Ombudsman Tasmania

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7 March 2019

The Hon Ivan Dean MLC
Chair
Parliamentary Standing Committee of Public Accounts
Parliament House
HOBART Tas 7000

Dear Mr Dean

Re: Inquiry to Examine the Office of the Ombudsman and Health Complaints Commissioner

Thank you for your letter of 4 December 2017 and the invitation to make submissions in response to the above Inquiry's terms of reference. In response, I provide the following.

The Office of the Ombudsman is responsible for six separate jurisdictions: the Parliamentary Ombudsman, the Health Complaints Commissioner, the Energy Ombudsman, the external review of decisions under the *Right to Information Act 2009*, the Official Visitors Programs and the Custodial Inspectorate. The Energy Ombudsman is separately, and adequately funded by the state's energy entities and will not be referred to further in these submissions.

The functions of each jurisdiction require slightly different skill sets with officers in RTI completing technical, legal decision-making, Ombudsman officers conducting research and investigations, Custodial Inspectorate staff undertaking inspections against a set of established standards and Health Complaints officers working to resolve complaints made by consumers against health service providers.

The functions and duties of the Office have increased over recent years while at the same time, funding has been cut. A significant reduction in budget following the Global Financial Crisis in 2008 led to the closure of our Launceston office and the loss of an Investigation Officer and further cuts made in 2014 as part of a failed colocation strategy meant that another position could not be filled.

1. OMBUDSMAN

Fulfilling All Statutory Responsibilities

1.1 The Ombudsman performs a vital role in ensuring public confidence in government and providing an oversight function to ensure good administrative decision-making, investigating

public interest disclosures and personal information breaches as well as having an advisory and educative role.

1,2 The Ombudsman has responsibilities and functions under a range of statutes, the number of which continues to grow. This broad range of functions requires the diversion of considerable resources away from the more traditional complaint-handling and investigative functions under the Ombudsman Act. The need to perform these additional functions puts a significant strain on existing resources; staffing levels are inadequate and significant issues of public interest cannot be investigated.

1.3 The Ombudsman's responsibilities include the following:

- general Ombudsman Act complaint-handling and investigations;
- disclosures under the *Public Interest Disclosures Act 2002* (whistle-blowers legislation) - the office receives and investigates disclosures and also has an advisory function;
- taking complaints under the *Personal Information Protection Act 2004*;
- undertaking inspections pursuant to various police powers statutes;
- conducting a review of the use of new police powers under Part II, Division III of the *Police Offences Act 1935* (the consorting laws) to be undertaken within four years of the commencement of the Act; and
- rarely used review powers under adoption and witness protection legislation.

1.4 The office also has a direct telephone line on the Tasmania Prison Service's Arunta phone system which is connected to all the states detention facilities that prisoners can use to lodge complaints. We receive many calls from prisoners each day that require additional work and follow-up.

1.5 All of these functions are performed with a current staff establishment of 4.0 FTE. The present establishment is comprised of one 1.0 FTE Principal Officer Band 8, one 1.0 FTE Senior Investigation Officer (SIO) at Band 6 and two Band 5 Investigation Officer (IO) positions.

1.6 The Ombudsman provides a vital service not only by promoting best practice in public administration and decision-making, but also by promoting good governance more generally. Any inability on the part of the office to adequately perform all or any of its functions may compromise the delivery of services and adversely affect public confidence in it. Under-resourcing an office such as this could also give rise to a perception that vital oversight is not a genuine priority for government, and our inability to accept and investigate matters of public interest strengthens that perception. A properly resourced Ombudsman providing effective oversight is an indicator of a robust executive government.

1.7 Although the office saw a slight reduction in the number of complaints received in the 2017-18 financial year (9%), as noted, the amount of work generated by areas outside the traditional complaint-handling function has been steadily increasing. Public interest disclosure activity has increased significantly in recent years, with many public authorities making use of the Ombudsman's advisory function, as well as reporting disclosures to us. This legislation is complex and prescriptive and its administration is time-consuming and resource–heavy.

1.8 In addition, twice each year we undertake inspections of documents in the possession of Tasmania Police in relation to the exercise of invasive police powers and must report on these. We have already met with police to discuss the new, unfunded review function in relation to the consorting provisions recently included in the Police Offences Act.

1.9 The office has received several personal information protection complaints in the last financial year when historically this legislation has rarely been utilised. We are currently scoping a number of significant investigations, of complaints and own motion, but find it difficult to undertake any major investigation with such a small team, far less run more than one at any time. This means that significant issues that we have identified, and which are of public interest and importance, cannot be investigated due to inadequate resourcing.

1.10 We regularly receive requests for training from government departments and local government councils, particularly in relation to public interest disclosures, responding to general Ombudsman Act complaints and about principles of administrative law, but we are unable to provide training due to staffing levels. Training in good administrative practice, as well as how to properly comply with whistle-blower and information protection legislation, is a vital part of promoting good governance but we just cannot address this need with a staff of four.

1.11 Additional funding is required, and has been sought, to recruit an additional 1.0 FTE permanent Band 6 Senior Investigation Officer and 1.0 FTE permanent Band 4 Intake and Assessment Officer to address the staffing shortfall. A new full time SIO position would allow us to undertake the investigation work and the Band 4 position would assess and manage the simpler complaints and deal with the bulk of the prisoner calls in the first instance. This would also free up officer hours to formulate and deliver some much-needed training to stakeholders.

2. HEALTH COMPLAINTS

2.1 The Health Complaints Commissioner performs a vital role in promoting and protecting health rights. It receives assesses and resolves complaints and feeds back into the safety and quality framework of the Tasmanian health system. The Commissioner is independent, impartial and an alternative to costly litigation.

Fulfilling Existing Statutory Responsibilities

2.2 Increased complaint numbers and decreased staffing levels over the last ten years, and particularly the last four years, have resulted in an inability to meet the legislative obligations of the *Health Complaints Act 1995*.

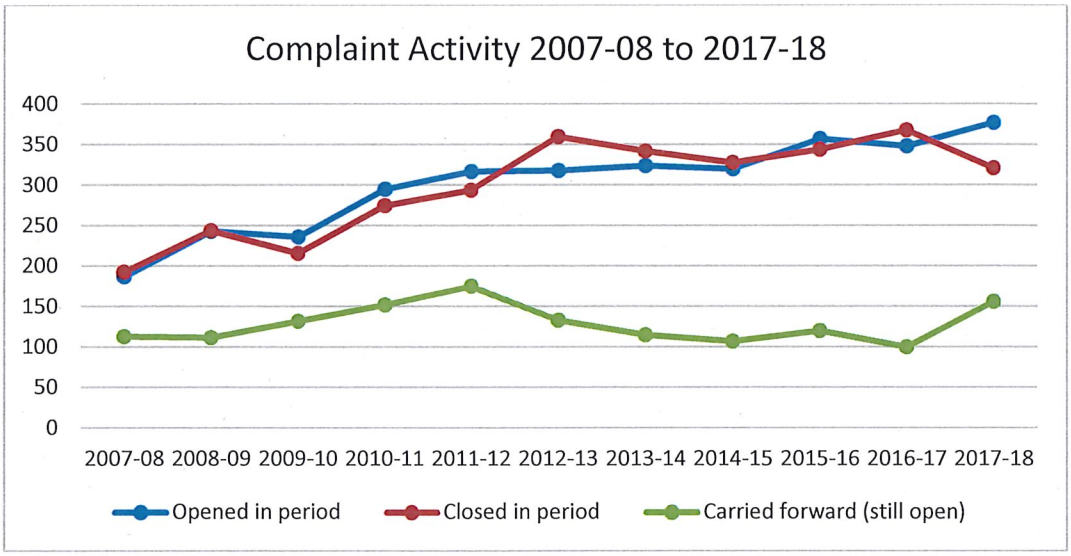
2.3 More complaints are being opened than closed, assessment times are not being met, matters that require investigation are not being investigated and matters that would benefit from conciliation are not being conciliated. The Charter of Health Rights has not been reviewed since its inception and there has been no outreach or education about health rights and responsibilities. There has been an increase in the number of complaints about delays on the part of the Commissioner and the impact of those delays on both consumers and providers of health services.

2.4 The Health Complaints jurisdiction includes all health services in Tasmania, public, private, individual and organisational. Under the Act, the Commissioner is required to receive, assess, and resolve complaints about health services in Tasmania and to use those complaints to feed

back into the safety and quality framework. By virtue of the definition of a 'health service', and in the absence of a Disability Service Commissioner in Tasmania, the jurisdiction also includes disability services.

2.5 Since July 2010 any complaints received about registered health practitioners are required under the *Health Practitioner National Law Act 2009* (National Law) to be notified to the Australian Health Practitioner Regulation Agency (AHPRA) and agreement reached as to how the complaint ought be handled. This consultation process, which is guided by an MoU between AHPRA and the Health Complaint Entities throughout Australia, has added an extra level of complexity to complaint management.

2.6 The number of complaints received over the past ten years has doubled. Throughout the same period, staffing levels available to manage those complaints has reduced by one third. The result is an inability to manage the volume of complaints received and an increase in the number of complaints carried forward each year.



2.7 Over the past four years, the number of matters referred to and resolved at conciliation has fallen dramatically. This followed the retirement of a part time conciliator and coincided with the need for the remaining conciliator (who is also the Principal Officer) to undertake additional management responsibilities as well as undertake assessments in the absence of adequate resourcing to recruit and retain investigation and resolution officers. For five years prior to this conciliation had been the cornerstone of the HCC complaint resolution process. Not only were complaints resolved without the need for litigation but significant systemic improvements were made by collaboration between the parties, and relationships were restored.

2.8 A number of significant issues have been brought to our attention that would benefit from investigation by the HCC. These are in areas that impact adversely on vulnerable groups (people with disabilities, non-English speaking people and those with mental health issues). Lack of resourcing has meant that these have not yet progressed.

2.9 Low staff levels have not only had an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, they have resulted in an inability to perform other functions of the Commissioner, including:

- to undertake assessment, investigations and conciliations in a timely manner;

- to undertake own motion investigations.

- to monitor and audit outcomes from complaints and coronial investigations;

- to bring about changes and improvements in the delivery of health services;

- to undertake outreach or community education, resulting in vulnerable groups in the community, including those with low health literacy, being unaware of their rights or our existence;

- complaints go unreported - people with complaints about health and disability services are often the most vulnerable, they are afraid of repercussions or lack the skills to make a complaint, they need encouragement and support but current resourcing does not allow for this; and

- to respond to, attend or provide input into requests for stakeholder involvement and consultations in areas relevant to our jurisdiction, for example: proposed amendments to the Health Practitioner National Law; the development of guidelines for registered health practitioners; the review of the *Disability Services Act 2011* and the *Guardianship and Administration Act 1995*; and Mental Health symposia.

2.10 There are significant risks posed by an inadequately funded Health Complaints Commissioner. Over the past four years, the number of matters referred to and resolved at conciliation has fallen dramatically. This followed the retirement of a part time conciliator and coincided with the need for the remaining conciliator (who is also the Principal Officer) to undertake additional management responsibilities as well as undertake assessments in the absence of adequate resourcing to recruit and retain investigation and resolution officers. For five years prior to this conciliation had been the cornerstone of the HCC complaint resolution process. Not only were complaints resolved without the need for litigation but significant systemic improvements were made by collaboration between the parties, and relationships were restored.

2.11 The Health Complaints Act was, at least in part, designed to provide an alternative avenue of redress to highly regulated, time consuming and expensive civil court proceedings. It was intended that the Office would develop procedures which emphasise conciliation rather than court-based litigation, which is becoming increasingly expensive and does not identify, address or attempt to remedy the underlying causes of concerns about health services. It was also intended to establish an accessible, structured complaints resolution system providing health consumers with a focus for complaints, and consistent procedures for assessing, resolving and following up those complaints.

2.12 Inadequate resourcing undermines these intentions and the role of the Commissioner because health service users are not always able to have their complaints and concerns dealt with and resolved in a timely and appropriate manner. There is a risk of the perception arising that government is not committed to this vital part of the Tasmanian health system, and good, affordable and timely outcomes for its users.

2.13 In order to meet current legislative obligations funding to recruit an additional 0.8 FTE permanent Band 6 Senior Investigation Officer, a 1.00 FTE permanent Band 6 Conciliation Officer and a 1.00 FTE permanent Band 5 Complaint Resolution Officer. This would restore

the health complaints jurisdiction to the establishment as it was in 2006/7 and 2007/8 at which time, although there were significantly less complaints, we were able to fulfil most of our statutory obligations. It would also bring the HCC jurisdiction into closer alignment with other entities with a similar mandate.

Additional Responsibilities - A National Code of Conduct for Unregistered Health Care Workers

2.14 Australia's Health Ministers agreed in principle to the establishment of a National Code of Conduct for Unregistered Health Care Workers (such as naturopaths, social workers and counsellors) at a meeting of the Commonwealth Parliamentary Standing Committee on Health in June 2013. It was further agreed at the Council of Australian Governments Health Council meeting in April 2015 that the code would be established. Each State and Territory is responsible for enacting new, or amending existing legislation to give effect to the Code.

2.15 Amendments to the *Health Complaints Act 1995* were passed recently to implement the Code. Responsibly for administration of the Code falls to the Commissioner. A proclamation date has not yet been set. The Commissioner will have the power to issue prohibition orders and make public statements about unregistered health care workers who breach the code and pose a risk to the public.

2.16 The work involved will be different to what we presently do. Given the potential to impact on a person's livelihood it will carry a high degree of responsibility. The HCC will become, in effect, the equivalent of AHPRA for unregistered practitioners. The nature of the investigation required to justify the making of prohibition orders and public statements will be more in the nature of a prosecution than an investigation.

2.17 The additional staff necessary to meet existing responsibilities referred to above will be inadequate to meet the additional responsibilities involved in administering the code of conduct. Additional funding for specialist staff will be required and existing staff will require additional training before entering into that process.

2.18 Consultation with other Health Complaint Entities currently operating under the Code indicates that at the very least we will require a senior legal officer plus two full time Band 5 investigation officers.

2.19 It is not possible to say how many notifications we might receive but even one will mean an added strain on resources that are already stretched. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the code.

2.20 Though the numbers of complaints against unregistered practitioners in the jurisdictions which already have codes of conduct are small, they require considerable input in terms of resources. The very fact that the practitioners are unregistered means there is no board or other professional representative body to whom complaints can be referred: they all must be dealt with by the Commissioner.

2.21 The experience of the already codified jurisdictions is that the conduct of some unregistered practitioners poses a significant danger to the health of their patients, which is why the power to impose prohibition orders to avert that danger is included in the legislation. The risk of not providing additional funding and resourcing to address these matters in Tasmania is that the Office of the Health Complaints Commissioner will not be able to deal with them, with

the consequent risk to the Tasmanian public posed by dangerous and unlawful practices not being adequately addressed or prevented.

3. RIGHT TO INFORMATION

3.1 The Office continues to face resource pressure in managing the Right to Information (RTI) jurisdiction. The office currently operates with 1.0 FTE Band 6 Senior Investigation and Review Officer (SIRO). Additional resources are required to manage the RTI jurisdiction effectively and meet the legislative obligation to complete reviews as soon as practicable.

3.2 In order for the RTI jurisdiction to fulfil its functions additional funding is required to recruit an additional 1.0 FTE Band 8 Principal Officer, an additional 1.0 FTE Band 4 Investigation Officer (IO) and to retain the existing Band 6 SIRO. This would align RTI with the other jurisdictions administered by the office, each of which has a dedicated Principal Officer, and provide for managerial oversight with an appropriate two-tiered process. This would also allow the office to meet its other legislative obligations such as the provision of education and training, the review and maintenance of guidelines, and the review and update of the RTI Manual, which it is not at present doing.

3.3 No opportunities exist to reprioritise or discontinue any existing activities in order to fund or partially fund additional resources in the Right to Information jurisdiction. There are no additional activities or projects that staff are working on that can be cut. Current resourcing is insufficient to meet legislative requirements.

3.4 The additional 2.0 FTE permanent employees sought would establish an appropriate number of staff to manage the RTI function efficiently and meet the minimum legislative obligations of the office under the RTI Act.

3.5 Only having one 1.0 FTE Band 6 SIRO responsible for managing RTI matters involving all public authorities means that the current workload is not manageable; the office is unable to meet all legislative requirements and it needs significant assistance to meet the minimum requirements of the Act.

3.6 In 2016/17, the office was able to engage two 1.0 FTE Band 6 SIROs. For that financial year, the average time taken to complete an external review, which is the primary function of this jurisdiction, was 230 days. In 2017/18, with only the one 1.0 FTE Band 6 SIRO, the average time to complete an external review rose to 318 days. The 2018/19 YTD figure is approximately 881 days. This is an increase of 177% from the previous year.

3.7 The number of external reviews being requested remains static and the work required into the future is reasonably expected to compound. If the YTD figures remain steady, the 2019/20 average days can only rise further. There has been a consistent case load of approximately 53 current cases. The public, media, and Members of Parliament already complain on a regular basis, and RTI funding and delays in OHCC are frequently the subjects of media attention. Without significant resourcing to correct this long-term underfunding, it is anticipated the community, media, and political pressures will increase public dissent further.

3.8 In addition to conducting external reviews of decisions, the Right to Information Act also requires the Office to issue and maintain guidelines for the use of agencies and to issue and maintain a manual related to the operation of the Act. The Act also mandates the provision by the Office of advice to agencies and Ministers in relation to the Act. In the past, training has been offered to assist agencies to comply with their responsibilities but at the present,

there are no resources for training or revising and updating the guidelines and manual and the Office is unable to adequately meet its statutory role. As a result the government's commitment to openness and transparency in this space is hindered.

3.9 As at the date hereof, there are 53 active RTI files, and still only the one officer to deal with them. Many are extremely complex and involve a large volume of information. The average number of days open for these files is 408, an increase of nearly 50% over last year, which is completely unsatisfactory. It is not in the interest of either of the parties to a review that its finalisation takes so long, but perhaps particularly so for the applicant who often seeks information for a specific purpose which delays can easily overtake.

3.10 It is not only the size and complexity of reviews that contribute to the delay, but also the fact that a large number of agencies are not fully aware of their obligations under the Act and what is required of them when processing and making a decision on an application for information. If the Office were adequately resourced to provide training to agencies, then agency processes and decision making is likely to improve and the number of decisions requiring external review should reduce.

3.11 With additional staff, time and resources could also be devoted to the Office's other important functions under the Act. Funding for this jurisdiction is required on a recurrent basis to ensure the continued support of all public authorities in dealing with RTI requests for review and managing the significantly increasing associated complaints.

4. CUSTODIAL INSPECTOR

4.1 The Office of the Custodial Inspector was established in 2016 and has oversight of all five Tasmanian adult custodial facilities: the Risdon Prison Complex (medium and maximum security); the Ron Barwick Minimum Security Prison; the Mary Hutchinson Women's Prison; the Hobart Reception Prison; and the Launceston Reception Prison, all of which are operated by the Tasmania Prison Service (TPS). It also has oversight of the Ashley Youth Detention Centre which is managed by Children and Youth Services, an operational unit of the Department of Communities Tasmania. The jurisdiction of the Inspector also includes prisoner and detainee transport vehicles.

4.2 The Inspectorate is currently staffed by 1.5 FTE permanent employees – one 0.9 FTE Principal Officer and one 0.6 FTE Inspection and Research Officer - and is overseen by the Inspector. The Inspector is the Ombudsman and 10% of my time is allocated to the Inspectorate. This staffing establishment is proving insufficient to fulfil the Inspector's legislative responsibilities including completing the mandatory inspection of all custodial centres at least once every three years. The Inspectorate's experience to date also indicates consultancy costs are a major impost on budget and the current allocation for these services is entirely inadequate.

4.3 The first round of mandatory inspections and delivery of inspection reports is due to be completed by 31 December 2020. Without additional and adequate funding, this will not be achieved. This failure will be the subject of unfavourable scrutiny both internal and external to government. There is no action that can be taken by the Inspectorate to mitigate the risk. The staffing establishment is insufficient and requires further funding.

4.4 Currently, inspections at all custodial centres are undertaken by both staff members together. Inspectorate staff have unfettered access to custodial centres and prisoners and detainees and for safety and security reasons, inspection activities are never undertaken by one staff member alone. This restricts the time that at least one staff member could be using to undertake other

tasks such as report writing and research. It also results in both staff accumulating significant extra hours which are taken as flex time or time off in lieu after the inspection is completed. With only two staff, the absence of one or the other has a significant impact on productivity.

4.5 Following inspections, staff conduct further analysis of the evidence and prepare a draft report. Report writing is extremely time consuming and forms a major part of the work undertaken by the Inspectorate. There is currently a backlog of inspection reports; only one inspection has been reported, two inspections reports are yet to be written and one inspection is yet to be completed and must be reported on before the end of 2019. This is despite inspections commencing in earnest from May 2017.

4.6 As well as undertaking inspections and writing reports, the Inspectorate is constantly monitoring issues of concern with both Tasmania Prison Service and Communities Tasmania by way of ongoing spot checks and reviews. Issues of concern are investigated by interrogating information systems and holding discussions with staff and where relevant, prisoners. The issue will be considered by the Inspector and if it is determined to be necessary, a meeting will be arranged with management of the relevant facility to raise and discuss the issue. Where recommendations are made or changes are to be implemented, the issue will be noted for follow up and consideration at the next appropriate inspection.

4.7 Funding needs to be sufficient to recruit an additional two 1.0 FTE permanent employees, one at Band 6 and one at Band 5, and for the hours of the current Band 5 to be increased from 0.6 FTE to 0.8 FTE. This will establish an appropriate staffing infrastructure to manage the Inspector's functions and meet the Inspectorate's legislative mandate. This staffing model would ensure that all custodial centres will be inspected within the required three years, and the reports following those inspections will be completed within a reasonable timeframe for 2019 and into the future. Ideally, the Band 6 position will lead inspections and undertake report writing duties under supervision of the Principal Officer.

4.8 The proposed staffing establishment would allow for Inspectorate staff to 'pair up' for safety and security reasons, and inspect different custodial centres, or aspects of custodial centres, at the one time. The establishment will also lead to more timely reporting and time to develop a plan and strategy for future inspection processes and the ongoing operation of the Inspectorate.

4.9 Sick leave, recreation leave and long service leave are unable to be covered with the current staffing arrangement. Additional staff resources would ensure that the inspection and reporting schedule could continue year round to ensure the Inspector's legislative mandate is met, despite any leave taken. There would also be the opportunity for professional development, which does not really exist at present.

4.10 Additional funding is also required for other costs incurred by the Inspectorate, particularly consultancy fees and vehicle expenses.

4.11 Consultancy fees are a necessary expense, given the broad range of expertise required to inspect against all standards. The use of consultants is critical to provide independent expert advice and opinion to assist with and support the inspections. The use of consultants by prison inspectorates is an accepted practise both nationally and internationally, with other custodial inspectorates in Australia and Her Majesty's Inspectorate of Prisons for England and Wales using experts to assist with inspections.

4.12 As noted, the legislation requires that the Inspectorate must carry out a mandatory inspection of each custodial centre at least once every three years. The current budget for consultancy fees is insufficient to meet this legislative mandate as it means that only one consultant can be used per year based on the cost of consultants.

5. OFFICIAL VISITORS

5.1 The Ombudsman is the Co-ordinator of the Prison Official Visitors and the Principal Mental Health Official Visitor.

5.2 Section 10 of the *Corrections Act 1997* requires that each prison is visited once a month. There are six prisons in Tasmania including the two reception prisons, the maximum-security prison, medium and minimum-security prisons and the Mary Hutchinson women's prison. Currently six official Visitors make 94 visits to the various prisons over the course of the year to meet this requirement. Each visit is followed by a report to the Coordinating Official Visitor. These Visitors also meet with Director of Prisons every four months and with the Minister two or three times a year.

5.3 Official Visitors have an important role in identifying grievances and other issues that require rapid remedial action. Prisoners see Official Visitors as independent from prison management and Official Visitors are able to identify issues, which if not addressed quickly could escalate. In the past when there were disturbances in the prison, the Minister of the day requested that Official Visitors make twice as many visits to the prison each month. This was recognised as a way to resolve prisoner complaints as quickly as possible and reduce tension in the prison environment.

5.4 The *Mental Health Act 2013* requires that each approved hospital is visited once a month. There are six approved hospitals in the state for the purposes of the Act, namely: the North West General Hospital: the Launceston General Hospital; the Royal Hobart Hospital; the Roy Fagan Centre; the Millbrook Rise Centre; and the Wilfred Lopes Centre.

5.5 A team of two Visitors visits each hospital once a month and an average of 108 visits are made each year. After each visit, the team produce a comprehensive report for the Principal Official Visitor.

5.6 Mental Health Official Visitors, apart from reporting on complaints and issues that need resolution, are able to provide rapid feedback to senior staff about potentially serious issues that could affect a patient's care and treatment. Senior managers welcome the early identification of quality and safety issues. As with prison Official Visitors, patients see mental health Official Visitors as objective and independent from mental health staff, and able to bring problems and issues to the appropriate senior staff member as quickly as possible.

5.7 Official Visitors are not employees but receive remuneration of $25.00 per hour to perform their duties. This remuneration has not changed since 2009 and it is presenting recruitment and retention problems particularly in the north of the state. It is also less than the rates paid to Official Visitors in other jurisdictions.

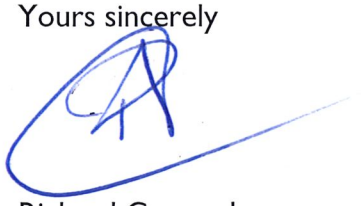
5.8 Visitors are recruited from interested and suitably qualified members of the public, and may be in part time employment or retired. They require training to gain a sound understanding of the functions of the role as required by the relevant act. To be an effective Visitor they must be skilled communicators and good report writers. The have to be comfortable undertaking their duties in a prison or on a closed mental health ward in a hospital.

5.9 Their role in receiving and investigating complaints from prisoners and patients requires a great deal of skill and their reports may ultimately result in an investigation by the Ombudsman or the Health Complaints Commissioner. Thus, integral to a professional and efficient Official Visitor program is a well-structured training program that provides Visitors with training when they are first recruited, and maintains and improves those skills during their period of appointment.

5.10 The overall budget of the program has not changed since 2009 when the program transferred to the Office of the Ombudsman. In the past training was funded from opportunistic savings in the operating budget, so has only occurred when these exist. Savings are not likely to exist into the future. To maintain a basic training program for Official Visitors requires additional funding.

Thank you for the opportunity to make submissions, and if you require anything further, please do not hesitate to let me know.

Yours sincerely



Richard Connock
OMBUDSMAN