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Ombudsman
New South Wales

20 December 2023

Dr Joe McGirr MP

Committee Chair

Select Committee on Remote, Rural and Regional Health

By email: remoteruralregionalhealth@parliament.nsw.gov.au

Dear Dr McGirr

Response to supplementary questions

Please find enclosed our response to the supplementary questions received on 6 December 2023 in relation to the Committee's inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

I confirm that we are happy for the information provided to be made publicly available.

If you have any questions in relation to this material, or would like further information please contact Christie Allan, Executive Strategy Officer, at [redacted]

Yours sincerely

[redacted]

Paul Miller
NSW Ombudsman

The implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health

Response to Supplementary Questions

Question

1. Noting that your office can receive complaints, are there any persistent themes that arise in complaints about the administrative conduct of NSW Health, local health districts and other public health organisations?

Answer

In respect of NSW Health and other public authorities in the NSW health system, we can receive complaints about conduct (whether action or inaction) relating to a matter of administration (section 12 *Ombudsman Act 1974*). However, we cannot receive complaints about 'excluded conduct' of a kind set out in Schedule 1 of the Ombudsman Act.

We refer to complaints that we are authorised to receive under the Ombudsman Act as 'actionable complaints'.

During the year 1 July 2022 to 30 June 2023, the NSW Ombudsman received approximately 1,000 actionable complaints relating to the conduct of public authorities in the NSW public health system.

Around two thirds of these (634) were complaints about **Justice Health and Forensic Mental Health Network (JHFMHN)**, which provides health services to adults and young people involved in the criminal justice and forensic mental health system. Most of these complaints are received from inmates in custody.

We received actionable complaints about the **Health Care Complaints Commission** (105). Most of those complaints concerned a decision not to investigate or take other action on a complaint or customer service issues (including complaint handling practices, communication and delays).

In relation to **NSW Health and the broader public health system**, actionable complaints were received about:

(a) metro Local Health Districts (LHDs) (83) and regional and rural LHDs (75)

(b) NSW Health (36)

(c) public health-related services (29), such as NSW Ambulance and NSW Health Pathology

(d) medical professional councils (15), and

(e) a small number of complaints about other speciality networks and affiliated health organisations.

In relation to these, the most common issues raised by the complaints (in order of prevalence) were:

- 'Customer service' issues – for example, poor communication and information (including in responding to complaints) and delays in treatment and service (these complaints to us are often made in the context of related concerns being raised about the quality of medical care and treatment).

- 'Duty of care' issues – for example, care and support to grieving relatives, neglect of patient needs, visitor restrictions.
- 'Objection to merits of decision' – for example, outcomes and decisions concerning practitioner registration.
- 'Misconduct' issues – for example, allegations of corruption, discrimination, assault, harassment, or bullying.
- 'Charges and fees' – for example, Ambulance costs, hospital and surgical charges, unexpected hospital fees for items not covered under private health insurance, charges for services not received.

We note that our current case management system (CMS) is over twenty years old and severely limited in its capacity to identify, report on and analyse issues and patterns in complaints, beyond the broad categorisations set out above. Our office is currently developing a new CMS which will enhance our data analytics capability in the near future.

Question

2. Can you advise on the number of complaints you receive from health workers, such as hospital staff, nurses, doctors, carers and patients?

Answer

Our current CMS does not allow us to accurately identify and report on the 'role' of a complainant across aggregate complaint data. However, it is apparent that the vast majority of complaints we receive are from patients and/or their families and carers, rather than from those working in the health system.

Question

3. How often does your office make findings or recommendations in relation to conduct within the NSW health system?

Answer

Recommendations arising from investigations

We may make 'recommendations' where a formal investigation has been undertaken under the *Ombudsman Act 1974*.

The primary purpose of an investigation is to determine if 'maladministration' of a kind referred to in s 26 of the Ombudsman Act has occurred – this includes conduct that is contrary to law, unreasonable, discriminatory, or otherwise wrong.

An investigation can be made in response to a complaint, or on our own motion.

Recommendations for correction and/or systemic improvement can be made following an investigation.[1]

This year we conducted one formal investigation into the conduct of an LHD and made a finding of unreasonable conduct under s 26 of the Ombudsman Act in relation to that LHD. That matter related to our investigation of the LHD's conduct in responding to child protection risk for a child who had died in 2018 as a result of non-accidental injury. We made 5 recommendations to NSW Health and the LHD in relation to that matter. A summary of that investigation is included in our special report to Parliament, 'Formal investigations summary report 2022-23' tabled in Parliament on 30 October 2023 under s 31 of the Ombudsman Act.[2]

Recommendations arising under our other functions

As well as (maladministration) investigations, the NSW Ombudsman has a range of other oversight functions that may result in the making of recommendations to relevant public authorities.

Of particular relevance, the NSW Ombudsman registers and conducts research regarding the deaths of all children in NSW in its role as convenor of the NSW Child Death Review Team (CDRT). It also has a separate function of reviewing the deaths of particular children, including those who died in circumstances of, or suspicious of, abuse or neglect ('reviewable deaths').

This work frequently includes examination of the role of NSW health organisations.

At the time of writing, the NSW Ombudsman is monitoring 5 open CDRT recommendations made to NSW Health. For further information about those specific recommendations, refer to our report, 'NSW Child Death Review Team Annual Report 2022-23' tabled in Parliament on 30 October 2023 under s 34F of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.[3]

Other 'suggestions' in the context of preliminary investigations

In the context of its complaint handling functions, the Ombudsman can take a variety of actions to seek to resolve or otherwise deal with a complaint, either before or as an alternative to conducting a formal investigation of alleged maladministration.

This includes making 'preliminary inquiries'. These involve investigatory steps, but is not a formal investigation – rather, preliminary inquiries are undertaken for the purpose of deciding whether to make the conduct of an agency the subject of formal investigation.

Preliminary inquiries can be made in response to a complaint, or on our own motion.

Most preliminary inquiries do not lead to a formal investigation. This may be because the preliminary inquiries prompt the agency to take corrective action in respect of the complained-about conduct, or because we decide that a formal investigation is not warranted.

During preliminary inquiries, we may make various suggestions to an agency about its conduct, including action that we think it could take to resolve the complaint or to address systemic issues

[1] Refer to document tendered at hearing on 24 November 2023, 'NSW Ombudsman paper regarding Health administration – December 2022'.

[2] NSW Ombudsman report, '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)' accessed at: <Formal investigations summary report 2022-23 (nsw.gov.au)> pp 10-11.

[3] NSW Ombudsman report, 'NSW Child Death Review Team Annual Report 2022-23' accessed at: <NSW Child Death Review Team Annual Report 2022-23> pp 15-18.

raised. These suggestions can be made formally by way of 'comments' to the relevant public authority under section 31AC of the Ombudsman Act.

In the 2022-23 financial year, we undertook preliminary inquiries in respect of around 20% of all actionable complaints received in relation to the NSW public health system.

Question

4. Your submission notes that 'it has not always been possible for us to investigate all matters that may warrant further scrutiny' in the NSW public health system (p.2).

a. What barriers prevent you from investigating more matters?

b. What resources would you need to investigate more complaints relating to the public health system?

Answer

a.

The most significant barrier to us taking investigatory action in respect of more matters (whether by way of formal investigation or preliminary inquiries) has been our resourcing constraints.[4]

However, it is important to highlight that even with abundant resourcing the Ombudsman would not seek to investigate all, or even, most matters of concern that are raised about conduct in the health system. There are two reasons for this:

- First, the Ombudsman's decision whether to formally investigate is discretionary and whether we investigate will depend on the nature and seriousness of the allegations raised. Most complaints do not result in a formal investigation, and this is often appropriate. We will continue to seek to resolve complaints at the earliest opportunity and in the least formal and most appropriate way such as by referral to the agency for further action, preliminary inquiries or conciliation.
- Second, consistent with our role as an ombudsman/independent integrity agency, our complaint-handling functions, including investigations, are generally and appropriately considered to be 'last resort'.

  This means that, in cases where a complainant comes first to us, we will generally guide the complainant to make an internal complaint through relevant agency or service complaint mechanisms, and thereby give the relevant agency or service the opportunity to investigate the matter and resolve the complaint itself, before (if the complainant remains unsatisfied) they may wish to return to us. That said, we have discretion to act on a complaint that has not previously been raised internally, and may do so if, for example, the complaint raises concerns about particularly serious, systemic and/or senior level maladministration that we consider warrants external investigation in the public interest and/or if it would otherwise not be appropriate to expect the complainant to raise their complaint internally (for example, because of vulnerability or legitimate fear of reprisal).

[4] Refer to document tendered at hearing on 24 November 2023, 'NSW Ombudsman paper regarding Health administration – December 2022'.

> The general point, however, is that complaints and the investigation of complaints – and particularly those that allege misconduct (such as bullying or harassment) by public officials within a public sector agency or service – should generally be dealt with by the agency or service itself, in the first instance. This is consistent with the model of 'ombudsman' oversight of the public sector. Although external independent oversight is critical, investigating and dealing with issues of officer misconduct or other integrity failures in an agency or service should primarily and in most instances remain the responsibility of the agency or service itself, in order that the agency or service does not lose "ownership" of its own integrity.[5]

That said, and as our submission pointed out, there are likely matters that have warranted external investigation by us that were not investigated because of our limited resources.

From 2022-23, our office has received a material enhancement of funding to support existing statutory functions, as well as to support preparation for new statutory functions. With our additional resources we anticipate being able to carry out investigatory action in respect of more matters across the jurisdiction of the office than has been possible in recent years.

For example, in the 2022-23 financial year, we commenced 10 formal investigations, whereas we had commenced 1 formal investigation in 2021-22.[6] The number of complaints in respect of which we were able to take preliminary inquiries also increased (by 69%) to 2,685 in 2022-23 compared to 2021-22.

b.

Currently, we have 68 FTE staff employed in our Complaints and Resolution Branch (CRB – including support staff). This branch is responsible for receiving and responding to complaints including undertaking inquiries, complaint investigations and conciliations across all public authorities and community service providers within our jurisdiction.

With the recent increase in resources, from 2024 we will be in a position to refine the structure of CRB to establish 'teams' that are focused on handling end-to-end complaints concerning groupings of specific sector/s. (Prior to this increase in resources, the small number of staff in CRB meant that structuring by way of sector-aligned teams was not operationally feasible.)

At this stage we anticipate having 5 teams, each with approximately 12 staff handling complaints, with the teams specialising as follows:

Team 1:	Corrective Services, Youth Justice and JHFMHN
Team 2:	Transport, Customer Service, Legal and Justice, Emergency Services, Treasury, Enterprise and Investment
Team 3:	Local Government, Land Administration, Planning, Environment
Team 4:	Health, Housing, Tertiary Education
Team 5:	Community Services, Child Protection, Primary and Secondary Education

[5] This was a point also made in the Wood Police Royal Commission.

[6] Refer further to our 2022-23 Annual Report accessed at: <NSW Ombudsman Annual Report 2022–23 - NSW Ombudsman>.

The groupings above are indicative at this stage. Once implemented it will be capable of adjustment, depending on the nature and volume of complaints received. Our jurisdiction is extremely broad (there are thousands of public authorities and service providers we could receive complaints about), and any complaints we receive about other agencies (not covered by one of the above sectors) will be allocated across the teams as necessary based on their capacity at the time.

As indicated above, one of our teams (Team 4 above) will specialise in dealing with complaints about the NSW public health system. However, given the volume of complaints we currently receive, and our current resources, we will not be able to have a team that specialises only in the NSW public health system.

In relation to formal investigations, each investigation is led by a Principal Investigator, of which we currently have 5. Given this number, and the fact that our investigation jurisdiction is extremely broad, we do not currently have a Principal Investigator dedicated to leading investigations in relation to the NSW public health system.

As noted in our submissions, our new Health Administration Unit will be established over the coming months. This will likely result in an increase in the complaints and other matters that are raised with our office. However, it will not materially increase our capacity to undertake investigatory action in response to those matters. That is because the function of that small unit is primarily to increase the visibility and accessibility of our office, and to help co-ordinate the work of our existing functional branches (including complaint-handling), rather than to undertake complaint-handling or investigatory functions itself. As such, the new unit will both increase our focus on health administration matters as well as likely drive an increase in visibility and accessibility – and consequently complaints – from the health sector to our office.[7]

Should this result in us identifying a clear need for additional resources to carry out our functions (for example, a need for an additional team in CRB that is devoted solely to NSW public health system matters and/or the need for additional Principal Investigator/s devoted to the investigation of NSW public health system matters), we will submit a budget proposal accordingly.

Question

5. The *Ombudsman Act 1974* and new *Public Interest Disclosures Act 2022* provide protection to those who complain or disclose information to the NSW Ombudsman (pp.3-4).

a. Are health workers are adequately protected from detrimental action if they make complaints about health administration?

Answer

There are robust (and broadly equivalent) statutory protections against detrimental action for those who:

(a) make a complaint to the Ombudsman about maladministration under the *Ombudsman Act 1974*,

[7] Refer further to our submission dated 13 October 2023 and the document tendered at hearing on 24 November 2023, 'NSW Ombudsman paper regarding Health administration – December 2022'.

(b) make a complaint to the ICAC about corrupt conduct under the *Independent Commission Against Corruption Act 1988*, and

(c) disclose 'serious wrongdoing' by way of a public interest disclosure (PID) under the *Public Interest Disclosures Act 2022* (the PID Act).[8]

However, in our submission to the Committee dated 13 October 2023, we noted that protections for public health workers who report other concerns may vary based on what they report and to whom.

In particular, the PID Act protections apply only if the person is reporting 'serious wrongdoing', which is defined exhaustively as 'corrupt conduct', 'serious maladministration', 'serious and substantial waste or public resources', and a number other specific kinds of wrongdoing.

However, there may be some matters that health workers wish to report, such as a clinical incident or failure, a risk to public health or safety, or sexual or other harassment, that are not explicitly including as a category of 'serious wrongdoing' under the PID Act.

This means that, whether those who report such matters will be protected may depend upon:

(a) whether the matter being reported also raises some allegation of 'serious wrongdoing' as defined in the PID Act

For example, if a report is made of a clinical failure and *also* alleges that there has been a 'cover up' of that failure, then that would bring the report into the category of 'corrupt conduct' or 'serious maladministration' and so may constitute a PID that would attract the protections under PID Act.

or

(b) whether there may be other protections available under other legislation

For example, there are some protections available to those who make a complaint to the Health Care Complaints Commission (see s 98 *Health Care Complaints Act 1993*) or to SafeWork NSW (see ss 104-106 *Work Health and Safety Act 2011*). However, these protections appear to be more much more limited than those under the PID Act.

We have previously noted that consideration could be given to amending the new PID Act to include additional categories of 'serious wrongdoing' such as serious risk to public health and safety which would attract the protections under the PID Act.[9] Alternatively, the protections under other legislation (such as the Health Care Complaints Act) could be enhanced to be consistent with those in the PID Act.[10]

Question

6. When will the new Health Administration Unit and Health Administration Deputy Ombudsman role be established (pp.4-5)?

[8] NSW Ombudsman guideline, 'Protections under the PID Act' accessed at: <Protections under the PID Act - NSW Ombudsman>.

[9] See for example NSW Ombudsman report, 'Special report by the NSW Ombudsman on the Public Interest Disclosures Bill 2021' accessed at: <Special Report by the NSW Ombudsman on the Public Interest Disclosures Bill 2021>.

[10] Refer further to evidence given at hearing on 24 November 2023 and document tendered same date, 'NSW Ombudsman paper regarding Health administration – December 2022'; and NSW Ombudsman report, 'Oversight of the *Public Interest Disclosures Act 1994*: Annual Report 2022-23' at <Oversight of the Public Interest Disclosures Act 1994 Annual Report 2022-23 (nsw.gov.au)> p 23.

Answer

Recruitment of the Health Administration Deputy Ombudsman is underway, and we expect the new deputy ombudsman to be onboarded around February 2024. The deputy ombudsman will initially focus on recruiting the 3 other team members for the Health Administration Unit and developing the unit's operating model and work plan. The Health Administration Unit should be operational within the next 3-6 months.