QUEENSLAND OMBUDSMAN

Learning from experience

Insights from 20 years of Queensland Ombudsman investigation reports

November 2022

The *Ombudsman Act 2001* accords the Ombudsman the dual functions of investigating administrative actions and improving the quality of administrative practices and procedures.

Our improvement function was ushered in by the 2001 Act, which replaced the previous *Parliamentary Commissioner Act 1974*.

To recognise the 20th anniversary of our 'improvement' function, we analysed the rich seam of insights contained in the public reports and casebooks of our investigations since 2001.

Comparing performance across **time**, **contexts** and **sectors** has been identified as a useful way for the public service to learn to improve from its successes and failures.

Our aim was to compare the insights from our reports to identify the most common causes of problems for agencies, and strategies to address them.

I hope that agencies will find these insights to be a useful perspective for their organisational improvement and risk management processes.

Anthony Reilly
Queensland Ombudsman

Summary

What did the Ombudsman find?

Analysis of 20 years of Ombudsman reports found that problems consistently occurred in these top five areas:

1. Policies and procedures

69% of QO reports

Operational policies and procedures form the fundamental framework to guide staff on how to perform their jobs well. Policies need to comprehensively address operational issues, be effectively communicated to staff and be regularly reviewed.

2. Communication

58% of QO reports

Good communication with stakeholders, clients and other agencies is vital. Strategies such as providing reasons for decisions, using human-centred design and improving governance arrangements with partner agencies support fairness, ensure transparency and promote accountability in decision-making.

3. Performance monitoring

56% of QO reports

Performance report information needs to be meaningful, and the performance of operational areas should be regularly reviewed.

4. Information and records management

50% of QO reports

Good information and records management is fundamental to quality, compliance and accountability.

5. Workforce capacity

47% of QO reports

To achieve their objectives, agencies need well supported staff with the right knowledge and skills to fulfil those objectives.

The reports and casebooks referred to in this report are on our website: www.ombudsman.qld.gov.au/improve-public-administration/reports-and-casebooks

1. Policies and procedures

69%
of QO reports identified an **issue about policies and procedures** as a factor for the problem under investigation

Insights

Operational policies and procedures form the fundamental framework to guide staff on how to perform their jobs well.

Report insights include:

- **policies and procedures should comprehensively address operational issues** – 15 reports recommended developing new policies and procedures due to identified gaps. Gaps are particularly problematic when they relate to operational areas of high risk or matters of legislative compliance. Policies and procedures must always have a legal basis and not go beyond (or limit) the law
- **policies and procedures need to be regularly reviewed and updated** to ensure that they remain up to date, respond to changes in the operating environment and reflect good practice
- **policies and procedures need to be effectively communicated** in a way that ensures they are received, read and recalled by staff. Policies and procedures should be collated in a single area that is easily accessible to all staff
- **overlapping policies can create confusion** – agencies should avoid having multiple policy manuals or different requirements in guidelines that overlap.

Case studies

***Casebook 2022* – Review of dog attack procedures**

A council's procedures for responding to dog attacks required improvement relating to assessing declared dangerous dog enclosures.

***Brisbane Youth Detention Centre report* (2019)**

The report highlighted the challenges of effectively communicating operational directives from managers to frontline staff. In this case, as it was common for some operational staff to not access emails for extended periods of time, the use of emails was not effective.

***Workplace Death Investigations report* (2015)**

A review of 20 workplace death investigation files found investigation planning consistently resulted in more comprehensive investigations and reports. On this basis, the report recommended that the policies and procedures manual be amended to establish a mandatory planning process for all investigations.

***Workplace Electrocution Project report* (2005)**

In relation to one of the incidents investigated, it was found that that were seven guidelines and manuals containing numerous overlapping requirements. This was a source of considerable confusion in the industry.

***Brooke Brennan report* (2002)**

A lack of written policies or procedures about issuing '96 hour orders' under the then Health Act contributed to inconsistent decision-making.

2. Communication

58%
of QO reports identified **ineffective communication** as a factor for the problem under investigation

Insights

Good communication with stakeholders, clients and other agencies is vital. Strategies such as providing reasons for decisions, using human-centred design and improving governance arrangements with partner agencies support fairness, ensure transparency and promote accountability in decision-making.

Report insights include:

- confusion and dismay that incorrect or inconsistent information can create for community stakeholders
- the importance of providing reasons for decisions to people affected by the decisions
- the benefit of human-centred design when designing forms
- poor inter-agency communication can lead to service delivery problems
- communication strategies should be sensitive to impacts on clients.

Case studies

***Casebook 2020* – Better management of expectations**

Insufficient provision of public information about the rights and obligations of people under a work and development order resulted in clients agreeing to orders without fully understanding them.

***Indigenous birth registration report* (2018)**

The use of a single online application form for birth registration and obtaining a birth certificate caused confusion about which process incurred a cost.

***Hendra Virus report* (2011)**

The report found that the different approaches adopted by response agencies to Hendra virus incidents may have given rise to a perception of inconsistency between the agencies, leading people to be confused about the correct approach and eroding public confidence in the government's response.

***Classification and Movement of Prisoners report* (2009)**

Failure to provide reasons to prisoners for placement decisions was unreasonable administrative action.

***Pacific Motorway report* (2007)**

Residents' concerns about noise from a motorway upgrade were magnified as the increased noise levels contradicted statements made in the department's impact management plan.

***Baby Kate report* (2003)**

To improve coordination between hospital and child safety staff about at-risk babies, the report recommended that the departments involved develop a memorandum of understanding.

3. Performance monitoring

56%
of QO reports identified **poor performance monitoring** as a factor for the problem under investigation

Insights

Performance report information needs to be meaningful, and the performance of operational areas should be regularly reviewed.

Report insights include:

- monitoring reports need to have sufficient information to enable meaningful analysis
- oversight mechanisms, such as regular audits or reviews, are important to ensure that decisions are authorised
- customer complaints are an important source of information to understand and address problems.

Case studies

Casebook 2022 **– Improvements to breach of discipline hearing processes**

A review of 50 breach of discipline hearings identified areas for improvement such as communication of the process and outcomes.

Management of child safety complaints – second report **(2020)**

The report recommended the development of a meaningful reporting framework to identify systemic issues and opportunities for improvement emerging from complaints.

Strip Searching of Female Prisoners report **(2014)**

The lack of any review of strip search practices over a long period was considered to have contributed to their unauthorised use.

Air Link Project report **(2011)**

To improve noise monitoring from night-time surface work, the Ombudsman recommended that the agencies involved review noise data in the monitoring reports, and include further details such as monitoring undertaken, relevant noise goal, mitigations applied and instances where noise exceeded the limit.

4. Information and records management

50%
of QO reports identified **a deficiency in information and records management** as a factor for the problem under investigation

Insights

Good information and records management is fundamental to quality, compliance and accountability.

Report insights include:

- well-designed information systems can support improved outcomes
- poor information and records management can potentially impact on service quality and affect legislative compliance
- proper records improve accountability by enabling an agency to establish how particular decisions were made, in the event that the agency needs to revisit a matter for any reason.

Case studies

***Fire ants report* (2021)**

The introduction of a new digital data entry capability for field officers contributed to improvements in timeliness of service responses.

***Casebook 2020* – Lack of investigation recordkeeping**

The lack of analysis and apparent reasons in department records about an investigation of fraud allegations caused concerns about the quality of the investigation.

***Forensic Disability Services report* (2019)**

Identified failings in recordkeeping were considered to have impacts such as reduced capacity for clinical oversight, hindering information sharing across the service and reduced ability to measure outcomes and track the progress of people detained.

***Classification and Movement of Prisoners report* (2009)**

Technical limitations in the department's information management system undermined the ability of officers to comply with legislative requirements for information notices about security classification decisions.

***Justice on the Inside report* (2009)**

The report highlighted the importance of keeping records, such as video records of hearings, to enable compliance with policies to be assessed.

***Daintree River Ferry report* (2006)**

The failure by two officers to make a file or diary note of telephone discussions with the successful tenderer in a procurement process exposed those officers and the council to allegations of bias.

5. Workforce capacity

47%
of QO reports identified **a lack of workforce capacity** as a factor for the problem under investigation

Insights

To achieve their objectives, agencies need well supported staff with the right knowledge and skills to fulfil those objectives.

Report insights include:

- staff having the necessary skills and knowledge to fulfil their roles competently
- adequate staff training
- refresher training to maintain knowledge currency.

Case studies

***Casebook 2022* – Agency officers must understand how to apply policies**

Staff uncertainty led to incorrect application of agency complaints management procedures, which resulted in widespread public expression of dissatisfaction.

***Neville report* (2011)**

The report found a number of workforce issues in an emergency department, including staffing contrary to recommended standards, contributed to a defective system of care.

***Justice on the Inside report* (2009)**

The report highlighted the importance of refresher training on procedures for custodial officers who conduct breach processes.

***Q150 Contract report* (2008)**

Among the identified causes of problems with the procurement process was that the responsible project officer had not received adequate training in procurement procedures.

***Miriam Vale IPA report* (2006)**

The investigation identified a host of workforce capacity issues that contributed to problems with the quality and timeliness of the council's development application assessment services. Issues included not providing sufficient training to staff and lack of effective measures to deal with increases in planning workload.

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Authority

The Speaker of the Queensland Parliament, the Honourable Curtis Pitt MP, has authorised publication of this report under s 54 of the *Ombudsman Act 2001.*

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