Formal investigations summary report 2022–23

A summary of completed investigations
under section 13 of the *Ombudsman Act 1974*
(1 October 2022 to 30 September 2023)

Pursuing fairness for
the people of NSW.

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Ombudsman
New South Wales

30 October 2023

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

Formal investigations summary report 2022–23

Pursuant to section 31 of the *Ombudsman Act 1974*, I am providing you with a report titled *Formal investigations summary report 2022–23: A summary of completed investigations under section 13 of the Ombudsman Act 1974 for the period from 1 October 2022 to 30 September 2023*.

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

Yours sincerely

Paul Miller
NSW Ombudsman

OMBUDSMAN
ORTA RECENS QUAM PURA NITES
NEW SOUTH WALES

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About this report

This special report contains a summary of formal investigations completed by the NSW Ombudsman in the last 12 months. The Ombudsman may conduct an investigation into the conduct of a public authority or a community service provider 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.[1]

The Ombudsman may also investigate a community services 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.[2]

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, and if a satisfactory outcome can be achieved through inquiries or conciliatory engagement with the agency and the complainant, we will do that.

In the period from 1 October 2022 to 30 September 2023 the Ombudsman completed 5 investigations, the outcomes of which are summarised in this report.

Confidentiality of investigations

The *Ombudsman Act 1974* (NSW) requires that all investigations must take place in the absence of the public.

Investigation reports

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

The investigation report is not otherwise made public by the Ombudsman, unless the Ombudsman decides to issue a special report to Parliament. The investigation report is also '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. 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. Relevant public interest considerations against disclosure may include if the report contains personal or health information about a complainant or other person.

1. Section 26, *Ombudsman Act 1974*.
2. Section 27, *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

Special (public) reports relating to investigations

The Ombudsman may, at any time, make a special report to Parliament on any matter arising in connection with the discharge of the Ombudsman's functions. Occasionally, following the completion of an investigation, the Ombudsman may also prepare and present to Parliament 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.

A special report to Parliament relating to an investigation may differ from the corresponding investigation report that has been provided to the relevant public authority and minister, including, for example, by excluding or anonymising personally identifying information or by focusing only on the particular issues of public or systemic interest that were raised by an investigation.

Annual summary reports

Whether or not a special report has been prepared in respect of a particular investigation, it is the Ombudsman's current practice to publish and present to Parliament a special report periodically that identifies and briefly summarises the investigations. In some cases, we may anonymise or omit details in investigation summaries that may otherwise reveal identifiable personal information.

This report is the summary report for the period of 12 months to 30 September 2023.

Department of Planning and Environment and the Department of Regional NSW: investigation into the handling of public interest disclosures

Public authority:	Department of Planning and Environment; Department of Regional NSW
Responsible minister:	Minister for Planning and Public Spaces, and the Minister for Regional NSW
Investigation report issued:	13 December 2022
Finding:	Unreasonable conduct
Recommendations:	Policy and practice improvements

Three former senior staff members of the Department of Planning and Environment (DPE) (which at the relevant time had included the Division of Resources and Geoscience (DRG)) complained to our office, claiming they had made public interest disclosures (PIDs) about potential corrupt conduct and maladministration that had not been dealt with in accordance with the Public Interest Disclosures Act 1994 *(PID Act). The complainants told us they were subject to reprisals after making the disclosures, including termination of their employment. While we did not find any evidence of reprisals, we found that PIDs and allegations of reprisal were not handled appropriately.*

Background

When a public official reports serious wrongdoing in the public sector, their report is a PID if it meets specific requirements set out in the PID Act. The PID system is designed to encourage people who work in the NSW public sector to report serious wrongdoing without fear of reprisal.

In 2018, we received a complaint from 'Mr B', who complained to us on behalf of his wife, Ms B, a former senior staff member at DRG. Ms B's employment was terminated after an investigation into allegations of misconduct by her, in which several of the allegations were substantiated. Mr B claimed that Ms B's employment was terminated because she made disclosures about serious misconduct by DRG staff. Ms B also told us that when she raised concerns about reprisals against her, they were not considered or investigated.

What did we find?

While we did not substantiate the allegation that Ms B's termination was an act of reprisal, we did find that DRG had failed to identify that certain disclosures of alleged wrongdoing by Ms B were PIDs that met the relevant criteria in the PID Act, and did not act on those disclosures in accordance with the PID Act and its own internal reporting policies. DRG failed to maintain adequate records of the disclosures and any action taken in response, did not fully investigate the disclosures, and failed to act on serious issues highlighted by the disclosures.

The agency's conduct in relation to the assessment of, handling of, investigation of, and response to the disclosures was also unreasonable, as it did not take appropriate action on Ms B's allegations.

We also noted in our report that 'machinery of government' changes and internal restructures may have made it harder for staff to make PIDs, and that cultural issues may have contributed to a poor reporting environment. The information received indicated staff were reluctant to raise concerns, fearing no action would be taken or that they would suffer reprisals if they did. When some staff had raised concerns about alleged reprisal, those allegations had not been acted on or investigated.

What did we recommend?

Following our investigation, we informed the agency now responsible, the Department of Regional NSW (DRNSW), and the agency formerly responsible, DPE, that we would be provisionally recommending that they review their PID policies and procedures in light of the failings we had identified and determine whether further changes and improvements were necessary. We also provisionally recommended they review existing (or develop new) quality assurance mechanisms for investigations conducted into reports of wrongdoing. We also asked DRNSW and DPE to tell us what steps they had taken to improve how they handle PIDs, in particular to improve staff awareness of PIDs, recordkeeping practices, and how they handle allegations of reprisal.

DRNSW outlined improvements it had made to its handling of PIDs, including developing a code of ethics and conduct (including a 'PID framework') with annual training for staff and training for PID receivers.

Taking into account the actions already taken, we made no further recommendations in our final report. Due to the ongoing nature of the work described (and our office's role in oversighting the PID Act), we requested a progress update within 6 months.

DRNSW provided our office with a report on its progress on 6 July 2023.

DPE provided us with a report on its progress on 5 June 2023.

Department of Regional NSW: delays in processing mining applications

Public authority:	Department of Regional NSW
Responsible minister:	Minister for Regional NSW
Investigation report issued:	16 January 2023
Finding:	Unreasonable conduct
Recommendations:	Policy and practice improvements; reporting on progress

In 2012 we received a complaint about delays in processing applications made under the Mining Act 1992 *(Mining Act) on the part of the Division of Resources and Geoscience[3] (DRG), which had led to a substantial backlog of applications. We monitored the situation from 2013 to 2017, during which time reports from DRG showed a significant reduction of the backlog. Further complaints to our office indicated that the backlog had not in fact been reduced and the progress reports had not been accurate. We recommenced inquiries in 2018 and began an investigation in August 2019. We found the department had failed to address ongoing and unreasonable delays in processing applications, and had failed to keep and publish an accurate record of its progress.*

Background

When we received an initial complaint about the delays in April 2012, we inquired with DRG and established that it had no set timeframes or key performance indicators (KPIs) for determining mining applications. Significant delays were common, and this had led to a large backlog.

Following our inquiries, in 2013 DRG implemented service delivery standards with KPIs for the processing of applications under the Mining Act. Between 2013 and 2017, we monitored DRG's progress in addressing the delays, the backlog and other administrative issues. From 2014, DRG also commenced 3 different projects aimed at clearing the backlog of applications. The most recent project (the 'Ageing Dealings Project') is still underway, and includes a root cause analysis of the delays.

DRG provided us with progress reports, which indicated significant improvements. However, soon after we discontinued monitoring in 2017, we received a public interest disclosure (PID)[4] from a former DRG staff member claiming that the backlog had not actually been reduced, and that DRG's progress reports had not been accurate.

After receiving this disclosure, and another similar complaint in late 2018, we recommenced inquiries. DRG's response showed that a significant backlog of unprocessed applications remained. In December 2018, we received a third complaint from another former staff member who also claimed the backlog had not been addressed, and that cultural and operational issues at DRG were contributing to the backlogs. We began an investigation in August 2019.

3. At the time the division was known as the Division of Resources and Energy, and was located within the former Department of Industry. During the investigation period DRG went through several restructures and machinery of government changes. In April 2017 the division was transferred from the Department of Industry to the Department of Planning and Environment (DPE) and became known as the Division of Resources and Geoscience (DRG). The division is now part of the Department of Regional NSW (DRNSW), formed on 2 April 2020, and is known as Mining, Exploration and Geoscience (MEG).
4. under the *Public Interest Disclosures Act 1994* (PID).

What did we find?

The conduct of the former DRG (now Mining, Exploration and Geoscience (MEG) within the Department of Regional NSW) was unreasonable.

MEG, and DRG before it, failed over a protracted period of at least a decade to address ongoing and unreasonable delays in processing applications under the Mining Act. DRG also failed, during the period from 2015 to 2019, to keep and publish an accurate record of its progress on clearing the backlogs. The effect was that data made publicly available and provided to our office was at times inaccurate and misleading.

What did we recommend?

We recommended that MEG expand the root cause analysis of the recurring backlogs to identify and address any other causes contributing to the problem, and that it continue to review and update all relevant policies and procedures. We also recommended it continue to provide accurate reports about the processing of any backlogs – including progress made as part of the Ageing Dealings Project – in its quarterly performance reports, and that it reports monthly on progress to the Secretary of the Department of Regional NSW.

MEG provided quarterly reports to our office in April and August 2023 advising us of the progress that it has made in implementing our recommendations, as well as progress made in relation to the Ageing Dealings Project. MEG also advised us that the Secretary has received monthly reports. In July 2023 MEG provided us its root cause analysis.

A NSW Local Health District: response to child protection risk for a child who presented with suspicious injury

Public authority:	A NSW Local Health District
Responsible minister:	Minister for Health
Investigation report issued:	23 June 2023
Finding:	Unreasonable conduct
Recommendations:	Review of child protection resources; policy and practice improvements

We investigated the conduct of a Local Health District (LHD) in responding to child protection risk for a child who had died in 2018 as a result of non-accidental injury. Prior to their death, the child was presented to hospital on 2 occasions as a result of injuries that their carers could not adequately explain. We found that the LHD's conduct was unreasonable. It failed to adequately assess that the child was at risk of significant harm in their home, and it also failed to assess discrepancies between the child's injuries and the explanation given by their carers. The LHD's information sharing with other agencies was poor, and the root cause analysis it conducted following the child's death was inadequate.

Background

Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, our office is responsible for monitoring and reviewing the deaths of children that occur in circumstances of (or those that are suspicious of) abuse or neglect, and deaths of children in care or detention. The death of the child examined in this investigation was a 'reviewable' death for our office under the Act.

The child was taken by their carers to hospital twice in a short period of time, presenting with suspicious injuries. A few days after being discharged from hospital on the second occasion, the child died from multiple inflicted injuries. The LHD then completed a 'root cause analysis' review of its involvement with the child, as required by policy.

As a result of the issues identified in our review of the death, and following the conclusion of criminal (homicide) proceedings, we commenced an investigation into the LHD's conduct.

What did we find?

We found that, while the LHD had identified child protection risks and made reports to the then Department of Family and Community Services (now the Department of Communities and Justice) at various points, the LHD's conduct overall had been unreasonable. It failed to adequately assess discrepancies between the injuries and the caregiver's explanation of those injuries, and did not adequately consider the child protection risks when making decisions about the child's care. The LHD did not have an adequate child protection information exchange system, contrary to NSW interagency requirements.

After the death, the LHD's root cause analysis was inadequate and did not comply with legislation and policy, as it failed to properly consider the child protection response and did not identify any system improvements.

What did we recommend?

We made 5 recommendations to NSW Health and the LHD, including that NSW Health undertake a systematic review of state-wide resources to support the effective response to children at risk of harm and establish a nominated child protection paediatric medical lead or case coordinator in each Local Health District and the Sydney Children's Hospitals Network. We recommended that particular issues be included in the planned review of the child protection policy, including clarifying escalation pathways for staff and improving the exchange of information, and that non-medical experts with child protection expertise be included in Serious Adverse Event Review teams in cases of suspected homicide or serious crime involving the death of a child.

We also recommended that the LHD include a clear pathway for responses to requests relating to 'social admissions' in its procedures. (Social admissions, also known as 'safety admissions', are where a person is admitted, or kept, in hospital despite there being no acute medical reason to do so, such as where it would not otherwise be safe for them to be discharged.) All the recommendations were either supported (4) or supported in principle (1). We will monitor the implementation of the recommendations.

Corrective Services NSW: inmate charged for stealing food

Public authority:	Corrective Service NSW
Responsible minister:	Minister for Corrections
Investigation report issued:	15 September 2023
Finding:	Conduct contrary to law and unreasonable conduct
Recommendations:	Apology; policy and practice improvements

In March 2022, an inmate complained that Corrective Service NSW (CSNSW) had found him guilty of a correctional centre offence for stealing a can of food, giving him a penalty of 21 days exclusion from the 'buy ups' program.[5] He denied the charge, and told us CSNSW has not allowed him to call another inmate as a witness. We found there was insufficient evidence to find the inmate guilty, and that CSNSW had denied the inmate his procedural rights with respect to examining witnesses. We also found that CSNSW had contravened its own policy around CCTV footage retention.

Background

The *Crimes (Administration of Sentences) Act 1999* requires correctional centre offences to be established beyond reasonable doubt.[6] It also entitles inmates who are subject to a correctional centre offence hearing to examine and cross-examine witnesses.[7]

The inmate in question was employed in the correctional centre's canteen or 'buy ups' unit. A correctional officer noticed a can of food sliding across the floor near the inmate toilet block. The officer later viewed CCTV of the area and saw the inmate near the same toilet block at around the same time. The officer recorded what she had seen in a misconduct report.

Soon after, the inmate was transferred to another correctional centre, and a senior correctional officer at the new centre charged the inmate with stealing and conducted an inquiry. The inmate called for a witness during the hearing, but the hearing officer disallowed his request as the inmate could only provide the witness's first name and the officer considered the witness would be 'virtually impossible' to find. The inquiry was then decided solely on the basis of the written report made by the officer, who was not examined. The inmate was also not allowed to cross-examine that officer. CCTV footage of the alleged offence could not be reviewed, as CSNSW had failed to retain it.

What did we find?

CSNSW's conduct was unreasonable and contrary to law: the finding of guilty was not legally open on the evidence, as the evidence before the officer was incapable of proving the offence beyond reasonable doubt. In particular, there was no direct evidence that the inmate had stolen the can of food and the circumstantial evidence (that is, that the inmate was seen in a location close to where an empty can of food had been seen) could reasonably be consistent with the inmate's innocence.

5. Allows inmates to purchase a fixed range of consumer items from a generic grocery 'buy-up' list, up to a set monetary limit.
6. Section 53, *Crimes (Administration of Sentences) Act 1999*.
7. Section 52(2)(c), *Crimes (Administration of Sentences) Act 1999*.

CSNSW's conduct was otherwise wrong, as it:

a. made no attempt to enable the inmate to exercise his right (under the *Crimes (Administration of Sentences) Act 1999*[8]) to examine and cross-examine witnesses
b. acted contrary to the *Custodial Operations Policy and Procedures 13.9 on video evidence* by failing to retain CCTV video footage that allegedly recorded the innate committing the offence.

What did we recommend?

We recommended that CSNSW apologise to the inmate, amend his file to record a finding of 'not guilty', and review its retention practices for video footage of correctional centre offences. CSNSW accepted the recommendations.

8. Section 52(2)(c).

Investigation into the hiring of a contingent worker to act in a chief audit executive position

Public authority:	Anonymised
Responsible minister:	Anonymised
Investigation report issued:	27 September 2023
Finding:	Contrary to law; wrong conduct
Recommendations:	Policy and practice improvements

We investigated the conduct of a NSW Government department in retaining a contingent worker[9] in the position of chief audit executive, after we received a public interest disclosure (PID) from another staff member at the department. The PID-maker's complaint included that the appointment breached NSW Treasury guidelines and did not represent value for money. They also claimed that the contingent worker had wrongly exercised functions that required delegated authority. We found the department had contravened several public sector guidelines in hiring and retaining the contingent worker in the role of chief audit executive. We also found the department failed to ensure that the contingent worker did not make decisions they did not have legal authority to make.

Background

The Public Service Commissioner's (PSC) *Contingent Workforce Management Guidelines* apply to all NSW government sector agencies. Because of the cost and other issues associated with using contingent workers who cannot make decisions that require delegated authority, contingent labour should be used for a limited period and for a specific purpose.

The staff member who made the PID to our office raised several concerns, including that:

- the contract did not represent value for money, as the contingent worker was paid more than a person occupying the role on a full-time basis
- the contingent worker appeared to have been paid for days on leave and public holidays, in contravention of the department's internal guidelines
- the contingent worker mispresented themselves as an ongoing employee as their email signature did not indicate they were only 'acting' in the chief audit executive position, and improperly exercised functions that required delegated authority that, as a contingent worker, they did not have
- the appointment did not comply with NSW Treasury policy and guidelines, which required that the role in question be held by an employee.

What did we find?

The department's conduct was contrary to law. In retaining the contingent worker in the role of chief audit executive, the department breached the *Government Sector Finance Act 2018*[10] (GSF Act) by not complying with a Treasurer's Direction[11] which provides that the chief audit executive of an agency

9. Contingent workers are people employed by a contingent labor supplier (usually a recruitment firm) that are hired from that supplier by a NSW Government sector agency.
10. Section 3.4.
11. *Treasury Policy and Guidelines Paper TTP 20-08*.

must be an employee of the agency. During the course of our investigation we confirmed with Treasury that this requirement of the Treasurer's Direction is considered an important mandate, as it protects the operational independence and objectivity of the role and ensures that the agency maintains an appropriate internal audit function.

The department's conduct was also wrong in that it:

- acted contrary to the Public Service Commissioner's *Contingent Workforce Management Guidelines* in failing to re-evaluate whether it was appropriate to continue to fill the role using contingent labour hire
- failed to ensure that the contingent worker did not make decisions they did not have authority to make
- failed to ensure that the chief audit executive role had the required independence to effectively undertake the role
- failed to document key decisions in relation to the engagement and ongoing management of the contingent worker.

We did not substantiate the PID-maker's other concern that the contingent worker may have been paid for days when they were on leave.[12]

This investigation further highlighted issues raised in an earlier special report to Parliament[13] regarding use of contingent labour and other contractors to fill senior roles that would normally need to be filled following a competitive merit-based recruitment under the *Government Sector Employment Act 2013* (GSE Act). As these workers cannot be delegated functions under the GSE Act or the GSF Act, they legally cannot make decisions that are a routine part of many senior roles, including decisions about staffing and expenditure. This should be considered when retaining and continuing to retain contingent workers in senior management roles – noting that there are some roles (such as the chief audit executive role in question) that can never be filled by contingent workers.

What did we recommend?

We recommended that the department provide guidance to staff around the use of contingent labour. Among other things, the guidance should:

- require hiring managers to re-evaluate the use of individual contingent workers after 6 months of tenure, considering the cost and benefits and whether there are alternative ways to fill the role
- make it clear that contingent workers cannot make decisions which require delegated authority under the GSE Act or GSF Act, and clarify which decisions contingent workers can and cannot make
- require contingent workers who are acting against a vacant public sector role to refer to themselves as 'acting' in that role
- document any arrangements that are made for decision making while a contingent worker is acting in a role where they need to make decisions requiring delegated authority
- provide guidance about roles that are not suitable for contingent workers to occupy.

We also recommended that the department amend its *Internal Audit Charter* to clarify that the role of chief audit executive must only be held by an actual employee as mandated by the Treasurer's Direction.

12. Contingent workers are not entitled to payment for days on which they do not work, including days when they are on leave or public holidays.
13. *Investigation into the procurement of an acting Executive Director at the former NSW Department of Planning and Environment*.

Pursuing fairness for the people of NSW.

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