act 1974.

First home buyers grant approved

Public authority: Revenue NSW

Complaint overview

The complainant was the executor of their father's will and received a house following their father's death. As the complainant was the Executor the title to the house was placed into their name. The house was eventually sold, and they distributed the funds as the Executor. A few years later, the complainant then bought their first property with their partner. Revenue NSW told the complainant they were not eligible for the First Home Buyers Assistance scheme because their name was previously on the land title for their father's property. The complainant told us that they were required to pay a large sum of money under a notice of investigation relating to unpaid stamp duty, interest and a fine.

We made preliminary inquiries with Revenue NSW.

What was the outcome?

Revenue NSW told us that it had not (yet) demanded payment of unpaid stamp duty, but had issued a notice of investigation to the complainant requesting supporting documents be provided in respect to their being the Executor of their father's estate. At the time the complaint was lodged with us, Revenue NSW was still in the process of reviewing the information provided in response to that notice, and had not yet made a determination.

After Revenue NSW reviewed all relevant records and documentation provided by the complainant, it determined that the complainant had met the eligibility criteria for the First Home Buyers Assistance Scheme. Revenue NSW confirmed this outcome in a finalisation letter to the complainant.

What can we learn?

The complaint information allowed our office to provide feedback to Revenue NSW prior to them issuing the finalisation letter. The case highlights that the complaint process can provide an opportunity for parties to exchange further information which can ultimately resolve the issues that are the subject of the complaint.

Vehicle damage whilst travelling on a highway

Public authority: Transport for NSW

Complaint overview

A complainant told us their vehicle had been damaged by a fallen tree whilst travelling on a highway. The complainant lodged a liability claim with Transport for NSW (**TfNSW**) for the damage caused to their vehicle. The claim was referred to TfNSW's insurer and the complainant received correspondence from the insurer that led the complainant to believe the claim would be settled. The claim was handed back to TfNSW for determination and next steps.

Once returned to TfNSW, the claim underwent further review. A decision was made after this review to deny the claim. The complainant followed up twice with TfNSW and it eventually confirmed by email that the claim had been denied.

We made preliminary inquiries with TfNSW to understand the history of the claim and the reasons for the decisions.

What was the outcome?

Following escalation through our office's complaint process, TfNSW escalated the matter with its insurer for a further review. Transport's insurer confirmed that, given the claimant was previously advised by the insurer that the claim would be paid, the insurer was prepared to honour that position. Accordingly, the insurer accepted liability for the claim and arranged payment. The complainant was advised of the outcome.

What can we learn?

Agencies should communicate decisions clearly and consistently. Complaint processes provide an important opportunity to identify and correct unfair outcomes arising from administrative error or inconsistent communication, particularly when third parties, such as insurers, are involved.

Extension of temporary accommodation

Public authority: Homes NSW

Complaint overview

After a fire destroyed their home, a complainant and their young family were facing homelessness when Homes NSW declined to extend their temporary accommodation.

On the day renewal was due, the complainant was intending to pay the renewal amount directly to the accommodation provider (on the misunderstanding that such payments were to be made to that provider, when in fact they should be made to Homes NSW). Before they made the payment (which was due by midnight), they received a message that afternoon from Homes NSW informing them that it had declined temporary accommodation due to unmet obligations.

The complainant attempted to contact Homes NSW staff unsuccessfully, before learning from temporary accommodation staff that the payment was now overdue and should have been made directly to Homes NSW. It appears the payment had not been due by midnight as the complainant had thought, but rather earlier that afternoon. They immediately made a payment to Homes NSW, and followed up with a request for a review of the decision and a copy of the receipt showing their payment had been made.

They continued their attempts to contact Homes NSW by phone and email multiple times, but several days passed without contact from the Homes NSW officer who was overseeing their case. Their eviction was imminent.

We made urgent inquiries with Homes NSW.

What was the outcome?

Homes NSW advised that there were some complicating factors, but there was ultimately nothing preventing the family from accessing temporary accommodation, and the application was sitting with the local office for assessment.

Homes NSW confirmed that the family's temporary accommodation would be extended and that the administrative steps to facilitate this had now commenced.

What can we learn?

This complaint shows how miscommunication and delays in the administration of assistance (including temporary accommodation) can have a direct bearing on the risk of homelessness, and highlights the importance of timely communication and prompt remedial action.

Improving a local council's complaint handling

Public authority: Central Coast Council

Complaint overview

Last year we reported that Central Coast Council (**Council**) generated the highest number of local government complaints to our office.¹⁶ We continued to receive a high volume of complaints, and noted that several matters raised concerns about Council's inaction and lack of response to complaints made to it. This resulted in members of the public having to repeatedly escalate their concerns with Council.

We raised concerns with Council about the adequacy of its complaint management systems and resources.

What was the outcome?

Our office publishes a range of resources to support all agencies with effective complaint management.¹⁷ We gave Council copies of our resources and made comments under s 31AC of the Ombudsman Act.

Our comments centred on improving the timeliness, effectiveness and transparency of Council's complaint management, with the aim of improving outcomes for members of the public. We suggested that Council:

- change how it triages and responds to complaints
- implement a complaints management system that supports appropriate recordkeeping, monitoring, escalation and tracking of responses to complaints.

Council responded positively to our suggestions, implementing several initiatives focused on continuous improvement. The general manager convened a cross-functional workshop that set an expectation that complaints are to be addressed as quickly as possible by an appropriate staff member. Council is now providing complaint-handling training to multiple teams to support consistency. It is also reviewing the effectiveness of its internal complaint-handling guidance material.

We will continue to monitor Council's progress over the coming months.

What can we learn?

This matter highlights the importance of having an effective complaints management system, that is appropriately resourced and supported by qualified or trained staff, so it can be responsive to the needs and expectations of complainants. It also underscores the important role of agency heads and senior leaders in fostering a culture where complaints are welcomed and valued.

¹⁶ NSW Ombudsman Annual Report 2024-25, p 38 ([NSW Ombudsman Annual Report 2024-25](#))

¹⁷ Available on our website www.ombo.nsw.gov.au

Clarifying the limits of the Building Commission NSW's role

Public authority: Building Commission NSW

Complaint overview

A complainant contacted us after not receiving a response to concerns they had raised with the Building Commission NSW (**Commission**) about a builder whose work had led to water leakage in their home.

We contacted the Commission to better understand its informal dispute resolution service and how it handled the matter in line with its complaint assessment framework.

What was the outcome?

The Commission acknowledged that it had not clearly explained the limits of its role in providing an informal dispute resolution service, and that it should have clarified this in response to the complainant's multiple follow-up emails. It apologised for not doing so.

The Commission contacted both the complainant and the builder to remedy the confusion. Subsequently, rectification works commenced and a Building Commission NSW inspector was assigned to assess the works and any remaining defects to determine whether further regulatory action was warranted.

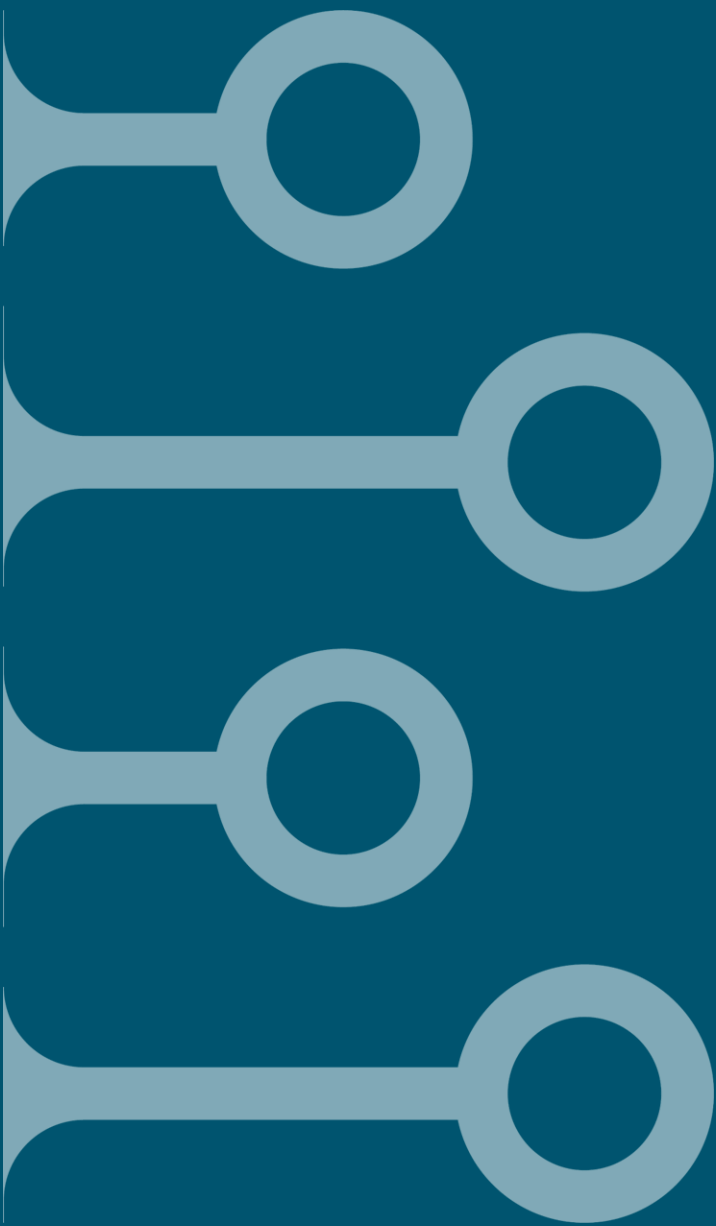
The Commission provided feedback and additional training to the officer involved to improve the clarity of future complaint finalisation notices.

What can we learn?

Agencies should clearly explain the scope and limits of their role. This helps manage expectations around what the agency can do, where its involvement ends and what people can expect as a matter progresses.

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.



Communication

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.



Taking ownership

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.

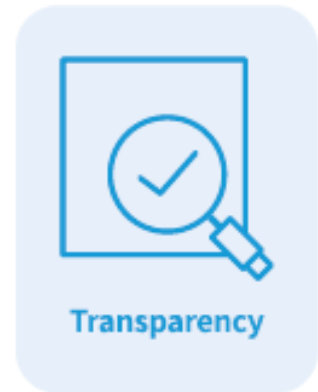


Timeliness

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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