Ombudsman’s recommendations – third report

June 2020
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The Victorian Ombudsman pays respect to First Nations custodians of Country throughout Victoria. This respect is extended to their Elders past, present and emerging. We acknowledge their sovereignty was never ceded.
Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council
and

The Honourable the Speaker of the Legislative Assembly


Deborah Glass OBE
Ombudsman

30 June 2020
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The greatest privilege of an Ombudsman is to be able to make a meaningful difference to the lives of our fellow beings. To know our reports have had an impact, that they have changed people’s lives for the better.

That impact was brought home to me powerfully on 27 November 2019, as I sat in Parliament’s Visitors’ Gallery to witness the apology to the victims of a serial sex abuser for the historical failures of the State to protect them. For decades, the management of Puffing Billy and other entities had turned a blind eye to this life-long offender, to protect his reputation and that of the railway. His young victims had to seek justice for themselves, or worse, suffered in silence, afraid they would not be believed.

Some of those victims, no longer young, sat in the gallery near me. The intense silence as we witnessed the apology, delivered not only by the Premier but also a succession of Ministers and Shadow Ministers, was palpable. Both the pain and the relief on people’s faces was visible.

That public apology was one of 109 recommendations I made in 17 public reports in the last two years. The vast majority of my recommendations were accepted. In some cases, as this report demonstrates, the acceptance proves to be token; while others openly acknowledged identified failings, supported the solution and improved their service to the public. Only the latter are worth the paper they are written on.

The purpose of this report is not to tick the box, to report I’ve met my target that 95 percent of my recommendations were accepted; but to explore how change has been implemented, if at all, and whether it has been effective.

The Government’s response to the Puffing Billy report underlines the difference between the token and the real. I commend its authenticity, and I know from multiple sources of feedback how much it helped.

On a systemic level, the response of State Trustees to my report also demonstrates this difference. I do not often receive a thank you email from a CEO on the day I table a highly critical report exposing an agency’s failings in its dealings with vulnerable people. But in his email the CEO wrote:

’It has been a sombre day for our organisation as staff digest the report, however, the feedback I have received from talking to literally dozens of staff is that there is a strong appetite to make the changes we need to make to better deliver on our mission. Your intention to monitor progress against the recommendations contained in the report is welcome in order to help keep State Trustees and all relevant stakeholders focused on achieving outcomes.’

This report not only presents the agency’s response; where we receive regular complaints about an agency we also sought feedback from people who deal with them.
Encouragingly, those who deal regularly with State Trustees, such as Financial Counsellors Victoria, have confirmed to us the improvements are real. And on 1 June 2020 the Treasurer announced a funding boost for State Trustees, which the CEO advised would not have happened but for the Ombudsman’s report.

Similarly, the response of Ambulance Victoria addressed concerns about unfair invoicing to ensure no-one else would be wrongly charged for treatment without transport. Wellington Shire Council alongside the Department of Environment, Land, Water and Planning were equally quick to adopt my recommendations, using my report into the Ninety Mile Beach subdivisions to resolve a planning debacle that had raged for decades.

Formal investigations and recommendations are not always necessary to achieve change. This report also references my public reports on VicRoads and Fines Victoria, two agencies subject to numerous grievances, where we sought to work with them to address the problems evident in patterns of complaints. By bringing systemic themes to their attention, documenting their responses and keeping them under review through monitoring further complaints, we can collectively achieve real improvement in public services.

On the other hand, an unenthusiastic response to an Ombudsman report without an acknowledgement of failings or desire to tackle them means the issue simply does not go away.

Hence my long, painful, and even more censorious second report into WorkSafe and the handling of complex workers compensation claims, launched on the back of continued complaints to my office. Those complaints confirmed that the failings identified in my first investigation had not been fixed, despite the acceptance of my recommendations. The second investigation revealed that my first report had barely scratched the surface.

This time, my recommendations have focussed on major systemic reform. I am heartened by the Attorney-General’s stated commitment to achieving change, and WorkSafe’s pledge – much more robust than last time – to address the issues within its responsibility. Real system reform will take time, but WorkSafe’s initial actions are encouraging, and I will continue monitoring to confirm improvements are real. As I noted in my report, I do not want to have to investigate this issue again – but the impact on people’s lives means it is too important not to get right.

Another continued area of concern is prisons and other closed environments such as youth justice facilities. Since first reporting on these facilities in 2015, my focus has been on how the system is supporting rehabilitation – reducing recidivism and making the community safer. Yet year-on-year the prison numbers grow, swollen by the continued increase in the remand population, and recidivism remains essentially unchanged. Tough-on-crime rhetoric continues to dominate headlines across the political divide, but investment in perimeter fencing rather than therapeutic facilities is not making us safer.

In the last reporting period, I examined these issues through the lens of the UN treaty OPCAT, with a particular focus on the practice, by whatever name, of ‘solitary confinement’.

We investigated the case of ‘Rebecca’, who was unfit to stand trial but spent 18 months in prison – mostly in solitary confinement – because there was nowhere else for her to go. This not only exacerbated her disability but was also a serious breach of her human rights – and it is an indictment on our claim to be a just society that her case was far from unique. Such cases are still being reported today. While I am pleased the Minister has accepted my recommendation that the State invest in therapeutic alternatives to prison, we have not yet seen meaningful progress.
My second OPCAT report found that children and young people in Victorian prisons and youth justice systems were being damaged rather than rehabilitated through excessive use of isolation and separation. My 27 recommendations in that report were mostly accepted, but so far, little has changed. Too often it appears we promote security over rehabilitation, but provide neither.

Disappointingly, nearly three years after Australia finally ratified the OPCAT treaty, bringing our country into line with over 90 countries who open up their closed environments to independent inspection, Victoria has at the time of writing made no visible progress in designating the body or bodies who will do this work.

Whichever office is designated to do this vital work, such a body must be truly independent, empowered, and properly resourced. The current pandemic – in which Ombudsman offices are working across the globe to ensure that the rights of all people are respected – has highlighted the importance of independent monitoring.

As the International Ombudsman Institute, of which I am proud to be a board member, has noted: “Fundamental rights do not cease to apply, even when a state declares a state of emergency or derogation from its human rights obligations”. Victoria used to be a leader in correctional reform; in looking to the future to implement OPCAT we have the chance to be so again, but it does not look as if we are seeking that mantle.

The fewest recommendations in my reports come from my investigations into improper conduct – usually because appropriate action is taken by the responsible agency before my report is made public. Sometimes I do not need to make recommendations, because the alleged conduct is unproven. Ombudsman investigations can also exonerate, as the referrals I receive from Parliament occasionally demonstrate. But even when they exonerate, they might identify systemic issues, such as the litany of scandals involving MPs’ expenses, and I am pleased the Parliament has taken steps to address these. Time will tell if the changes implemented will be enough.

So of my recommendations in the past two years, how many will really achieve the changes needed? In some cases the changes are already evident, in others we wait to see – but we can all tell the difference between an authentic response and where the box is merely being ticked.

Memo to box tickers: the problems will not go away, and it is in the community’s and your own interests to fix them. And until then, the Ombudsman will stay on your case.

Deborah Glass
Ombudsman
Introduction

1. Every two years I report on the progress the State Government and its departments, statutory authorities and local councils have made to implement the steps I recommended they take to address the issues arising from my investigations.

2. This report is a statement of record. It underscores my commitment to improving administration in the public sector with the ultimate objective of enhancing socially beneficial outcomes for all Victorians.

3. My recommendations are not enforceable. Rather, under the Ombudsman Act 1973 (Vic), my power lies in my ability to investigate, and to report my findings and recommendations to Parliament and the public.

4. Being the subject of an Ombudsman investigation can be a daunting and difficult experience for agencies and their staff. It is therefore encouraging to see agencies view my investigations as a positive process – an opportunity to improve practices, rather than defending an unsatisfactory status quo.

   ‘While recognition of the experiences of clients that have suffered from our mistakes is important in its own right, your report is significant because it helps all of us at State Trustees to better understand the factors that have contributed to the problems and provides a blueprint for how we can improve ourselves.’ – Matt Carrick, Chief Executive Officer of State Trustees

5. This report follows up to see if agencies have effected practical change to ensure the Victorian public sector and the community actually benefit from my investigations. Reporting on this provides accountability for both my office and the agencies concerned.

6. The report revisits recommendations I made between 1 April 2018 and 31 March 2020. It reflects the significant progress made in many cases by agencies, and discusses instances where further work still needs to be done.

7. The report has four sections; each highlighting a theme that represents an area of focus for my office:

   **Protecting human rights**
   - OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people in three institutions
   - Investigation into the imprisonment of a woman found unfit to stand trial

   **Dealing with improper conduct**
   - Investigation into allegations of improper conduct by officers at Goulburn Murray Water
   - Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust

   **Improving public administration**
   - Investigation into State Trustees
   - Investigation of a complaint about Ambulance Victoria
   - Investigation into Wellington Shire Council’s handling of Ninety Mile Beach subdivisions
   - Investigation into Maribyrnong City Council’s internal review practices for disability parking infringements
   - Investigation into Wodonga City Council’s overcharging of a waste management levy
   - Investigation into three councils’ outsourcing of parking fine internal reviews
   - WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims
   - Revisiting councils and complaints
Independent Commissioner for administrative investigations

- Investigation into child sex offender Robert Whitehead’s involvement with Puffing Billy and other railway bodies
- Investigation of matters referred from the Legislative Assembly on 8 August 2018
- Investigation of allegations referred by Parliament’s Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria

8. Each section contains an overview of the theme and summary of the public investigation reports that fall within it. The summaries explain why I investigated, what my investigation found, and the steps taken by the agencies to implement my recommendations. Further details about each of my recommendations, and information about the status of their implementation, are provided beneath each summary.

9. I made 109 recommendations in 14 public reports tabled between 1 April 2018 and 31 March 2020. I published three further reports in which I made no recommendations. One-hundred and six recommendations (98.1%) were accepted, either at the time or subsequently. At the time of writing, the State Government has not formally responded to one recommendation (0.9%); and only one recommendation was not accepted (0.9%).
Follow-up on my 2016 and 2018 reports on recommendations

Over the past two years, I have revisited and followed-up on two of my previous investigations. In *WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims* I revisited my 2016 *Investigation into the management of complex workers compensation claims and WorkSafe oversight*, and in *Revisiting councils and complaints* I followed up on my 2015 *Councils and complaints – A report on current practices and issues* enquiry, to assess whether the issues identified in the original reports had been addressed.

My investigation of *OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people* enabled me to expand on the work reported in *Implementing OPCAT in Victoria – report and inspection of Dame Phyllis Frost Centre* on 30 November 2017.

Revisiting an investigation is unusual. Generally, I monitor implementation through ongoing communication with agencies, and use complaint trends to evaluate their effectiveness. In 2018, I reported that 30.4% of the 125 recommendations made between 1 April 2016 – 31 March 2018 had been implemented. As at 31 March 2020, 73.6% of these 125 recommendations had been implemented.

Investigation into the transparency of local government decision making

In December 2016, I completed my *Investigation into the transparency of local government decision making*. The investigation highlighted major inconsistencies between Councils’ openness with their community.

Some Councils modelled best practice in being transparent, while others demonstrated a preference for making decisions at closed council meetings without involvement of, or accountability to, those they were elected to represent.

Since tabling this report, the Government completed a significant review of the local government sector. On 24 March 2020, the *Local Government Act 2020* (Vic) came into force and replaced the previous 1989 Act. The 2020 Act addresses some of the issues identified in my report, including restricting the grounds for closing council meetings, establishing basic standards that apply to Councillor codes of conduct and encouraging the use of technology to connect with the community.

It has also been encouraging to see a number of Councils taking steps to improve their transparency, for example, through the increased adoption of live streaming of council meetings. In December 2016, only 10 of 79 councils live streamed council meetings. In 2020, more than half of councils live stream or broadcast their meetings. At least 15 more councils began live streaming council meetings in response to the COVID-19 emergency, when the public were no longer permitted to attend council meetings in person. I hope this practice will continue.

10. This report presents a snapshot, at a point in time, of the progress made to address issues identified in my investigations’ recommendations. Beyond this report, my office continues to monitor the implementation of my recommendations and to evaluate their effectiveness – a process essential to realising the full benefit of my investigations.
Investigation into the financial support provided to kinship carers

In December 2017, I completed my *Investigation into the financial support provided to kinship carers*. This investigation found serious deficiencies in the Department of Health and Human Services’ (DHHS) administration of financial supports provided to kinship carers. I found DHHS’s actions often placed carers, who are essential to providing children out-of-home care, under unnecessary financial hardship.

The examples of mismanagement uncovered by my investigation included DHHS requiring carers to repeatedly prove their entitlement to financial support, significant processing delays for applications and payments, and providing poor information and incomplete advice to kinship carers about their eligibility for higher care allowances.

Following my investigation, DHHS introduced a new model of kinship care which was supported by funding, clarified policies, updates to the assessment process and training for staff and workers involved with kinship carers. Under this model, Community Service Organisations and Aboriginal Community Controlled Organisations deliver a ‘First Supports’ program to support new kinship placements. DHHS’s Kinship Engagement teams provide kinship carers with advice and assistance, and brokers the purchase of essential items and services.

Despite these improvements, my office is still receiving complaints about kinship carers not being aware, or informed, of their potential entitlements and DHHS refusing to make back payments.

Kinship carers also raise concerns about extensive delays, financial hardship experienced while payment issues are resolved, and barriers to accessing essential items and supports, such as furniture, respite and education.

Following the 2017 report, my office’s enquiries into some of these complaints have led to DHHS reviewing individual cases and paying carers more than $190,000. These cases have included a payment of approximately $130,000 to a carer who had not received payments for over eight years, and another payment of approximately $19,000 to a carer whom DHHS failed to inform was eligible for higher payments because of a young person’s complex needs.

DHHS acknowledges more work is needed to better support kinship carers, and states that it is looking for opportunities to further streamline decision making, improve practitioners’ understanding and capabilities through learning and development, and to implement practice improvements.
Protecting human rights

11. Human rights promote essential freedoms and protections for everyone, regardless of their background, where they live or their standing in society. Everyone has a responsibility to respect the rights of others. The State has a particularly important role in promoting and protecting the rights of its citizens through the establishment of human rights laws.

12. Victoria has led the way in supporting adoption of international human rights standards in Australia, as the first state to enact specific human rights legislation. The Charter of Human Rights and Responsibilities Act 2006 (Vic) (Human Rights Charter) requires all Victorian public sector bodies to promote and observe 20 basic rights and freedoms that citizens can expect of their government.

13. My office is responsible for considering whether Victorian public sector bodies are acting compatibly with Victoria’s Human Rights Charter Act; and since 1 January 2020, that these bodies are taking human rights into consideration in their decision making.

14. Between 1 April 2018 and 31 March 2020 two of my major investigations focussed on the human rights of people in detention:
   - OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people
   - Investigation into the imprisonment of a woman found unfit to stand trial.

Human rights for people in detention

A place of detention can be a prison, a police cell, youth justice centre or mental health facility where individuals do not have an option to leave and are subject to imposed regimes. In these facilities, the activities that occur within are largely hidden from public view, increasing the risk of human rights breaches. Critically, access to these facilities by independent bodies is essential to ensuring the rights of detainees are respected.

‘Solitary confinement’ was a dominant theme in my two human rights-focussed investigations completed between 1 April 2018 – 31 March 2020. Relevant standards and laws are described below.

The Mandela Rules

The United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the ‘Mandela Rules’, set out minimum standards for the treatment of prisoners. According to these Rules, ‘solitary confinement’ is defined as physical isolation of individuals for 22 or more hours a day without meaningful human contact. ‘Prolonged solitary confinement’ is 15 or more days of consecutive solitary confinement.

Human Rights Charter

Victoria’s Human Rights Charter and Responsibilities Act contains 20 basic rights, including the following which are particularly relevant to those in detention:

- protection from torture and cruel, inhuman or degrading treatment (section 10)
- humane treatment when deprived of liberty (section 22)
- children in the criminal process (section 23).
OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people

Why I investigated
In December 2017, the Federal Government signed up to the UN Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), thereby committing the Commonwealth, States and Territories to regular independent inspections of places of detention, including by local inspection bodies called National Preventive Mechanisms (NPMs).

While the original deadline for implementing these arrangements was understood to be December 2020, recent advice from the Commonwealth Attorney-General’s Office suggests it is now January 2022.

As the deadline drew closer, I completed my second OPCAT-style investigation in two parts:

• examining different operating models for OPCAT and recommending an appropriate model for Victoria

• a thematic inspection of ‘solitary confinement’ of children and young people, i.e. those under the age of 25, in three institutions.

I focussed on this, as the practice of solitary confinement of children and young people is inherently harmful. The scientific evidence is compelling given young people, until around 25 years, are still developing physically, mentally, neurologically and socially.

The inspections looked at an adult prison, a youth justice centre and two secure welfare service facilities. The aim of these inspections, consistent with OPCAT’s purpose, was to identify risks that increase the potential for torture and other cruel, inhuman or degrading treatment and protective safeguards that reduce those risks.

To ensure my investigation was informed by appropriate expertise, I established an Advisory Group consisting of key oversight agencies and representatives of civil society. The Group provided advice and guidance on the inspection methodology, as well as staff to the inspection team.

What I found

Part 1: Implementing OPCAT in Victoria

My investigation analysed different NPM models currently operating in other countries, including ‘centralised’ and ‘decentralised’ models.

Applying these models to a Victorian context, where there are multiple oversight bodies with an interest or expertise in matters an NPM might deal with, I concluded the State would benefit from having a single NPM with the support of a legislated Advisory Group. This would ensure a single, clear and consistent voice.

Part 2: Thematic inspection

While ‘solitary confinement’ is not officially used in Victorian detention facilities, it manifests in practices that isolate, separate, seclude or lock-down individuals – leaving them without meaningful human contact for extended periods.

Forms of isolation are sometimes necessary, for the safety of staff, the young person affected, and the other young people. But in reviewing the use of these practices across three different facilities, we observed that the same behaviour in a young person had very different consequences in each facility.

Of the three facilities inspected, we found the adult prison particularly ill-equipped to deal with the challenging behaviour of young people, who were disproportionately subject to isolation practices.
The conditions of separation almost invariably amounted to solitary confinement, often for questionable or punitive reasons, and with no documented consideration of whether the mental health of the prisoner contributed to their behaviour or if isolation would aggravate an existing mental health condition.

Within the youth justice facility, the investigation found a genuine commitment at many levels to the welfare of the young people and their rehabilitation. But we noted a culture that appeared to prioritise security, as well as a chronic problem of lockdowns, which was often in response to staff shortages. The secure welfare facilities offered the most therapeutic approach, but this was somewhat undermined by outdated facilities.

We found a direct correlation between the use and length of isolation practices, and the extent to which a facility recognised the harm caused by them. I urged the Government to review how young people are managed in the adult prison system, with a view to moving them out of mainstream prisons into a closed environment capable of addressing their behaviour in a way that does not make it worse.

While much good work is being done to improve youth justice facilities, cultural shifts are still needed, along with a full suite of tools: therapeutic spaces, trauma-informed behavioural management, training in mental health and de-escalation techniques. The environment is undoubtedly challenging but we are not best served by practices that promote security over rehabilitation, and provide neither.

What has happened since

My report was widely welcomed by members of the human rights community in Victoria and internationally but the Victorian Government is yet to respond to my recommendation about designating an NPM.

The Minister for Corrections and Youth Justice and the Department of Justice and Community Safety (DJCS) accepted my recommendations relating to adult prisons and youth justice centres. While progress has been made in relation to youth justice facilities, with work underway to prohibit the use of solitary confinement in a new dedicated youth justice legislation, it appears that progress in the adult prison system has been slower.

By contrast, DHHS, which is responsible for the secure welfare facilities, has begun work on proposed amendments in the Children Youth and Families Amendment (Child Protection) Bill 2020 (Vic) to limit and regulate the use of isolation or seclusion in secure welfare and youth justice facilities. DHHS has also made material improvements to its two secure welfare facilities. Further consideration on the development of a purpose-built facility is underway, but has been temporarily placed on hold while DHHS responds to the COVID-19 emergency.

DJCS has advised that a considerable amount of work has been done on the government’s implementation of its responsibilities under OPCAT, and that a lack of public statements about OPCAT is not an indicator that progress is not being made. But the silence is nonetheless disappointing, particularly in light of my two detailed reports intended to assist the State in fulfilling its responsibilities, including involving the key statutory officeholders in an Advisory Group.

In light of the feedback below, the lack of active engagement with my office in response to my reports and, at the time of writing, no designation of a suitably qualified, resourced and independent NPM, it is troubling that there appears to have been little progress on some of the important issues identified in this report.
Observations of Professor Bronwyn Naylor, Graduate School of Business & Law, RMIT University, human rights law expert and member of the Advisory Group, 15 May 2020

As an academic closely involved with public debates and advocacy around OPCAT in Australia, I’ve seen the Report playing an important role in public discussion and the implementation of OPCAT in several ways. It is the only detailed analysis of requirements for Australian NPMs and for an NPM for Victoria specifically. It provides a practical model for inspections of places of detention with multi-disciplinary inspection teams. And it presents detailed findings of the inspections themselves, specifically in relation to uses of solitary confinement of children and young people in Victoria facilities.

The [Ombudsman’s] Report has to my knowledge been widely cited and referred to in relation to models for NPMs, and for a Victorian NPM, and in relation to its findings and inspection methodology in relation to solitary confinement. The following are a few examples.

The Report was cited extensively in a substantial submission to the SPT and the UN Working Group on Arbitrary Detention by the Australia OPCAT Network, a briefing report for the (then) planned visits to Australia by those international agencies.

It was the focus of an invited presentation by the Ombudsman to a Roundtable for civil society agencies convened by RMIT and the Office of the Public Advocate, ‘The role of civil society in preventing the ill-treatment of people deprived of their liberty’ (RMIT, 16 September 2019).

It was a focus of a Panel Session addressed to criminal justice practitioners, ‘Preventing abuses in prisons? Current and future prison monitoring and the Optional Protocol to the Convention Against Torture’ at the Australian and New Zealand Society of Criminology Conference in Perth, WA, 13 December 2019.

The report is also discussed in a recent article by me, for an international journal Special Issue on OPCAT and rights monitoring, ‘Human Rights oversight and accountability of correctional institutions in Australia’ (under review, European Journal of Criminology).

The Report continues to be the only analysis of its kind in Australia, and an important reference point for the ongoing OPCAT implementation process, and for evidence-based reforms around solitary confinement.
Observations of Nerita Waight, Chief Executive Officer of the Victorian Aboriginal Legal Service (VALS) and member of the Advisory Group, 21 May 2020

In VALS’ view, introduction of an OPCAT compliant NPM in Victoria is an essential step towards ensuring transparency and accountability in the treatment of all Aboriginal and/or Torres Strait Islander Victorians in places of detention, including prisons and police cells.

Despite the recommendations in [the Ombudsman’s] report – which VALS and many other stakeholders have supported – we are yet to see any progress in relation to the introduction of an NPM in Victoria. This is particularly concerning for VALS given we continue to assist clients who have been mistreated in places of detention, as well as the families of Aboriginal community members who have died in custody.

[...] the Corrections Act 1986 (CA) and the Children, Families and Youth Act 2005 (CYFA) have not yet been amended to prohibit solitary confinement or to address the legislative gaps highlighted in your report.

• Regarding the CYFA, VALS has been consulted in relation to phase one of developing the Youth Justice Bill, and will be further consulted when phase two of the Bill is developed later in the year. It is our understanding that phase two will include conditions and treatment in custody, and we will proactively advocate for legislative changes relating to the use of isolation and seclusion. [...]

• Regarding amendment of the CA and the Corrections Regulations 2019, we are not aware of any progress.

[...] Given that the emergency measures [introduced by the Government in response to the COVID-19 emergency] currently being taken in custodial facilities pose significant risks for Aboriginal people in custody, we are extremely concerned that the government has not designated an NPM, and that there is no independent oversight mechanism with physical access to custodial facilities. This is particularly concerning given that all personal and non-essential professional visits to prisons have been suspended, meaning that informal transparency and accountability mechanisms have been reduced. In our advocacy to date, we have repeatedly emphasised the urgent need for an independent oversight mechanism, in line with the government’s obligations under OPCAT.
### Part 1: Implementing OPCAT in Victoria

**Recommendation 1 – to the Victorian Government**
- designate an NPM in accordance with the principles set out in paragraphs 267 to 280 of the investigation report; and
- resource that NPM adequately to allow it to demonstrate compliance with OPCAT standards.

The Government has not responded to this recommendation.

**DJCS advises:**
There has been a considerable amount of work done on the government’s implementation of its responsibilities under OPCAT. However, OPCAT requires a strong policy basis, funding and legislative support. It will affect multiple government departments and statutory agencies, including Corrections Victoria and Victoria Police. Processes are underway to address all these aspects of the implementation and are subject to Cabinet approval. Until Cabinet approves the final approach, this work will remain confidential.

### Part 2: Inspection report

**Recommendation 1 – to the Victorian Government**
Recognising the significant harm caused by the practice, that it is not unreasonable for detaining authorities to provide meaningful human contact even when a person is isolated, and that separation and isolation do not invariably amount to ‘solitary confinement’, establish a legislative prohibition on ‘solitary confinement’, being the physical isolation of individuals for ‘22 or more hours a day without meaningful human contact’.

The Government has indicated it accepts this recommendation and intends to also consider a legislative prohibition on solitary confinement through the development of standalone youth justice legislation. In the interim, the Isolation Practice Instruction has been updated to more explicitly state that solitary confinement, being the physical isolation of young people for 22 or more hours a day without meaningful human contact, is prohibited in the youth justice system.

Within the adult system, work continues to reduce the number of people subject to separation regimes, and in providing meaningful contact to those subject to such regimes, so that the practice does not meet the criteria for solitary confinement.

DHHS supports this recommendation, where it relates to Secure Welfare Services (SWS), and is working on the proposed amendments in the Children Youth and Families Amendment (Child Protection) Bill 2020.
### Recommendation 2 – to the Victorian Government

Recognising that young people until around 25 years are still developing and present a greater risk of irrational and volatile behaviour than the overall adult cohort, carry out a system-wide review of how young people are managed with a view to removing them from mainstream prisons to a dedicated facility.

The Government has indicated it is not feasible to implement this recommendation, but it is committed to better managing young people in detention.

The Minister for Corrections advises that DJCS will explore options to strengthen the consideration of the needs of young people in adult custody, such as in policies and procedures, and special training for corrections staff who work in youth units, in lieu of a dedicated facility for young people in adult prisons. It would not be feasible to accommodate all young people in a dedicated facility given the large number of young people in the adult corrections system.

The new *Corrections Regulations 2019* (Vic) include some additional requirements for decisions involving children under 18 years.

### Recommendation 3 – to the Victorian Government

Ensure that culturally supportive therapeutic spaces as an alternative to separation, isolation or seclusion rooms are established in prisons, youth justice centres and secure welfare services.

The Government accepts this recommendation. The Minister for Corrections states DJCS will explore options for alternative spaces in adult custody that may be used in lieu of cells to house those in separation, according to international best practice.

Work is underway to develop an operating model and pilot an Intensive Intervention Unit as a secure, therapeutic unit within the Parkville Youth Justice Centre to accommodate young people who present a significant or heightened risk of harm to themselves or others. The Intensive Intervention Unit will commence by the end of June 2020. There will also be a dedicated Intensive Intervention Unit at the new Youth Justice facility at Cherry Creek, which is currently under construction. The development of an Intensive Intervention Unit also responds to a recommendation from the Armytage Ogloff Youth Justice Review.

DHHS supports this recommendation, where it relates to SWS, and is identifying culturally sensitive options for, and alternatives to, seclusion. It anticipates that additional resources and training in the new procedures will be completed by June 2020.
**Recommendation 4 – to the Victorian Government**

Take all necessary steps to address the following shortcomings of the legislative and regulatory framework applicable to separation:

- Neither the *Corrections Act 1986* (Vic) nor the *Corrections Regulations 2019* (Vic) prohibit the use of separation as a punishment.
- Prison staff are not required to regularly observe children, young people and other prisoners who are subject to separation.
- Prisons are not required to maintain a register of separations made under the *Corrections Regulations 2019* (Vic).
- Amendments to the *Corrections Regulations 2019* (Vic) introduced in April 2019 authorise separation ‘for the management, good order or security of the prison’, without the requirement that the separation not be longer than is necessary to achieve that purpose.

The Government has indicated it accepts this recommendation. Amendments to Corrections Regulations are currently under consideration, however this has been delayed due to the COVID-19 emergency.
**Recommendation 5 – to the Victorian Government**

Recognising that new legislation for youth justice may be drafted, take all necessary steps to address the following shortcomings of the legislative and regulatory framework applicable to isolation and seclusion:

- The *Children Youth and Families Act 2005* (Vic) does not require that a child or young person’s isolation or seclusion be terminated once the reason for isolation or seclusion ceases.
- A necessary element of isolation and seclusion under the *Children Youth and Families Act 2005* (Vic) is that the child or young person be placed ‘in a locked room’, which potentially excludes situations where a child or young person is kept on their own in other areas of a facility, such as Malmsbury’s Intensive Supervision Annexe and other areas of the SWS.
- The *Children Youth and Families Act 2005* (Vic) does not guarantee each child or young person to a minimum period of fresh air per day.
- Staff are not required to inform children and young people of the reasons for isolation or seclusion.
- Children and young people who are isolated ‘in the interests of the security of the centre’ are not required to be observed at regular intervals.
- Isolations ‘in the interests of the security of the centre’ are not required to be recorded in the Isolation Register.
- Neither the Act nor the Regulations require proper consideration be given to the medical and psychiatric condition of a child or young person before isolating or secluding them.

The Government has indicated it accepts this recommendation. The Minister for Youth Justice advises DJCS will consider this recommendation as part of the development of the Youth Justice Act. In addition, the Minister states the recently introduced *COVID-19 Omnibus (Emergency Measures) Act 2020* (Vic) contains safeguards and entitlements for young people in isolation due to the need to detect, prevent or mitigate the spread of COVID-19 or other infectious diseases. The approach taken to this legislation has been informed by this recommendation, and includes requirements for access to the outdoors; for young people to get the medical and mental health treatment and support they require; for them to have their developmental needs catered for; for them to receive visits via virtual means; and for them to be supported with their religious and cultural needs, including for Aboriginal children.

In practice, all isolations of young people undertaken ‘in the interests of the security of the centres’ are recorded in the Isolation Register and reported to the Commission for Children and Young People (CCYP).
<table>
<thead>
<tr>
<th>Recommendation 6 – to the Victorian Government</th>
<th>The Government has indicated it accepts this recommendation and will consider it as part of the development of the Youth Justice Act.</th>
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<tbody>
<tr>
<td>Recognising that isolation under section 488(7) of the <em>Children Youth and Families Act 2005</em> (Vic) was intended to be used to maintain security in an emergency, and that it is now routinely used in response to staff shortage, take all necessary steps to enact a provision similar to that of section 58E of the <em>Corrections Act 1986</em> (Vic) allowing the Secretary to reduce the length of a sentence of imprisonment of a youth justice client on account of good behaviour while suffering disruption or deprivation, during an industrial dispute, emergency or in other circumstances.</td>
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<tr>
<th>Recommendation 7 – to DJCS</th>
<th>Accepted.</th>
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<tr>
<td>Ensure that principles and practices of trauma-informed behavioural management, including the impact on mental health, harmful effects of separation and isolation, and cultural awareness, are core elements in staff training across Corrections Victoria and Youth Justice, both to new staff and on an ongoing basis.</td>
<td>DJCS advises that pre-service training is delivered to all Youth Justice custodial workers. In addition, Youth Justice is planning to develop a specific vocational qualification for custodial staff, to also be supported by refresher training. A Certificate IV in Youth Justice is being designed that will strengthen the focus on learning and development for entry-level custodial staff during the first 12 months of employment. This will enable an increase in the level of training that staff receive in trauma-informed practice and behaviour management. Corrections Victoria states that it will develop and deliver a training package to relevant staff across all prison locations.</td>
</tr>
</tbody>
</table>
### Recommendation 8 – to DJCS / Corrections Victoria

Recognising the ‘extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement’ as described in the *Royal Commission into Aboriginal Deaths in Custody*, ensure that detaining authorities are required to notify Aboriginal support workers of each instance of separation or isolation of Aboriginal or Torres Strait Islander peoples, and to give proper consideration to their cultural advice, including advice about relevant recent or upcoming sorry business and other sensitivities.

Accepted.

Aboriginal children and young people detained in Youth Justice custody have ongoing access to their culture and are strongly connected to Aboriginal family, Elders and community through the work of Aboriginal Liaison Officers. Aboriginal Liaison Officers are available 24 hours a day to advise non-Aboriginal staff about their work with Aboriginal young people, inform critical decision making about their care and directly support young people if any urgent situations arise. It is current practice in Youth Justice that an Aboriginal Liaison Officer is notified when an Aboriginal child or young person is isolated. Youth Justice has added a specific field to the isolation register to record that an Aboriginal support officer was contacted upon isolation.

Aboriginal Wellbeing Officers are posted at most Victorian prisons. They provide support in all specialist units, including Management Units, are advised following any significant incidents or placement decisions and are involved in the development of risk management plans for Aboriginal prisoners. Amendments to the Deputy Commissioner’s Instructions have been drafted to require an Aboriginal Wellbeing Officer be notified when an Aboriginal prisoner is separated and an Aboriginal Wellbeing Officer visit separated Aboriginal prisoners at least twice per week after separation exceeds seven days. Although the draft is not yet published, the requirements have been adopted in practice.

<table>
<thead>
<tr>
<th>Recommendation 9 – to DJCS / Corrections Victoria</th>
<th>Accepted. DJCS states the same level of prison officer is authorised under section 32 of the Corrections Regulations to order and revoke a separation of a prisoner.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Secretary should delegate her power under Regulation 32(7) of the <em>Corrections Regulations 2019 (Vic)</em> to revoke a separation order at any time down to the same level of local prison officer authorised to order the separation of a prisoner.</td>
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</table>
### Recommendation 10 – to DJCS / Corrections Victoria

Require each adult prison to establish and maintain a register of separations made under the *Corrections Regulations 2019 (Vic)* including:

- the name of the person separated
- the time and date separation commenced
- the reason why the person was separated
- consideration of any risks to health and well-being
- the authorising officer’s name and position
- the frequency of staff supervision and observation
- the time and date of release from separation whether the separated person identifies as Aboriginal or Torres Strait Islander, and if so whether an Aboriginal support officer was contacted upon separation.

Accepted.

Corrections Victoria is developing a centralised state-wide separations database, which will encompass all of the recommended points with the exception of ‘the frequency of staff supervision and observation’ which cannot be recorded due to the administrative burden it would place on staff. Other records will keep track of this information and all separated prisoners are required to be observed a minimum of twelve times per day.

The design of the database includes a new ‘Young Offender’ flag for prisoners aged under 21 years, and an alert for prisoners approaching a milestone (eg due for a review) to provide wider visibility of these events.

Although work on the database has commenced, delays have been encountered due to DJCS’s response to COVID-19. The database is now due to be completed in late 2020.

### Recommendation 11 – to DJCS / Corrections Victoria

Recognising that in other Victorian prisons people subject to an Intermediate Regime are eligible to receive up to six hours of out-of-cell time per day, and noting that the Intermediate Regime at Port Phillip is largely indistinguishable from a separation regime, amend policy and practice to increase the out-of-cell time on an Intermediate Regime.

Accepted.

DJCS advises that in January 2020, the Scarborough South unit was re-gazetted as a stand-alone intermediate regime unit. This has allowed greater flexibility in housing prisoners of different regimes across the Borrowdale and Scarborough South units, increasing out of cell hours for prisoners subject to these regimes.
<table>
<thead>
<tr>
<th>Recommendation 12 – to DJCS / Corrections Victoria</th>
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<tbody>
<tr>
<td>Recognising the impact separating people in mainstream units at Port Phillip has on those people, others in the unit and staff, develop as a priority a strategy to reduce to zero the number of people separated on mainstream units.</td>
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<tr>
<td>Accepted.</td>
</tr>
<tr>
<td>Port Phillip Prison and the Sentence Management Division will monitor the number of prisoners separated to mainstream units in an attempt to keep these numbers low.</td>
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<tr>
<td>In September 2019, DJCS received funding to obtain expert advice to inform the development of a new separation regime operating model that supports the management of problematic behaviour in the least restrictive way possible at Dame Phyllis Frost Centre’s new management unit.</td>
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<tr>
<td>DJCS have also identified that there is a need for this activity to form part of a larger project considering separation practices at Victorian prisons systemwide. Work on this project is ongoing and will include developing further strategies to reduce the incidence and impact of separation. As part of the project, it is proposed that a Reference Group will be established to provide input and expert advice, together with research into other jurisdictions that have implemented similar reforms.</td>
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<tr>
<th>Recommendation 13 – to DJCS / Corrections Victoria</th>
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<tr>
<td>Pursuant to section 41(c) of the Human Rights Charter, request the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) to review Corrections Victoria’s Management Regimes, Intermediate Regimes and other Violence Reduction Strategies, to determine their compatibility with human rights, and with a particular view to address the material conditions of Management Units (including run-out spaces) and measures to alleviate the potential detrimental effects that being accommodated in those units would have, especially for vulnerable people, including young people and those with disability or mental illness.</td>
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<tr>
<td>Accepted.</td>
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<tr>
<td>The Commissioner of Corrections committed to writing to VEOHRC requesting a review against the Charter of Management Units at maximum-security prisons, and the central governing policy surrounding separation regimes.</td>
</tr>
<tr>
<td>DJCS met VEOHRC in late January 2020. There are currently three outstanding requests for reviews (all stemming from Victorian Ombudsman recommendations), which are yet to progress further due to COVID-19 restrictions. Work will recommence once restrictions have been lifted.</td>
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</table>
**Recommendation 14 – to DJCS / Corrections Victoria**
Amend policy and practice and immediately cease the routine use of restraints without a contemporaneous risk assessment.

**Accepted.**
DJCS advises that departmental policies clearly require a decision by a General Manager to place someone on a handcuff regime must be recorded and regularly re-assessed. It acknowledges the routine application of restraints on prisoners subject to a management regime (but not a handcuff regime) is less clear and states it is committed to exploring opportunities to reduce the use of restraints in line with the risks presented by the prisoner.

DJCS has also reviewed and found Port Phillip Prison has complied with these policies. However, the resulting report recommended a trial be conducted that allows separated prisoners to be escorted within prison grounds without handcuffs if a risk assessment considers this a viable option. Currently, this trial is on hold.

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**Recommendation 15 – to DJCS / Corrections Victoria**
Reconsider the detention conditions, namely isolation and observation, of people identified as being at risk of suicide or self-harm, particularly those on an ‘S1’ or ‘S2’ rating, with a view to ensure:

- active treatment and therapeutic interventions are provided
- staff record their consideration of whether to transfer a person to a designated mental health service pursuant to section 275 of the *Mental Health Act 2014* (Vic).

**Accepted.**
Professor James R P Ogloff AM (assisted by the Justice Assurance and Review Office) recently conducted a review into ‘at risk’ practices in Victorian prisons. Work continues to implement the accepted recommendations from this review.

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**Recommendation 16 – to DJCS / Corrections Victoria**
Remind staff of the importance, and requirement under the Corrections Regulations, for staff to give proper consideration to the medical and psychiatric condition of a person before separating them, and adequately record that assessment. For Aboriginal and Torres Strait Islander prisoners, this should include consideration of social and emotional wellbeing.

**Accepted.**
In March 2020, amendments to separation policies were being drafted, and consultation was underway. The amended policies are due to be published in late 2020.
<table>
<thead>
<tr>
<th>Recommendation 17 – to DJCS / Corrections Victoria</th>
<th>Accepted. DJCS is implementing this recommendation in conjunction with recommendation 16.</th>
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<tbody>
<tr>
<td>Ensure that before disciplinary sanctions are imposed, including issuing a separation order, proper consideration is given as to whether and how a prisoner’s mental illness or disability may have contributed to their conduct, and that assessment is adequately recorded.</td>
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<tr>
<th>Recommendation 18 – to DJCS / Youth Justice</th>
<th>Accepted. Youth Justice has added a specific field to the isolation register to record that an Aboriginal support officer was contacted upon isolation. The update is currently being designed and tested, with an expected release date of June 2020.</th>
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<tbody>
<tr>
<td>Ensure Isolation Registers record whether an Aboriginal support officer was contacted upon isolation.</td>
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<tr>
<th>Recommendation 19 – to DJCS / Youth Justice</th>
<th>Accepted. Youth Justice has introduced a risk assessment process prior to the use of mechanical restraints. Reports on the use of mechanical restraints across both youth justice precincts are being regularly reviewed by General Managers to ensure that an appropriate risk assessment has been applied prior to each use. The Youth Justice Management Team are continuing to explore strategies to reduce use of mechanical restraints.</th>
</tr>
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<tbody>
<tr>
<td>Amend policy and practice and ensure that the routine use of restraints without a contemporaneous risk assessment cease immediately.</td>
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<tr>
<th>Recommendation 20 – to DJCS / Youth Justice</th>
<th>Accepted. Youth Justice is communicating with staff regularly and exploring options for enhancing CRIS (its centralised client management system) to include an assessment of the immediate threat as a required field in the isolation register. Development of situational awareness training is underway to further develop the skill and ability of staff to identify issues earlier, to prevent the use of restraint and isolation when the issue escalates. Daily monitoring and reporting of use of behavioural isolation continues, with data provided to CCYP.</th>
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<tr>
<td>Remind staff and ensure that behavioural isolations under section 488(2) of the Children Youth and Families Act 2005 (Vic) are only authorised where all other reasonable steps had been taken and the relevant behaviour presents ‘an immediate threat’. Details of the steps taken before resorting to isolation and assessment of the immediate threat should be adequately recorded in the Isolation Register.</td>
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**Recommendation 21 – to DJCS / Youth Justice**

Implement as a priority its plan to reduce to zero the number of lockdowns and rotations due to staff shortage at the Malmsbury Youth Justice Precinct.

Accepted.

DJCS reports that there have been fewer instances of isolations of young people during the COVID-19 emergency, including isolations due to staff shortages. DJCS is focussing on the recruitment and retention of staff, particularly during the COVID-19 emergency. The Youth Justice Workforce Strategy is under development. It will focus on attraction, retention, quality and skill development, and occupational health and safety. From its launch on 20 March until 20 April 2020, the Youth Justice recruitment marketing campaign has generated additional applications.

A dynamic risk assessment process has been introduced at both precincts to inform decision making on ending a lockdown. A lockdown based on low staffing requires staff to engage with Unit Managers in risk mitigation with a view to work towards ending the lockdown.

There is ongoing focus on peer support workers, staff mentors and squad leaders (for new recruits) to better support and retain staff. Recruitment of Behaviour Support Specialists is also underway to work alongside staff to undertake behavioural assessments with young people and develop appropriate interventions.

The daily monitoring and reporting of rotations and lockdowns caused by staff shortages continues and is provided to CCYP.

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**Recommendation 22 – to DHHS**

Recognising that Secure Welfare’s therapeutic ethos is to some extent undermined by the material conditions of the Ascot Vale and Maribyrnong facilities, the Department should consider options for replacing the facilities with a purpose-built facility.

Accepted.

Funding is required to develop a new purpose built facility for SWS. Assessment of the current facilities, and an option of a purpose-built facility, will be considered; however, this work is temporarily on hold due to DHHS’s response to COVID-19.
<table>
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<tr>
<th>Recommendation 23 – to DHHS / SWS</th>
<th>Accepted. DHHS has updated the SWS manual to ensure the Operations Manager is to check the Seclusion Register and shift notes daily, to ensure appropriate recording of all instances of seclusion are followed. Seclusion has been added as an agenda item to the regular SWS management meeting to ensure reminders occur.</th>
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<tr>
<td>The General Manager should remind staff and ensure that the prescribed particulars for all instances of seclusion are accurately recorded in the Seclusion Register as required by the Children, Youth and Families Regulations 2017 (Vic).</td>
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<tr>
<td>Recommendation 24 – to DHHS / SWS</td>
<td>Accepted. DHHS have started scoping renovations for a toilet and washbasin in the seclusion rooms at each facility; however, this work is temporarily on hold due to DHHS’s response to COVID-19.</td>
</tr>
<tr>
<td>The seclusion rooms at Ascot Vale and Maribyrnong should be replaced with dedicated therapeutic spaces, however, if they are to remain in use, the General Manager with assistance from the Department should ensure they meet the relevant human rights standards and are, at a minimum, fitted with a toilet and washbasin.</td>
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<tr>
<td>Recommendation 25 – to DHHS / SWS</td>
<td>Accepted. DHHS installed a new cordless phone in both facilities in October 2019. The cordless phone allows clients to take the phone and make calls in the privacy of their rooms or other therapeutic spaces.</td>
</tr>
<tr>
<td>The General Manager should, as a priority, improve the arrangements for children and young people to access the telephone at the Secure Welfare Services, including being able to privately make calls, including complaints.</td>
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<tr>
<td>Recommendation 26 – to DHHS / SWS</td>
<td>Accepted. DHHS has completed all planned maintenance and refurbishment works. This has included painting the interiors of both units, refurbishing windows and applying anti-graffiti film to windows, and repairing and installing recreational equipment and facilities.</td>
</tr>
<tr>
<td>The General Manager should ensure that outstanding maintenance repairs and necessary refurbishments are completed as soon as possible.</td>
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Investigation into the imprisonment of a woman found unfit to stand trial

Why I investigated

The Victorian Public Advocate raised concerns with my office about the treatment of one of her clients. The client, whom I called ‘Rebecca’ to protect her privacy, has a disability and had been declared unfit to stand trial in relation to a breach of an intervention order and for resisting police. Although not convicted of a crime, she had been detained in harsh conditions at Victoria’s main women’s prison, the Dame Phyllis Frost Centre, for 18 months.

The Office of the Public Advocate (OPA) outlined numerous issues about Rebecca’s treatment in prison, not least that:

• she was being locked in her cell for 23 hours a day, in a state of acute distress
• her 18-month imprisonment had lasted much longer than had she been tried and sentenced
• facilities and necessary support and care were inadequate
• it was unacceptable that more appropriate accommodation could not be found.

My investigation was undertaken in two parts. The first part looked at the prison’s management of Rebecca and steps taken by relevant government bodies and support services to find an appropriate placement. It also considered whether the administrative actions of Victorian government agencies responsible for Rebecca’s custody, care and treatment were incompatible with the human rights set out in the Human Rights Charter and international human rights treaties to which Australia is a signatory.

The second part of my investigation sought to examine the prevalence of cases similar to Rebecca’s – the number of persons declared unfit to stand trial who are in prison because alternative suitable accommodation is not available.

What I found

Rebecca’s history was important to understanding her situation. At a young age, she developed cognitive and behavioural difficulties and received support through the mental health system from childhood to her 30s. In her early 30s, Rebecca was diagnosed with a developmental disorder which meant she was no longer eligible for mental health services, but was at the same time unable to access disability support. Without necessary supports, Rebecca’s behaviour and disability could not be managed – which ultimately led to her extended stay in prison without an associated conviction.

Prison is not a suitable place for a person with high and complex needs, and the women’s prison system has no specialist unit for prisoners with an intellectual disability. Rebecca was placed in the mental health unit, kept in a locked cell for 22 to 23 hours a day – effectively in solitary confinement – for both her own and others’ protection. Despite efforts by individual prison officers and staff to support her and treat her with kindness, there is clear evidence of the environment and her isolation having a detrimental effect on her physical and mental wellbeing.

Although it was obvious to many people involved in Rebecca’s case that prison was not a suitable place for her, it took more than 16 months to find alternative accommodation and support. The fact no one individual or agency took responsibility resulted in a significant failure to drive a timely resolution.
Rebecca’s placement in what was effectively solitary confinement was a breach of her human rights under Victorian law and international human rights treaties.

Looking at the wider picture, my investigation was unable to obtain definitive figures on the number of individuals declared unfit to stand trial as no single agency is responsible for overseeing such cases. But I was provided with examples of equally distressing cases demonstrating Rebecca’s situation was not unique.

What has happened since

When the investigation report was being drafted, Rebecca was already living in the community with around the clock support from her care provider, under the supervision of DHHS and with OPA continuing as her legal guardian. OPA has since informed my office that after Rebecca could not be successfully supported to reside in the community, she was admitted to a specialist secure hospital unit. OPA have observed improvements in Rebecca’s behaviours and ability to engage while in this stable therapeutic environment, with the consistent support of her treating team. OPA, together with Rebecca’s therapeutic team, continue to work towards supporting her to reside in the community in the future.

Sadly, others declared unfit to stand trial remain in prisons when no alternative suitable accommodation can be found. For example, on 15 November 2019, the Age reported that a 49 year old, wheelchair-bound man with an acquired brain injury had spent more than three years in prison after being declared unfit to stand trial.

Observations of Dr Colleen Pearce AO, Public Advocate, 27 May 2020

Following her incarceration at Dame Phyllis Frost, Rebecca’s situation was chaotic, transient and managed in a responsive fashion to frequent crisis.

Your investigation report contributed to the political will for a high-level multi-agency interest and response, including positive engagement with DHHS and the NDIA in their commitment to identify properties that could be used to accommodate Rebecca (although ultimately this did not prove successful).

OPA is aware of people with a disability who continue to be inappropriately placed and who remain in prisons. Recommendation 1 remains urgently outstanding; there are very few options for people in this cohort.

[...]

As you highlighted in your investigation report, the locked custodial environment was detrimental to Rebecca, but since then, her time in a locked therapeutic environment has been life changing.
### Status of my recommendations

<table>
<thead>
<tr>
<th>Recommendation 1 – to the Minister for Housing, Disability and Ageing and the Minister for Mental Health / the Victorian Government</th>
<th>Accepted. The Minister commented that this investigation, together with other reviews, highlighted the need for investment in secure therapeutic alternatives to prison. Currently, DHHS is engaged in planning to address service gaps for prisoners, including for women and young people, including both short-term responses to address demand and long-term capital planning. Forensic planning will also be guided by the final recommendations of the Royal Commission into Victoria’s Mental Health Services, due for release in February next year.</th>
</tr>
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<tbody>
<tr>
<td>Invest in secure therapeutic alternatives to prison for people found unfit to stand trial and/or not guilty because of mental impairment under the <em>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</em> (Vic) (the CMIA). Priority should be given to the service gaps identified in this report and the Victorian Law Reform Commission’s 2014 report.</td>
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<tr>
<td>Recommendation 2 – to the then Department of Justice and Regulation</td>
<td>Accepted. In May 2019, the Government announced $20 million in funding to reduce the incarceration of women, including for programs targeted at women in prison with a mental illness, intellectual disability or cognitive impairment. DJCS received funding to engage a consultant to identify the prevalence and severity of cognitive impairment amongst women prisoners and develop a service pathway for prisoners with an intellectual disability or cognitive impairment. This work will include consideration of a special unit and services required in the women’s prison system. This work will inform a business case for funding in the 2021 state budget.</td>
</tr>
<tr>
<td>Consider options for specialist units and services for women with an intellectual disability or cognitive impairment in Victorian prisons.</td>
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</table>
### Recommendation 3 – to the then Department of Justice and Regulation

Seek advice from relevant disability experts when determining placements within the prison system in complex cases of prisoners with mental impairment.

**Accepted.**

DJCS advises that Intensive Case Management Plans (ICMPs) and the case conference process within prisons involves consultation with specialists in all aspects of a prisoner’s individual needs, including disability needs. For prisoners with complex needs, case conferencing involves a multidisciplinary team that includes senior custodial, sentence management, clinical, and medical staff, and may also include external support staff that have worked with the prisoner in the community or will work with them upon release.

The consultant referred to in recommendation 2 will also review the Complex Case Conference and ICMP process to identify any improvements that can be made.

### Recommendation 4 – to the then Department of Justice and Regulation

Within three months of this report, request VEOHRC under section 41(c) of the Human Rights Charter to review the application of the following policies and practices to prisoners with mental impairment at the Dame Phyllis Frost Centre:

- the use of behavioural management plans and separation to address behaviours of concern
- strip-searching
- use of restraint
- personal care support.

Once the review is completed, the department should develop a plan to apply the review’s findings and recommendations to other prisons.

**Accepted.**

DJCS has commenced discussions with VEOHRC about a review in relation to Dame Phyllis Frost Centre.

Relevant to this recommendation, DJCS has installed a scanner in the visits centre to remove routine strip searching of women after contact visits and discontinued the practice of routine strip searching of women being transferred from DPFC to the minimum security Tarrengower Prison. Additionally, a saliva drug testing trial has commenced at DPFC, which will further reduce the number of strip searches required.
**Recommendation 5 – to the then Department of Justice and Regulation**

Through the Sentence Management Division in Corrections Victoria:

- Ensure compliance with the Corrections Regulations and Sentence Management Manual where prisoners with a mental impairment are subject to separation outside management units.
- Oversee ICMPs that require separation or modified regimes for prisoners with a mental impairment. The Assistant Director responsible for the Sentence Management Division should endorse changes to the Plans, and DHHS should provide relevant health service advice.

| Accepted. |
| A state-wide separation register is being developed and will include those outside management units. In the interim, Sentence Management staff are keeping manual records. |
| The Assistant Commissioner will remind prison General Managers of the requirement to document the out of cell hours for separated prisoners. |
| Work has commenced to update the Sentence Management Manual to reflect the requirement prisoners subject to an order under the CMIA have in place an ICMP. |
| Development, including consultation within DJCS and with VEOHRC, of a revised ICMP template was completed and endorsed by the Assistant Commissioner, Sentence Management Division and Prison Managers in January 2020. |
| Some delays in publishing the template and finalising related policy have occurred as a result of DJCS’s response to COVID-19. |

**Recommendation 6 – to the then Department of Justice and Regulation**

Coordinate regular, whole-of-government reporting on the management of people subject to custodial and non-custodial supervision orders under the CMIA. To ensure appropriate decisions about placements, the department should share the reports with relevant agencies including DHHS, the Office of Public Prosecutions, the courts, Forensicare and the OPA.

| Accepted. |
| DJCS has begun discussions with Victoria Legal Aid and the Judicial College of Victoria in relation to prisoners who may potentially be subject to the CMIA, including developing criteria to capture this vulnerable cohort without requiring an application to court. |
| In January 2020, the Corrections Victoria Cognitive Impairment Project acknowledged it is not possible to model demand without reliable information about the prevalence and severity of cognitive impairment. |
| Although this information will be identified through the project discussed at recommendation 2, in the interim, prisoners that could potentially be subject to the CMIA will be flagged as Special Category prisoners in the Prison Information Management System until more reliable criteria can be developed. |
Recommendation 7 – to DHHS
Designate a senior officer to:

- Coordinate and oversee DHHS service responses to people subject to CMIA proceedings.
- Act as a contact point regarding DHHS service responses and advice for agencies and people involved in CMIA proceedings. These should include people subject to CMIA proceedings, their families and/or guardians, the courts, the Office of Public Prosecutions, defence lawyers and other advocates.

Accepted.

The Deputy Secretary, Health and Wellbeing is accountable for coordinating and overseeing DHHS’s responses to persons subject to CMIA proceedings.

DHHS has developed a web-based application for disability justice clients, including those on CMIA orders, which provides information on the needs, location and status of those clients. Forensicare maintains records of people subject to CMIA orders on behalf of the department.

DHHS has established the CMIA and Complex Needs Advisory Panel of experts, from across DHHS and providers, to support the Deputy Secretary, Health and Wellbeing, in coordinating service delivery options for people subject to the CMIA who risk falling outside the standard service responses. The Panel has oversight of all people subject to CMIA proceedings and supervision orders, provides an opportunity for escalation if existing arrangements are leading to poor outcomes or increased risks, and provides active case conferencing where no other appropriate coordinator or panel is available, or where it would be of benefit to the person.

The Deputy Secretary has informed organisations involved in representing and assisting persons subject to the CMIA of his new role and the establishment of the panel. This includes the courts, the Office of Public Prosecutions, the Office of the Public Advocate, Victoria Legal Aid, the Mental Health Complaints Commissioner, the Disability Services Commissioner and Victorian Advocacy League for Individuals with Disability.

Recommendation 8 – to the DHHS
Provide, or commission, guidance about acting compatibly with the Charter for public authorities providing mental health and disability services, including Forensicare.

Accepted.

DHHS’s forensic disability program has developed a Diversity and Inclusion policy for its services. It has also drafted a Human Rights Toolkit, in consultation with VEOHRC, and has commenced delivery to the forensic disability workforce as part of a human rights training package. DHHS’s Mental Health Branch is in the process of engaging VEOHRC to deliver Charter education training to the mental health workforce.
Dealing with improper conduct in the public sector

15. Individuals employed in the public sector are in a position of trust to act in the public interest, using funds provided by the public purse. We are entitled to expect the highest standards of integrity of public officials. While the vast majority strive to meet these standards, a small minority exploit their positions for personal gain.

16. Victoria’s integrity regime is essential to exposing misconduct by public officers. This regime was reinforced recently through the commencement, on 1 January 2020, of amendments to the Public Interest Disclosures Act 2012 (Vic) which strengthen laws to offer further protections to disclosers and provide for a broader range of conduct to be reported and investigated.

17. I rarely publish my findings on public interest complaint investigations, formerly known as protected disclosure complaint investigations. Whether or not allegations of improper conduct are substantiated, they have a significant personal impact on those whose conduct is under investigation, the people close to them and employees of the agency involved. This impact is further heightened if the investigation report is published. But there are times where a subject shows such disregard for the standards of integrity, or the issue itself is of such significance, that publishing a report is in the public interest. In these instances, a report serves not only as a reassurance to potential disclosers that reporting inappropriate behaviour matters, but also as a warning to those ignoring or flouting the rules.

18. Between 1 April 2018 and 31 March 2020, I investigated 42 protected disclosure complaints (as they were named at the time) and published three investigation reports. All three involved regional entities – a water authority, a public cemetery trust and a state secondary college.

19. These reports showed a link between minimal or arms-length oversight allowing poor practices to flourish and, in two of the cases, continue unchecked for more than a decade.

20. In each instance, the subjects suggested their past achievements, work ethic or endeavours to facilitate better value services to the community justified activities or practices that were contrary to the public interest, such as nepotism in recruitment processes, using a position for personal or financial gain or misusing public money and assets. Policies and training were not enough to prevent the behaviours, and supervisors continued to miss opportunities to identify and address the conduct.

21. In all three cases, the subjects of my investigations had departed their public roles before my reports were published. I made recommendations in relation to only two of these investigations:
   - Investigation into allegations of improper conduct by former officers at Goulburn Murray Water
   - Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust

22. Although I did not make recommendations as a result of the third investigation, Investigation of three protected disclosure complaints regarding Bendigo South East College, I have included a summary of the investigation in this report. It stands as an example of a public official misusing their position for the benefit of themselves, their family and associates while the department with oversight responsibility largely sat back as individuals raised concerns about the conduct.
Investigation of three protected disclosure complaints regarding Bendigo South East College

I received three protected disclosure complaint referrals from the Independent Broad-based Anti-corruption Commission (IBAC). The complaints alleged the then Principal of the Bendigo South East College had used his position to employ his wife and one of his children to positions at the school, mismanaged the College’s finances and failed to manage his conflicts of interest. It was further alleged that the Principal's son’s business partner had, in his role as Bus Coordinator, misused his position to further his personal business interests.

My investigation substantiated that for approximately a decade, the Principal had failed to manage his conflicts of interest and misused his position at the school to the benefit of his family. He was inappropriately involved in recruitment processes to employ his wife and one of his sons, and promoted his wife and son without proper process.

The Principal’s disregard for departmental policies and advice extended to his promotion of an in-law of another son, as well as another staff member, to two newly created Assistant Principal positions, without conducting a required open selection process.

I also found that the Principal’s son’s business partner channelled business to a bus company at which he was a manager. Evidence showed that he went on to purchase the bus company jointly with the Principal’s son and continued to direct business from the College and other schools in the region to the company.

The Principal was aware of these arrangements but failed to fully declare them to the Department of Education and Training’s regional office and the School Council, allowing the company an unfair advantage over other companies in the region.

An audit of the Principal’s financial practices commissioned by the Department, on request of my investigation, revealed a pattern of unexplained and insufficiently documented reimbursements to the Principal, without the requisite approval of the School Council and in contravention of the Schools Purchasing Card guidelines. Both the Principal and his son misled parents and students to believe that this sports program delivered the mandatory Health and Physical Education Curriculum, when it did not, leaving students without having completed the Curriculum.

The North Western Victoria Region office of the Department received over 20 complaints between August 2014 and February 2016 about the Principal’s nepotism and financial mismanagement. The Department’s failures to meaningfully address the complaints not only allowed the Principal to run the College as his own fiefdom for many years, they discouraged staff from reporting further concerns.

By the end of my investigation, the Principal, members of his family and business associates had left their employment at the College. The Principal resigned after the Department informed him of its intention to terminate his employment. The conduct substantiated by my investigation occurred despite the Department having in place a comprehensive policy framework for recruitment processes, conflicts of interest, financial accountability and complaint handling.
Investigation into allegations of improper conduct by officers at Goulburn Murray Water

Why I investigated

In September 2017, IBAC referred to me a protected disclosure complaint which alleged the Managing Director (MD) of Goulburn Murray Water (GMW) claimed inappropriate financial benefits, and that the Chair of GMW, by approving the claims and allowances without confirming a legitimate business need and ignoring advice from staff, was complicit in the MD’s conduct.

GMW is Australia’s largest rural water corporation. It has faced serious governance and financial mismanagement issues over the last decade, leading to multiple interventions by the State and responsible Minister. This period, prior to my investigation, was also marked by a high turnover in senior positions; five Chairs and seven MDs since 2012.

What I found

The allegations were substantiated. On top of his annual remuneration package, the MD wrongfully claimed substantial expenses, including relocation expenses, while retaining his Melbourne residence, claiming for hotel stays in Melbourne and receiving a tax-free ‘Living-Away-from-Home-Allowance’ (LAFHA). He ignored or was ignorant of relevant policies, public sector standards and legislation, and disregarded advice of his experienced executive team.

The MD’s activities were directly enabled by the Chair, who approved the MD’s claims (including for her own expenses), supported his application for the LAFHA and ignored legal advice and internal concerns about the MD’s spending and disregard for relevant laws and guidelines. In doing so, the Chair failed to ensure responsible expenditure of public funds and failed to apply government policy or the codes of conduct to both herself and the MD.

When responding to my draft report, both the MD and Chair denied they had acted improperly.

What has happened since

The Chair resigned from the GMW Board in July 2018 and the MD ceased his employment with GMW in September 2018, shortly before my investigation report was published.

The new Chair of GMW has led a program of activities to give effect to my recommendations. This has included strengthening GMW’s personal expense policies and aligning them with the Victorian Public Sector Commission’s (VPSC) and Department of Environment, Land, Water and Planning’s (DELWP) policies, improving financial controls, delegations and oversight at GMW, and engaging GMW’s internal auditors to audit GMW against all Directions of the Minister for Finance. These steps were completed within 12 months of my investigation being finalised.

Notably, the Board addressed further issues raised in my report such as updating its hospitality policy, ceasing to provide Board dinners and alcohol, and requiring all incoming Directors and General Managers to confirm they have received and understand the Director’s Code of Conduct and GMW’s policies for expense reimbursement. The new MD, who started in February 2019, completed the revised induction procedure.

DELWP has also monitored GMW’s implementation of my recommendations and finalised a model policy on gifts, benefits and hospitality which public agencies within the portfolio were asked to adopt by 1 November 2019. It has asked its agencies to report on other related policies such as travel, personal expenses and hospitality practices as part of their annual Financial Management Compliance Reports, and it intends to provide further guidance to agencies that have not demonstrated compliance.
DELPW has also developed and started delivering training to Directors and Executives of its portfolio agencies on their responsibilities, public sector values and integrity.

The VPSC published a handbook for public sector entity executives in July 2019 and piloted a workshop on integrity and governance, which informed the further development of an induction program for Directors of Public Entities.

GMW, DELWP and the VPSC have kept me updated of their progress to implement my recommendations and I hope their collective efforts result in better awareness of, and compliance with, the standards we expect of employees in the public sector.

Figure 3: Presentation slide from DELWP training materials for Directors and Executives

Source: Department of Environment, Land, Water and Planning
## Status of my recommendations

### Recommendation 1 – to the GMW Board

Rectify the governance issues identified in this report through improved processes that address, including but not limited to:

- personal expense policies and reimbursements
- caps and use of financial delegations
- GMW’s compliance with tax obligations
- internal financial controls
- other areas of compliance with the Standing Directions for the Minister for Finance.

In doing so, report progress on steps taken quarterly to DELWP, and consider the appointment of an independent external auditor and/or probity practitioner.

Accepted.

GMW provided quarterly updates to both my office and DELWP about the progress to implement this recommendation, as well as additional steps it took to address other issues identified in the report.

The action by GMW has included:

- adopting VPSC’s Policy on Executive Remuneration in Public Entities and DELWP’s Model Gifts, Benefits and Hospitality policy
- ceasing to apply the LAFHA and reaching an arrangement with the ‘Australian Taxation Office (ATO) on correct taxation rates
- improving financial controls, delegations and oversight
- ceasing monthly dinners and paying for alcohol
- requiring Directors and General Managers to attest to having read and understood the code of conduct
- engaging GMW’s internal auditor to audit GMW’s performance against all Directions of the Minister for Finance.

GMW’s internal auditor also verified the Board’s completion of its action plan to address the issues identified in the report.

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<tr>
<th>Recommendation 2 – to the GMW Board</th>
<th>Accepted. The MD ceased employment at GMW on Friday 21 September 2018.</th>
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<tr>
<td><strong>Recommendation 2 – to the GMW Board</strong></td>
<td>Taking into account the findings of this report, consider if the MD has complied with his employment contract and/or codes of conduct and take appropriate action.</td>
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<td><strong>Recommendation 3 – to the GMW Board</strong></td>
<td>Accepted. GMW received legal advice that it was not cost effective to seek repayment from the MD.</td>
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<td><strong>Recommendation 3 – to the GMW Board</strong></td>
<td>Consider whether GMW has grounds to seek repayment from the MD in relation to: the MD’s relocation expenses any tax liability or any associated penalties owing due to the LAFHA personal expense claims reimbursed.</td>
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| Recommendation 4 – to the Minister for Water | Accepted.  
DELPWP gained assurance during meetings, which included a discussion of the Board’s action plan comprising 15 action items, and quarterly progress updates provided by the Board.  
DELPWP is satisfied that the 15 action items, which include the requirements of recommendation 1, have been implemented. |
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<td>Require assurance from the Board, via reports to DELWP, of the rectification of governance issues identified in this report, including but not limited to compliance with the Standing Directions of the Minister for Finance.</td>
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| Recommendation 5 – to DELWP | Accepted.  
Rather than reviewing each entities’ policy, the Secretary of DELWP wrote to each of the 31 entities asking that they review their existing policy.  
DELPWP also updated its model policy on Gifts, Benefits and Hospitality based on the VPSC’s policy, with additional guidance on catering and purchase of alcohol. Portfolio agencies were asked to adopt the model policy by 1 January 2020.  
DELPWP asked portfolio agencies to comment on the policy, procedures and monitoring/reporting systems that assure compliance with relevant government policies, including the issues highlighted in the report.  
In conjunction with VPSC and DHHS, DELWP developed training for board directors and executive members of public sector entities on director’s duties, governance, public sector values and integrity. This training will form a core module in induction, and was delivered to board directors of water corporations, catchment management authorities and other agencies on 4 March 2020. |
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<td>Review the hospitality and related personal expense policies of Victorian water corporations, to ensure consistency and that public expenditure is in accordance with relevant whole of government policies, codes of conduct and community expectations.</td>
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| Recommendation 6 – to VPSC | Accepted.  
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<td>Develop a handbook for public sector entity executives, drawing on the approach adopted in the existing Victorian Public Service Executive Employment Handbook.</td>
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Recommendation 7 – to VPSC

The Ombudsman made the following recommendation to DELWP relevant to this investigation in the report *Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board* tabled in March 2017:

The Department, in partnership with an external provider, consider developing and delivering an education and training program for people who are appointed to Board or Chief Executive Officer positions in public sector entities under the Department’s portfolio to:

a. build their awareness and skills regarding public sector policies, obligations and accountabilities, particularly regarding the expenditure of public money

b. target relevant parts of the program at office holders who have little or no experience in the public sector.

The Department subsequently implemented a program.

Given the issues identified in this investigation, the Ombudsman further recommends the VPSC, in conjunction with, and supported by other relevant entities, develop induction for incoming Board and Chief Executive Officers/Managing Directors. This should include instruction on the codes of conduct; gifts, benefits and hospitality policy; guidance on managing conflicts of interest; and information on key items of executive employment policy.

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Accepted.

VPSC has developed an induction program for incoming Board Members, CEOs and MDs. The program, which focusses on integrity and governance, was piloted in partnership with Victorian Government Solicitor’s Office and the Victorian Managed Insurance Authority.

VPSC is finalising a best practice induction suite of resources for incoming Board members. These resources build on insights from the piloted workshop, together with existing work from Departments.

VPSC is also exploring virtual options to support public entity board members in 2020-21.
Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust

Why I investigated

IBAC referred to me two protected disclosure complaints in June and August 2018 about the former Sexton/Cemetery Team Leader for the Mildura Cemetery Trust, who was employed by the Mildura Rural City Council.

The complaints involved allegations of illegal exhumations of deceased persons, conflicts of interests in promoting and selling memorial chairs for a personal benefit, misuse of position, improper receipts of payments for cemetery services and allegations of gross incompetence and neglect of professional standards in the execution of a public cemetery’s operations.

What I found

My investigation uncovered a series of misdeeds, mistakes and incompetence during an almost 20-year period. The most troubling instances of misconduct substantiated by my investigation involved the subject:

- Exhuming and/or causing an exhumation without a licence, and disregarding health and safety procedures.
- Promoting and installing memorial seats manufactured by a relative, without the knowledge of the Trust, during work hours. By 2018, there were 157 of these memorial seats installed across two cemeteries.
- Arranging to receive cash payments from funeral directors to lift ledgers, without the knowledge of the Trust.
- Mismanaging the operations of the cemeteries, including selling and digging grave sites that did not exist in areas beyond the designated grave plinths, failing to ensure grave plinths were properly numbered or marked, selling and interring into a grave sold previously to another person, and maintaining poor and inaccurate records which caused difficulties for visitors and cemetery staff in being able to identify graves and, in one case, resulting in the sale of an occupied grave.

The evidence indicated the Trust and the Council were aware of some of the subject’s conduct. Nevertheless, the overriding response to any concerns raised appeared to be to ‘ask no questions’, leaving him to continue his inappropriate activities and allowing them to escalate.

I found the Trust’s Board took a permissive and detached approach to operational matters, leaving the subject to operate with little or no accountability.

What has happened since

Before my investigation was completed, the Trust had already made significant improvements to its governance and operating procedures. After my report, they were prompt in referring the subject’s conduct relating to exhumation to Victoria Police. My office subsequently provided information to police.

The Council resolved on 22 April 2020 to allocate ongoing additional resourcing to support cemetery operations, including a grounds person and administrative support to the Trust. The Trust is also consulting other cemetery trusts to share and learn from each other’s experience. The Trust’s policies continue to be reviewed and developed.
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<tr>
<th>Recommendation</th>
<th>Accepted.</th>
<th>The matter was referred to Victoria Police on 13 November 2019. The Victorian Ombudsman subsequently provided information to Victoria Police.</th>
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<tr>
<td>Recommendation 1 – to Mildura Rural City Council and Mildura Cemetery Trust  That [the subject’s] conduct in respect of the exhumation case studies and [another] be referred to Victoria Police for investigation.</td>
<td>Accepted.</td>
<td>The Manager resigned from the Council, effective from 31 January 2020.</td>
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<td>Recommendation 2 – to Mildura Rural City Council and Mildura Cemetery Trust  That Council consider whether to take disciplinary action or management action in respect of [the subject’s] Manager.</td>
<td>Accepted.</td>
<td>The Trust and Council:  • identified training for Trust staff and are implementing this training plan  • engaged in a continuous process of reviewing, developing and formally adopting policies, processes and procedures to improve governance  • is working with DHHS, with advice from other similar councils/cemeteries, to determine the most appropriate governance and operational structure. Following the investigation, Council temporarily provided an administrative support officer and grounds person to assist the cemetery team to maintain day-to-day operations as well as implement the changes required to implement the recommendations. The Council resolved on 22 April 2020 to permanently resource these positions. Under a revised structure, during 2020, Cemetery operations will become a team within the Council, reporting through to the Council’s Chief Executive Officer. The Trust has also applied for a grant to improve row-markings and undertake a GPS marker location project to be included on a publicly accessible grave search website.</td>
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<td>Recommendation 4 – to Mildura Rural City Council and Mildura Cemetery Trust</td>
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<td>That suitable replacement memorials be installed where memorial chairs sold by [the subject] are removed.</td>
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<td>Accepted. The Trust adopted a Memorial Seat Policy. It has also agreed to consult families on memorial chairs needing removal due to deterioration or OH&amp;S concerns and to provide a suitable replacement memorial. Both the Memorial Seat Policy and Floral &amp; Ornamental Tribute Policy have been published on the Mildura Cemetery Trust website. The Trust is also designing signage for the cemeteries to communicate these policies to the community.</td>
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<tr>
<th>Recommendation 5 – to Mildura Rural City Council and Mildura Cemetery Trust</th>
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<tr>
<td>That the Council and the Trust provide suitable support to individuals and families affected by the contents of this report, including further investigation into individual circumstances, as necessary.</td>
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<tr>
<td>Accepted. The Trust and Council provided affected families and individuals, including those who were the subject of the investigation, access to the Council’s Employee Assistance Program. They have also received and responded to a number of enquiries from members of the public in relation to individual circumstances.</td>
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23. Investigations into poor administration by public organisations are the bread-and-butter of an Ombudsman’s work, often triggered by patterns of public complaints.

24. My office receives thousands of complaints a year; and while my staff are often able to quickly and effectively resolve them informally, sometimes formal investigation is necessary. This may be due to the seriousness of the issues involved, because the detriment caused disproportionately impacts a large or particularly vulnerable group, or as a result of seeing a trend in complaints that point to a systemic failing which is likely to have broader impact.

25. My office’s enquiries are no less important than investigations. Investigations do, however, enable me to compel agencies and individuals to provide me with relevant evidence.

26. In the last two years, I conducted two investigations that specifically looked at the actions of companies that carry out a duty on behalf of the State. These investigations highlighted the inherent challenge in managing the tension where an organisation has a corporate profit-making imperative while dealing with people who have few assets and/or limited ability to independently earn an income:

- Own motion investigation into State Trustees
- WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims.

27. Five investigations concerned local councils:

- Investigation into Maribyrnong City Council’s internal review practices for disability parking infringements
- Investigation into Wodonga City Council’s overcharging of a waste management levy
- Investigation into Wellington Shire Council’s handling of Ninety Mile Beach subdivisions
- Investigation into three councils’ outsourcing of parking fine internal reviews
- Revisiting councils and complaints.

28. I also investigated a complaint about Ambulance Victoria charging unreasonable fees for ‘treatment without transport’, which explored whether it was fair to charge someone without them providing, or being capable of providing, full, free and informed consent.
Improving systems for the public without investigating

Investigations and recommendations are not the only way my office improves public administration. Every year my staff conduct thousands of enquiries into complaints and matters to determine if I should investigate or if the issue can be resolved. In many cases these enquiries deal with an isolated issue in specific circumstances, however sometimes these individual issues collectively point to broader problems.

In the last two years, I tabled two reports that detailed some common issues effectively resolved through my office encouraging agencies to address issues and make broader improvements to their processes without an investigation.

Fines Victoria complaints

Fines Victoria came into existence on 31 December 2017 as part of major reforms to the infringements system in Victoria. These reforms were intended to provide a fairer and more equitable system, particularly for the most vulnerable and disadvantaged in the community. Fines Victoria was tasked with administering all fines and acting as a single accessible point of contact for people with fines.

While the intent behind Fines Victoria was worthy, it quickly became evident that something was not working when complaints about Fines Victoria to my office soared throughout 2018. The complaints showed patterns in delays for processing nominations, completing reviews and implementing payment plans. I also received multiple complaints about call wait times, difficulties making contact and concerns about the way Fines Victoria shared information with VicRoads, which led to further frustration as people were referred between agencies.

The end result led to licences being wrongly suspended, people left liable for fines when they had committed no offence and individuals facing serious financial hardship without proper administration of their infringements. Complainants repeatedly told my office of the frustration, anxiety and distress dealing with Fines Victoria had caused.

To address these issues, my office met with Fines Victoria throughout 2018. Fines Victoria told my staff that its new IT system, which was necessary to administering the new legislation but was not fully functional at the time it was launched, was the source of many of the challenges. However, my office’s analysis suggested that not all issues originated from the IT systems – they also concerned how discretion was exercised, the quality of its communications with the public and its complaint handling processes.

Pointing out the issues and asking Fines Victoria what they were doing to address them encouraged action. Fines Victoria has improved its internal processes and recruited more staff to clear backlogs and process fines. While the IT issues have not fully been resolved, manual workarounds are limiting the impact felt by members of the public. My office continues to monitor complaints about Fines Victoria and its progress to address the issues highlighted in the report.
VicRoads complaints

Almost every adult in Victoria deals with VicRoads, with 70% of us holding a driver licence and almost as many registered vehicles as there are residents. In 2017-18 my office received over 800 complaints about VicRoads.

By reviewing six months of complaints data about VicRoads, my office identified the following five emerging themes:

• processing of incomplete applications to transfer vehicle registration
• recognition of concession status
• processing of refunds and correction of payment errors
• issuing of suspension and renewal of registration notices
• administration of suspensions, or ‘overlapping suspensions’.

Over three months, my office wrote to VicRoads outlining what the public was telling us and worked with VicRoads’ leadership and operational teams to improve its practices. VicRoads accepted all of our proposals for improvements and worked toward finding solutions to support VicRoads’ practices, while also helping to informally resolve individual complaints.

Some of the changes introduced by VicRoads ranged from developing business rules and staff guidance on exercising discretion when processing incomplete applications for vehicle registration transfers, and informing the registered owner so they have an opportunity to dispute the application, to more flexibly applying concession entitlements.
Investigation into State Trustees

Why I investigated

State Trustees is Victoria’s public trustee. It is a company wholly owned by the State of Victoria, providing financial services to approximately 10,000 Victorians who cannot manage their own affairs because of an injury, illness or disability, often appointed by an order of the Victorian Civil and Administrative Tribunal (VCAT). Its role is critical in supporting some of the most vulnerable members of the community.

I decided to investigate after my office observed an increase in complaints about State Trustees’ administration of its financial management services during 2017 and 2018.

Those who contacted my office – clients of State Trustees, their families, friends, advocates and legal representatives – told similar stories. There were repeated complaints of unpaid bills, trouble getting money for everyday expenses, difficulties in contacting consultants and frequent failures to hear back from State Trustees, in the most serious cases leading to threats of utilities being disconnected and of eviction.

For this investigation, we closely examined the case files of 30 State Trustees clients. This approach not only enabled the investigation to better understand the client’s experience, it also provided the opportunity to resolve specific issues as they were identified.

What I found

Of the 30 files reviewed in depth, 23 involved instances of poor financial management, including late or incorrectly paid bills, lost entitlements, unnecessarily accrued debts, and failures to challenge fees, debts and fines that were likely to be rescinded or waived.

These failings alone were unacceptable, however for many clients, their frustrations were exacerbated by poor communications from State Trustees, including long call wait times and a lack of response to requests. When State Trustees did respond, its written communications were overly technical, leaving clients without the option to make an informed decision on their own finances.

My investigation identified numerous and repeated examples of State Trustees making financial decisions without consulting or having any regard to preferences and requests previously expressed by its clients. This goes directly against Victorian and international human rights laws which seek to ensure those with a disability are involved in decisions that affect them.

My investigation not only looked at whether State Trustees was acting in its clients’ interests, but also at the underlying causes of the many deficiencies identified through the review of client files.

It was evident that many State Trustees staff were dedicated but working in a challenging environment of high caseloads without adequate training or support.

Notably, State Trustees officers repeatedly raised concerns with my staff about the operating model introduced in 2017, intended to increase efficiency, which had replaced a one-to-one arrangement for consultants and clients. The result was a transactional style of case management where, in effect, no-one took responsibility for clients’ individual needs.

Despite the improvements during the investigation, fundamental questions remained about State Trustees’ establishment, noting it is the only public trustee in Australia set up under corporations law.
While we found no evidence of individual decisions being made for commercial reasons, there was evidence of commercial pressures limiting its service as a whole. I observed that after so many reports over many years questioning whether State Trustees acts in the interests of clients, it was time to review the model.

The introduction of the Guardianship and Administration Act 2019 (Vic), which replaced the 1986 Act, with a sharpened focus on the human rights and dignity of persons with a disability, also offered an opportunity to reconsider Victoria’s approach to their support.

**What has happened since**

Throughout the investigation, State Trustees took immediate steps to rectify individual cases as they were brought to its attention. Since then, it has used my investigation as a springboard for organisational cultural and operational reform.

State Trustees has refined its operating model to ensure new clients are assessed, and that clients with higher and complex needs are identified and provided with adequate support from consultants. Clients’ needs and capacity are subject to regular reviews, and modifications made to their arrangements. It has also consulted widely to improve the accessibility of the information it publishes and provides to clients.

The structural issues identified in my report are being addressed by a working group comprised of representatives from the Department of Treasury and Finance (DTF), DHHS and State Trustees. Collectively the working group is looking at alternative operating models in an effort to ensure State Trustees meets its community service obligations.

This sort of holistic review is likely to take some time. In the meantime, State Trustees has been granted $4.2 million over 2020/21 and 2021/22 to fund compliance requirements under the new legislation and says it will continue to monitor progress made by Government to ensure those unable to manage their finances alone are given proper and continuing support.

The effect of the stated improvements to systems and processes made by State Trustees is noticeable. Not only has my office seen a decrease in the number of complaints about State Trustees, but other organisations, with shared clients, have noticed an improvement in State Trustees’ services and interaction with its clients, and a genuine commitment to providing a better service.
Figure 4: Complaints made to the Ombudsman about State Trustees

Source: Victorian Ombudsman
Observations of Dr Sandy Ross, Executive Officer, FCVic (Financial Counsellors Victoria Inc., formerly the Financial and Consumer Rights Council), 15 May 2020

State Trustees has embraced [the Ombudsman’s] report and recommendations and, amongst other things, has engaged on building a cooperative working relationship with the financial counselling sector. 

[...]

In preparing this letter, we invited comment from our members. We only received feedback from one financial counsellor, who indicated that State Trustees had provided valuable assistance to a client under an Administration Order. She also noted that she had observed an improvement in the performance of State Trustees, and while it is sometimes slow to respond to some issues, this reflects staff managing heavy client loads and inadequate resources. I comment further on this issue below. In my view, the lack of any expressed concerns from members, and the positive elements of this limited feedback are generally consistent with our confidence in State Trustee’s response to your report.

[...]

The main challenge still facing State Trustees is the low level of resources it receives from the Government to discharge its role. The people whose interests it is charged to represent are by definition vulnerable and often in hardship. As a group they are not in a position to co-fund, let alone primarily fund, the work of State Trustees. Increased Government funding for State Trustees is essential to enable it to discharge its role effectively.

Some of the issues of concern your report identified had, as a contributory factor, cost pressures deriving from inadequate Government funding. Addressing these issues means steps are being taken to reform State Trustees but these steps also involve transition and implementation costs. It is important the State Government support State Trustees through its transition as well as providing a funding base that enables it to meet its responsibilities to protect and support vulnerable Victorians.

Observations of Dr Colleen Pearce AO, Public Advocate, 27 May 2020

OPA is aware that State Trustees Limited (STL) is working to address many of the identified failings (recommendations 7-11), including improving staff skills, producing accessible information and increasing access to personal information. The ‘Client First’ program is well underway. 

[...]

OPA has not received any complaints from represented persons in relation to STL in the last 12 months. OPA is aware that STL is attempting to be innovative and responsive during COVID-19, for example, by lifting the threshold of delegation for staff allowing them to make faster decisions.

[...]

OPA’s view is that the issues of service delivery and resourcing cannot be separated. STL is attempting to do the best it can in the circumstances but until resourcing is commensurate with the demands of the task there will continue to be occasions when STL falls short.
### Status of my recommendations

<table>
<thead>
<tr>
<th>Recommendation 1 – Governance to DTF and DHHS (in consultation with State Trustees)</th>
<th>Accepted by DTF and DHHS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review State Trustees’ governance arrangements, including its status as a state-owned company, to determine if the current arrangements are the most suitable for meeting State Trustees’ community service obligations.</td>
<td>DTF, DHHS and State Trustees established a working group which has agreed on a workplan to implement recommendations 1 and 2. The workplan comprises three workstreams focused on:</td>
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<tr>
<td></td>
<td>(i) costing current and future operating models based on the Ombudsman’s recommendations and legislative reforms</td>
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<td>(ii) assessing whether the Community Service Agreement (CSA) adequately deals with State Trustees’ current and actual obligations</td>
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<td>(iii) reviewing whether State Trustees’ corporate status is meeting Government and community expectations.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Recommendation 2 – Funding to DTF and DHHS (in consultation with State Trustees)</th>
<th>Accepted by DTF and DHHS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine future government funding required to ensure State Trustees meets all obligations under the Guardianship and Administration Act 2019 (Vic) and Powers of Attorney Act 2014 (Vic), including its obligations to:</td>
<td>As outlined at recommendation 1, the working group comprised of DTF, DHHS and State Trustees will analyse costs of future operating models to inform funding requirements.</td>
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<tr>
<td></td>
<td>• give effect to the will and preferences of each client</td>
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<td>• support clients to participate in decision making</td>
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<td></td>
<td>• act as an advocate for clients subject to administration orders.</td>
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<td></td>
<td>State Trustees has completed a financial review of its operations to form a baseline for a ‘cost to serve’ model. DHHS is conducting its own benchmarking and has engaged an adviser to help it review State Trustees’ business model and funding arrangements.</td>
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<td></td>
<td>To support compliance with the new Guardianship and Administration Act 2019 (Vic), the Government has granted State Trustees $4.2 million in funding over 2020-21 and 2021-22.</td>
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<td>State Trustees has prepared for and is incrementally implementing processes that support the commencement of the 2019 Act, including staff training, system upgrades and resources for clients.</td>
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<tr>
<td>Recommendation 3 – Disability expertise to DTF</td>
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<td>-------------------------------------------------</td>
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<tr>
<td>If the Government chooses to retain State Trustees’ status as a state-owned company, consider the following skills and experience when recommending State Trustees board members for appointment – lived experience of disability and mental illness, and experience as a carer or advocate.</td>
<td>Accepted. DTF introduced disability expertise or lived experience as part of the ‘skills based’ assessment process for the recruitment and appointment of State Trustees board members. Two recent board nominees met the criteria of having a lived experience of disability and mental illness, and experience as a carer or advocate.</td>
</tr>
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<table>
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<tr>
<th>Recommendation 4 – Fee relief to DTF</th>
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</thead>
<tbody>
<tr>
<td>In consultation with State Trustees, apply for a private ruling from the Australian Taxation Office regarding the application of the goods and services tax to State Trustees’ services.</td>
</tr>
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<table>
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<tr>
<th>Recommendation 5 – Fee relief to DHHS (in consultation with State Trustees)</th>
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<tbody>
<tr>
<td>Review and update the threshold for providing relief from State Trustees’ fees and commissions for clients in financial hardship</td>
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<tr>
<th>Recommendation 6 – Community services agreement to DHHS (in consultation with State Trustees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update the community services agreement to reflect State Trustees’ obligations under the Guardianship and Administration Act 2019 (Vic) and Powers of Attorney Act 2014 (Vic) and changes made under recommendations 2 and 5.</td>
</tr>
</tbody>
</table>
Recommendation 7 – Workforce
to State Trustees
Review State Trustees’ workforce for personal financial administration and power of attorney functions to determine:
• the level of resourcing required to meet State Trustees’ obligations under the Guardianship and Administration Act 2019 (Vic) and Powers of Attorney Act 2014 (Vic)
• the skills and capabilities required to meet State Trustees’ obligations under the Guardianship and Administration Act 2019 (Vic) and Powers of Attorney Act 2014 (Vic), including options for building disability, financial counselling and advocacy expertise.

Accepted.
State Trustees has estimated its resourcing requirements through its ‘cost-to-serve’ model which it provided to the working group, as part of its work to implement recommendations 1 and 2.
State Trustees has started to implement a new operating model which involves an assessment of the client’s needs, financial and personal capacity, and other risk factors, which will result in the client being allocated to a service tier based on their needs. This model also connects clients to other support services.
The operating model is supported by additional review triggers (including annual review cycles) enhanced recording keeping requirements, upskilling staff in legal advocacy and improving systems.

Recommendation 8 – Engagement
to State Trustees
Develop and implement a stakeholder engagement strategy to ensure State Trustees engages key disability, financial counselling and legal advocacy groups, and people with lived experience of disability and mental illness, regarding its services.

Accepted.
The State Trustees Board approved a new stakeholder engagement strategy in September 2019.
State Trustees now meets regularly with the OPA, VCAT and Victoria Legal Aid to discuss common issues and challenges, such as the implementation of the 2019 Act and preventing elder abuse.
State Trustees is better establishing its relationship with FCVic. It is also connecting with Anglicare, Good Shepherd and Bendigo Family and Financial Services to enhance opportunities for financial independence and personal support for clients.
It has participated in a benchmarking process led by the Australian Disability Network, from which State Trustees will build disability confidence within the organisation.
State Trustees consultants have also started undertaking human rights training, and State Trustees has updated its manual to ensure clients’ human rights are considered and protected.
Recommendation 9 – Accessible communication
to State Trustees
Update its communication for clients to:
• adequately explain all of State Trustees’ obligations and service standards and their rights as clients
• ensure information is available in easy English and other accessible formats
• provide regular budgets and account statements in a way that meets the communication needs and preferences of the individual client
• ensure free translation and interpreting services, when required
• make appropriate use of technology for clients to access information about their finances easily, such as SMS, automated voicemail and online access.

Accepted.
State Trustees has engaged Information Access Group (IAG) to review and help simplify the language used in State Trustees’ communications and publications. State Trustees’ welcome pack for new clients, Information about State Trustees’ commissions, fees and charges and a new financial statements explanatory document have developed into easy to understand information. Work is underway to translate the welcome pack into 17 other languages. Staff will also be provided training to develop skills in communicating and using easy to understand English. State Trustees has ceased charging for translation services and has a process for refunding such charges where a charge is incurred accidentally.

Recommendation 10 – Support for client independence
to State Trustees
Work with financial counselling and community support organisations to develop an effective program to build clients’ financial skills and capacity to manage their financial affairs independently.

Accepted.
State Trustees has developed and introduced training tools and modules aimed at supporting staff to develop their financial management capability. It is also investigating options for financial counselling qualifications for its employees. On 17 February 2020, State Trustees appointed an experienced financial counselling adviser who is focussed on improving in-house capacity to support clients to better manage their finances, as well as refining client programs and building relationships with community financial services. A new face-to-face Financial Independence Program, which is intended to lead to full financial independence, has been piloted with 10 clients identified as suitable candidates. The program has been evaluated and the new financial counselling advisor is making improvements to the program before the next iteration of the program is delivered.
<table>
<thead>
<tr>
<th>Recommendation 11 – Access to personal information to State Trustees</th>
<th>Accepted. Information on accessing personal information has been revised and updated on State Trustees’ website, together with plain English information and an email address for such requests.</th>
</tr>
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<tr>
<td><strong>Facilitate clients’ access to their personal information under Commonwealth and Victorian privacy legislation.</strong></td>
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<tr>
<td>Recommendation 12 – Access to personal information to the Department of Premier and Cabinet (DPC)</td>
<td>Accepted. DPC was reviewing the Freedom of Information Act 1982 (Vic) as part of a larger piece of work which will include reviewing the application of the Act to State Trustees. DPC notes, however, that ultimately the scope and timing for amendments to the Act will be for the Government to determine and that responsibility for freedom of information matters has been recently transferred to DJCS.</td>
</tr>
<tr>
<td><strong>Review the application of the Freedom of Information Act 1982 (Vic) to State Trustees.</strong></td>
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<tr>
<td>Recommendation 13 – Fee relief to DJCS</td>
<td>Accepted. Since the investigation, DJCS has met with Ombudsman staff to discuss the Guardianship and Administration (Fees) Regulations 2008 (Vic), and has also met with OPA and VCAT. DJCS states it is continuing this work and will consult on any proposed changes.</td>
</tr>
<tr>
<td><strong>Abolish VCAT’s annual fee for people subject to administration orders.</strong></td>
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<tr>
<td>Recommendation 14 – Accountability and transparency to DJCS</td>
<td>Accepted. VCAT has indicated it considers the current protections provided by clause 34 to the Victorian Civil and Administrative Tribunal Act 1998 (Vic) to be adequate. DJCS states it is continuing to work with VCAT to respond to this recommendation.</td>
</tr>
<tr>
<td><strong>Review schedule 1, clause 37 to the Victorian Civil and Administrative Tribunal Act 1998 (Vic) to ensure it does not prevent public debate about State Trustees, including in the media, where people consent to being identified.</strong></td>
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</table>
Investigation of a complaint about Ambulance Victoria

Why I investigated
A complaint made by telephone to my office prompted me to investigate Ambulance Victoria’s charges for ‘Treatment without Transport’.

A member of the public called an ambulance after witnessing a fight, which involved the complainant. Paramedics arrived at the incident, where they assessed and provided first aid to the complainant but determined transport to hospital was unnecessary. The complainant later received an invoice from Ambulance Victoria for $519 and complained he did not ask for an ambulance, had no idea there would be associated charges and said the treatment was minimal and did not warrant such a high cost.

When we made enquiries into his complaint we identified what appeared to be a systemic issue: fees being charged for treatment without transport, potentially involving invoices being charged unfairly. I decided to investigate these issues.

What I found
Ambulance Victoria had issued 17,758 invoices in the previous financial year to patients for Treatment without Transport. We reviewed a random sample of over 120 of these cases, finding multiple cases of questionable practices. These included numerous cases where more than one person was attended by paramedics, each of them, separately, being billed over $500 for treatment without transport, as well as people being invoiced for ambulances called by well-meaning friends or strangers.

We also looked at a sample of disputed invoices for treatment without transport. None of these reviews resulted in the fees being dropped. Several raised questions about Ambulance Victoria’s finance department’s lack of discretion in cases where the fee was plainly unfair. These practices also raised questions about whether people were given enough information to provide informed consent before being treated by paramedics.

We concluded that while not all the invoices were unfair, Ambulance Victoria’s practice of charging people for treatment without transport could result in outcomes that were unreasonable and unjust.

What has happened since
Ambulance Victoria was an exemplar of how an authority can positively engage with an Ombudsman investigation. It saw my investigation as an opportunity to improve its practices and systems, accepted my recommendations and fully implemented them within 12 months. As part of this implementation, Ambulance Victoria has:

• established a clear mechanism for individuals to dispute invoices, and ensuring officers dealing with them have the power to decide whether the charges should be reversed, reduced or referred to a manager
• changed its policies, to ensure that:
  • charges for multi-patient incidents are split between the patients; and
  • there is no charge to a patient who is not transported where the ambulance has been called without the patient’s knowledge or where it would not be possible for the patient to consent to the treatment
• taken steps to increase awareness of ambulance charges both through its own publications, and by working with other agencies and community groups to raise awareness through their publications and networks.

While my office continues to receive some complaints about billing by Ambulance Victoria, since my investigation these complaints have been resolved quickly with their cooperation.
<table>
<thead>
<tr>
<th>Recommendation 1</th>
<th>Accepted.</th>
<th>Ambulance Victoria cancelled the invoice and published information, including a phone number, for people wishing to have their invoice reviewed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancel the invoice issued to the caller who prompted this investigation for Treatment without Transport on 8 January 2018 and refund any other people who can provide evidence of payment in similar circumstances over the past 12 months, on the individual’s request.</strong></td>
<td><strong>Accepted.</strong></td>
<td><strong>Ambulance Victoria cancelled the invoice and published information, including a phone number, for people wishing to have their invoice reviewed.</strong></td>
</tr>
<tr>
<td>Recommendation 2</td>
<td>Accepted.</td>
<td><strong>Ambulance Victoria now splits the bill between multiple patients where they are treated at the one event, attended by one ambulance, if no one requires transport.</strong></td>
</tr>
<tr>
<td><strong>Cease charging each patient for a full Treatment without Transport fee at a multi-patient event, wherever practicable splitting the charge according to the number of patients.</strong></td>
<td><strong>Accepted.</strong></td>
<td><strong>Ambulance Victoria now splits the bill between multiple patients where they are treated at the one event, attended by one ambulance, if no one requires transport.</strong></td>
</tr>
<tr>
<td>Recommendation 3</td>
<td>Accepted.</td>
<td><strong>Ambulance Victoria no longer charges patients treated as a result of an ambulance request by an unknown third-party, or where the patient could not have reasonably consented to the treatment.</strong> <strong>Additionally, where patients are treated but not transported, they are now informed of the option to have their invoice reviewed.</strong></td>
</tr>
<tr>
<td><strong>Cease charging a Treatment without Transport fee where the ambulance service is activated by a third party and the patient did not know an ambulance was being called, or could not have reasonably consented to it, including when an ambulance is called by police.</strong></td>
<td><strong>Accepted.</strong></td>
<td><strong>Ambulance Victoria no longer charges patients treated as a result of an ambulance request by an unknown third-party, or where the patient could not have reasonably consented to the treatment.</strong> <strong>Additionally, where patients are treated but not transported, they are now informed of the option to have their invoice reviewed.</strong></td>
</tr>
<tr>
<td>Recommendation 4</td>
<td>Accepted.</td>
<td><strong>Ambulance Victoria’s work instructions have been updated to give Accounts staff the discretion and authority to make a decision on invoices under review on the merits of each case – that is, the ability to decide if the charges should be reversed, reduced or referred for further assessment to management. Staff have also been reminded of the relevant legislation.</strong></td>
</tr>
<tr>
<td><strong>Revise its process for dealing with disputed invoices to ensure:</strong></td>
<td><strong>Accepted.</strong></td>
<td><strong>Ambulance Victoria’s work instructions have been updated to give Accounts staff the discretion and authority to make a decision on invoices under review on the merits of each case – that is, the ability to decide if the charges should be reversed, reduced or referred for further assessment to management. Staff have also been reminded of the relevant legislation.</strong></td>
</tr>
</tbody>
</table>
| • staff are empowered to exercise discretion, and  
• legislation is not misquoted. | | |
| Recommendation 5 | Accepted. | **Ambulance Victoria now publishes information about fees, including a link to the ambulance fee schedule for non-members.** **It has also engaged with other bodies to assist in communicating ambulance costs. VicRoads has committed to including a message about ambulance costs in its registration reminders, and on electronic displays at its customer service counters. Ambulance Victoria has also engaged the Victorian Aboriginal Community Health Organisation (VACCHO) and Victorian Council of Social Services (VCOSS) to help communicate the costs of ambulance services to their members and clients.** |
| **Further to section 10(c) of the Human Rights Charter note that full, free and informed consent for Treatment without Transport may include conveying relevant information about potential costs, and consider ways to adequately inform patients accordingly.** | | |

improving public administration 59
Why I investigated

In the 1950s and 60s, a pristine part of the East Gippsland coast and lakes region was subdivided into small lots. These were promoted by a developer as an opportunity to buy into Gold Coast-style resort living; many were bought by new migrants investing in a dream holiday home and their future.

The land was mostly unsuitable for building, much of it sand dunes or flood prone, which over the succeeding decades became subject to tight building restrictions and prohibitions. Many landowners were left unable to build on plots of land that were worth almost nothing.

My office had received complaints from landowners about the Wellington Shire Council, which became responsible for the Ninety Mile Beach subdivisions, for a number of years. In 2018, the number of complaints to my office dramatically increased, accelerated by concerns that the Council was continuing to charge rates and other charges on worthless land, and that the Council was profiting from its buy-back program.

Many of the concerns raised by landowners were historical – being ‘scammed’ by a developer, the lack of a planning scheme in the 1950s and 60s, or the actions of a Council that ceased to exist more than 20 years ago – and were not matters I could meaningfully deal with. However, I could and did look at what had happened recently and what was happening now.

What I found

First it was necessary to look at the long and complicated history of the Ninety Mile Beach subdivisions. The lots were initially subdivided and sold in a largely unregulated environment from 1954. Successive State Government reviews into inappropriate subdivisions were undertaken with restrictions and prohibitions on building applied to different areas, at different times. Responsibility for planning shifted between the State and local Council, which changed and were superseded by others over time.

At various times the former Shire of Rosedale and its successor, Wellington Shire Council, levied rates and other charges on the land, with some landowners paying while others accrued debts which were largely unenforced. Various voluntary acquisition schemes were introduced and, during the 1990s, the Council started buying up lots to facilitate low density development in permitted areas.

Rather than resolving landowners’ concerns, I found that some of the Council’s initiatives had exacerbated their grievances. People accused the Council of bullying them into giving up their land and profiteering from reselling the land as consolidated lots. While the Council was not profiteering, it could have communicated better and it would have been wiser for the Council to limit its buy-back to land that cannot be developed at all.

We found that some of the complaints arose from misunderstanding or poor communication, not surprising given the apparent language difficulties of some owners and the complexity of the problem.
I concluded that rates and charges should not be levied on the Ninety Mile Beach subdivisions that cannot ever be developed. Ultimately, this land should be returned to state ownership for the benefit of all.

**What has happened since**

Wellington Shire Council was quick to act on my three recommendations to the Council, resolving at a meeting on 20 August 2019 to support them. The recommendations were again discussed at a meeting on 3 December 2019 during which the Council agreed to stop levying any charges on undevelopable land, and to refund landowners rates paid from 2006 and the Waste Infrastructure Charge paid from 2011.

The Council is giving landowners until 3 December 2020 to apply for the refund.

DELWP, to which I addressed the fourth recommendation, has started planning for a program to compulsorily acquire land from 1 July 2021 when the voluntary acquisition schemes end.

While I recognise my recommendations bring cold comfort to some landowners, I hope they recognise they are ultimately to the benefit of the public as a whole.

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**Figure 5: Original real estate advertisement**

![Original real estate advertisement](image)

*Source: Panel Report into the Wellington Planning Scheme Amendment C71 (2012)*
<table>
<thead>
<tr>
<th>Recommendation 1 - to Wellington Shire Council</th>
<th>Supported in principle and agreed to by the Council through resolution.</th>
</tr>
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<tbody>
<tr>
<td>Review its rating strategy with a view to:</td>
<td>Council resolved at its meeting of 3 December 2019 to reduce general rates on all undevelopable land in the Ninety Mile Beach subdivision to zero from 1 July 2019, with this strategy to be adopted in the 2020/21 budget onwards. No rate notices were sent out to affected property owners for the 2019/20 year which will essentially give effect to the strategy from 1 July 2019.</td>
</tr>
<tr>
<td>• reducing the rates levied against all undevelopable land in the Ninety Mile Beach subdivisions to zero</td>
<td>Council also intends to offer refunds of rates and Waste Infrastructure charges levied on undevelopable lots. Council has set aside a budget allocation and is currently seeking support from DELWP (through the existing $6 million grant funding) to appoint an officer to receive and process refund requests.</td>
</tr>
<tr>
<td>• cease levying the Waste Infrastructure Charge on all undevelopable land in the Ninety Mile Beach subdivisions</td>
<td>Communication with landowners about the above is planned to commence before the end of June 2020 and will include:</td>
</tr>
<tr>
<td>• as a gesture of goodwill, refund (on the request of current landowners or previous landowners who can provide evidence of payment, made within 12 months of this report):</td>
<td>• direct mailout to current landowners of undevelopable land to notify of the rating changes</td>
</tr>
<tr>
<td>• rates paid on all undevelopable land in the Ninety Mile Beach subdivisions since rates notices were reinstated against Flood-prone land in 2006</td>
<td>• direct mailout including a refund request form to eligible current landowners (who have made a payment of Council rates and charges since 2006)</td>
</tr>
<tr>
<td>• the Waste Infrastructure Charge paid on all undevelopable land in the Ninety Mile Beach subdivisions since the commencement of the Voluntary Assistance Scheme in 2011.</td>
<td>• providing a refund request form on the rates page of the Council website</td>
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<tr>
<td></td>
<td>• advertisements on Council’s website, in the local paper and a state-wide daily newspaper notifying landowners (current and previous) that they can make applications for a rates and charges refund as per the agreed timeframes.</td>
</tr>
</tbody>
</table>
### Recommendation 2 – to Wellington Shire Council

Actively facilitate the sale of single allotments between landowners in the Urban Nodes without itself acquiring land.

Supported in principle and agreed to by the Council through resolution.

Council has sold (or is in the process of selling) 4 restructured allotments owned by Council fronting Shoreline Drive, Golden Beach in the developable area.

Council is currently seeking resourcing support from DELWP (through the existing $6 million grant funding), for the appointment of a dedicated officer for a 2-year tenure to support implementation of this recommendation.

### Recommendation 3 – to Wellington Shire Council

Update its website to assist the communication of relevant information to affected landowners, including:

- information on the Rates Calculation webpage regarding special arrangements in place for Ninety Mile Beach subdivision landowners
- all significant events in respect of the Ninety Mile Beach Plan in the New and Public News feed
- facility be provided to enable landowners to determine the category of their land by searching their address.

Supported in principle and agreed to by the Council through resolution.

Council’s website now includes updated information about the Ninety Mile Beach Plan, a link to the Ombudsman report, and a map showing the developable and undevelopable land, and a link to obtain individual planning property information. Council has also prepared a new online mapping portal (searchable by property address, lot details or by mapping search), to be made available shortly, which clearly and simply differentiates developable and undevelopable land.

Further updates to the website will be made to communicate changes to the 2020/21 rating strategy once they have been confirmed.

The New and Public News feed will be updated for all significant events in respect to the Ninety Mile Beach Plan.

### Recommendation 4 – to DELWP

Work with Wellington Shire Council to facilitate a program of compulsory acquisition of privately-owned undevelopable land in the Ninety Mile Beach subdivisions once the Council’s Voluntary Assistance Scheme and Voluntary Transfer Scheme conclude in 2021.

Accepted.

DELWP and the Council have developed a joint action plan for critical tasks to ensure a smooth transition to the compulsory acquisition scheme and the sustainable future management of the land, from 1 July 2021.

DELWP has taken steps toward implementing this recommendation, including meeting with Traditional Owners, commencing development of funding options for the compulsory acquisition scheme and establishing a project group for assessment of environmental public land values to inform future management arrangements for the land that will come into the Crown land estate.
Investigation into Maribyrnong City Council’s internal review practices for disability parking infringements

Why I investigated

In January 2017, the Western Community Legal Centre (WEstjustice) complained to my office about Maribyrnong City Council’s approach to conducting internal reviews of infringements. WEstjustice provided examples which it said showed ‘Maribyrnong’s system for administering internal review applications is unfair, arbitrary, [and] overly rigid’.

Several cases concerned disability parking infringements where the driver or passenger had a valid permit which they had failed to display properly, but who had a reasonable explanation for the failure. Enquiries suggested this may be a systemic issue. Given the inherent vulnerability of people with disability parking permits, I decided to investigate the Council’s handling of internal reviews relating to disability parking infringements, to see if they were unfair, as alleged.

What I found

As part of my investigation, we examined case studies provided by WEstjustice, five of which featured in the report. We also reviewed internal review decision data and guidelines for Maribyrnong City Council and compared them to five other inner-city Councils.

The internal review data from the Councils showed that Maribyrnong overturned its infringements at less than half the rate of any other comparator Councils, and the discrepancy was even more striking with disability parking infringements.

In each of the five case studies included in my report, the recipients of the fines held a valid disability parking permit, but for various reasons had failed to properly display their permit.

In each of these cases we considered ‘exceptional circumstances’ should have applied: the failures occurred during hospital visits or were a consequence of an understandable mistake.

I expressed the view the Council had taken an overly rigid approach to all-too-human errors – fair systems of public administration need thoughtful exercise of discretion, not blanket rules, rigidly applied.

What has happened since

I made three recommendations to the Council. While it accepted two of the recommendations, it did not accept my recommendation that it make ex gratia payments to each of the persons identified in the five case studies, although it did refund one of the fines.

Following the investigation, Fines Victoria contacted Maribyrnong City Council to offer its assistance and advice on updating the Council’s Internal Review – Withdrawal Guidelines. The Council accepted this offer and has now finalised its updated guidelines which offer more opportunity for compliance officers to exercise their discretion.

Comments from Shifrah Bluestein, Policy and Projects Lawyer, WEstjustice

I have consulted with the other legal assistance agencies with whom we made the original complaint. Together, we have seen some further disabled parking infringements, but we have also observed Maribyrnong’s broader discretionary decision-making. Importantly, we believe this relates not just to internal review but also to decisions around prosecuting individuals with fines either outright or after special circumstances enforcement review.

In our view, Maribyrnong’s exercise of discretion in fines matters has not improved overall. Although we have had some examples of good practice ( ... where Maribyrnong has chosen not to prosecute following successful special circumstances internal review), we have seen more examples of poor decision-making.
### Status of my recommendations to Maribyrnong City Council

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Status</th>
<th>Details</th>
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</thead>
</table>
| **Recommendation 1**  
Work with Fines Victoria to update its *Internal Review – Withdrawal Guidelines* to ensure that when conducting internal reviews, compliance officers:  
- have a discretion to withdraw an infringement where a valid disability permit holder provides a copy of their disability permit  
- may exercise a discretion where individual and/or exceptional circumstances apply. | Accepted.  
The Council’s guidelines have been updated and reviewed by Fines Victoria. The Council has a program to annually review the guidelines and make ad hoc updates to reflect changes to legislation. | |
| **Recommendation 2**  
Provide training to staff involved in completing internal reviews on good administrative decision making and exercising discretion by 30 June 2018. | Accepted.  
The Council delivered training to staff and the issues raised regularly at staff meetings. | |
| **Recommendation 3**  
Provide an *ex gratia* payment to the individuals in case studies 1 - 5 [of the report] for the costs of the infringements and, where applicable, court costs paid. | Not accepted.  
While the Council did not accept this recommendation, it did refund ‘Peter’, from case study 3, $245.10. | |
Investigation into Wodonga City Council’s overcharging of a waste management levy

Why I investigated
In June 2016, I received a complaint alleging Wodonga City Council had been over-charging its ratepayers a waste management levy, above the cost of running the service, since at least 2008 and using the excess funds to pay for non-waste related operations.

Increases in general rates and municipal charges have been capped since 2016-17. In contrast, the Waste Management Charge is a flat fee, which raises issues of inequity and regressive taxation, and is not capped.

The complaint questioned the Council’s transparency and fairness which, following enquiries, were sufficiently significant to justify investigation, in the public interest.

What I found
The complaint was substantiated. In addition to rates, which already included a ‘garbage and recycling disposal charge’, Wodonga City Council had levied a Waste Management Charge since the early 2000s raising some $18 million surplus – that was spent on council services which would ordinarily be funded from general rates.

The Council said it acted in good faith, believing the practice to be compliant with the Local Government Act, and that it had consulted its community. I accepted the legislation did not explicitly require the Council to recover only its reasonable costs of waste management, but considered the intent to be clear. While the practice pre-dated rate-capping, the Council maintained it after rate capping was introduced. Intentionally or not, by doing so, the Council was able to avoid the scrutiny that necessarily attaches to rate rises.

I accepted that rate capping puts financial pressures on councils, especially rural councils with a smaller rate base and, often, ageing infrastructure.

But those financial pressures need to be faced head on, in partnership with their communities, rather than buried in the financial fine print.

I also noted that 72 of the 79 Victorian councils had separate waste charges; and in tabling the report I encouraged them to satisfy themselves that the charge reasonably reflected the service provided.

What has happened since
Within three months of my report, Wodonga City Council adopted and implemented a $112 reduction in the Waste Management Charge without having to seek a variation to the rate cap in its 2019-20 budget. The Council also introduced a new policy requiring the charge be levied on a cost neutral basis with any surplus generated available for waste-related activities only.

Since this investigation, my office was alerted to another Council raising a significant surplus through a waste management levy. In response to initial enquiries, this Council was able to demonstrate it was taking steps to ensure it no longer overcharged its waste levy. It has also been open with the community about what had happened and what it planned to do in the future.

While the Local Government Bill 2018 would have introduced a requirement that charges for the collection and disposal of refuse reflect the reasonable cost of providing that service, the Bill lapsed due to the 2018 State Government election. When the Bill was reintroduced to the Parliament in 2019, all provisions concerning rates and special charges were set aside until the Government completes its Victorian Local Government Rating System Review. The Rating Review Panel provided its final report to the Government on 31 March 2020. I await the outcome of the Government’s consideration of the review and will continue monitoring the implementation of my recommendation.
<table>
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<tr>
<th>Status of my recommendations</th>
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<tbody>
<tr>
<td><strong>Recommendation 1 – to Wodonga City Council</strong></td>
<td>Accepted.</td>
</tr>
<tr>
<td>• Reduce its waste management service charge, to only recover the reasonable costs of the collection and disposal of refuse</td>
<td>In June 2019, the Council adopted its 2019-20 budget which included a $112 reduction in the Waste Management Levy, without the Council seeking a variation to the rate cap. This equates to an average residential rate reduction of 3%. The Council commissioned its internal auditors to review waste budget calculations, which concluded the Council’s 2019-20 provides for a cost neutral expenditure-revenue position for waste. Council has also developed a Waste Management Reserve Policy that ensures any surplus is only used for waste-related purposes.</td>
</tr>
<tr>
<td>• Effect the above within three years from the finalisation of the investigation.</td>
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<tr>
<td><strong>Recommendation 2 – to Local Government Victoria</strong></td>
<td>Accepted.</td>
</tr>
<tr>
<td>Consider recommending that section 162 of the <em>Local Government Act 1989</em> (Vic) be amended to require that charges for the collection and disposal of refuse reflect the reasonable cost of providing that service.</td>
<td>In 2018, the Government introduced the Local Government Bill 2018 to Parliament which would have introduced a broad range of changes to the Local Government Act. Not least, the requirement that service charges, such as the waste management charge, are not to exceed the estimated costs for reasonably providing the service. However, this Bill lapsed due to the 2018 State Government election. In June 2019, the Government commenced a review of the local government rating system. As a result, it removed all amendments relating to rates from the Local Government Bill 2019. Further amendments to the Local Government Act will be introduced once the Government has considered the outcome of the rating system review.</td>
</tr>
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</table>
Investigation into three councils’ outsourcing of parking fine internal reviews

Why I investigated

In March 2019, Monash City Council and Kingston City Council announced they would refund more than 46,000 infringements issued over a 10-year period, at an estimated cost of $4.9 million. They said they had become aware of legal doubts about their arrangement to outsource the internal review process to a private company.

The commentary following these announcements suggested some councils were aware of doubts about the lawfulness of their outsourcing arrangements, and three Councils, Glen Eira, Port Phillip and Stonnington, issued statements defending them. I therefore decided to look into these councils, to see if they were indeed different.

What I found

The issues in this investigation originated from changes to the law in 2006, when new infringements legislation, the Infringements Act 2006 (Vic) (Infringements Act), set out processes for issuing, appealing and enforcing parking fines. It also included a right for people to seek an internal review from the council or agency that issued the fine. In practice, the law allows for councils to use private contractors to provide administrative assistance, but not to make decisions on behalf of the council.

When we examined a sample of files from the three Councils, we found one of the Councils had not only outsourced the administration of its internal review process but it had also outsourced its decision making responsibilities. The other two Councils had, in effect, rubber-stamped the contractor’s recommendations.

None of the Councils had disclosed who had made the internal review decision, contrary to the principles of transparency and accountability rightly expected by the community.

My interpretation of the law, consistent with that of Monash and Kingston Councils, was that internal reviews must be decided by the agency issuing the infringement. The evidence of the practices employed by all three Councils we investigated was that the decisions were outsourced and therefore appeared to be contrary to law.

The Councils disagreed with my opinion and maintained they had acted lawfully, noting the new Infringements Act was ambiguous and they had received conflicting advice on its application. However, each Council agreed to set up refund schemes for affected motorists.

What has happened since

Glen Eira, Port Phillip and Stonnington Councils all agreed to refund fines for internal reviews decided between 2006 – 2016 as a ‘gesture of goodwill’.

Within days of the report’s publication all three Councils published information on their websites outlining who can apply for a refund and how to do it.

They also agreed to use anonymised references in the signature block to identify the delegated decision maker. By doing so, the Councils are protecting the welfare and safety of review officers, a concern raised during the investigation, while providing accountability for decisions.
Following the publication of my investigation, several other councils that had outsourced parts of their infringements process announced that they would also address concerns about internal reviews being carried out by a third party. Some are considering refund schemes of their own, or reviewing their past practices.

More broadly, DJCS, which includes Fines Victoria, will incorporate my recommendations into the work already underway to review internal review processes.

Figure 6: Information published by Glen Eira, Port Phillip and Stonnington Councils about refund schemes

Source: Websites of Glen Eira City Council, City of Port Phillip and City of Stonnington
### Status of my recommendations

| Recommendation 1 - to Glen Eira, Port Phillip and Stonnington City Councils | Accepted.  
| Establish an arrangement by April 2020 under which: |  
| • motorists can contact the Council if their parking infringement internal review application was rejected between the commencement of the Infringements Act and changes to council internal review practices in late 2016 and 2017 | All three Councils agreed to refund infringements, on request, where the review application was rejected, without evidence that an appropriately delegated council officer read the application and exercised their own discretion, prior to the Councils bringing the internal review process in-house.  
| • refund the infringement where the Council does not have evidence that an appropriately delegated council officer read the application and exercised their own discretion | They have each also published information on their websites that clearly explains who may be eligible for a refund and how to apply.  
| • advertise the arrangement prominently on the Council’s website and social media accounts and via a media release. |

| Recommendation 2 – to Glen Eira, Port Phillip and Stonnington City Councils | Accepted.  
| Identify decision makers in internal review decision notices by name and title or, if preferred, by an anonymised but identifying reference. | All three Councils have started using an anonymised reference in the signature block of internal review decisions to identify the delegated decision maker. |

| Recommendation 3 – to the Director, Fines Victoria | Accepted by DJCS, on behalf of Fines Victoria.  
| Update the internal review guidelines for enforcement agencies by June 2020 to advise councils and relevant enforcement agencies: | The requirements of this recommendation will be subsumed into work already underway to review the internal review processes.  
| • not to use contractors to decide parking infringement internal reviews |  
| • to identify internal review decision makers in notices by name or, if preferred, by an anonymised but identifying reference. |
**Recommendation 4 – to the Director, Fines Victoria**

By the end of 2020, request the following information under section 53B of the Infringements Act from enforcement agencies that use contractors for parking infringement internal reviews:

- information about their internal review practices
- copies of relevant contracts with the contractor
- a sample of the internal review records and make recommendations under section 53C, as required, to ensure the councils and relevant enforcement agencies do not use contractors to decide parking infringement internal reviews.

Accepted by DJCS, on behalf of Fines Victoria. As with recommendation 3, the Department will incorporate this recommendation into work already underway to review the internal review processes.

**Recommendation 5 – to the Secretary, DJCS**

Seek amendments to the Infringements Act to clarify who can conduct internal reviews of parking infringements, for the avoidance of doubt.

Accepted. The Department supports the amendments but notes that ultimately the Government is responsible for the recommendation.
Why I investigated

In 2016 I tabled a report into WorkSafe agents’ handling of complex claims, which concluded that although the whole system was not broken, the handling of complex claims – the most difficult and expensive – needed fundamental reform. The report was widely welcomed by many and WorkSafe accepted all 15 recommendations made to it, with the support of the responsible Minister.

Despite the apparent implementation of my recommendations, complaints continued, raising the same themes: unreasonable decision making by agents, and inadequate oversight by WorkSafe. I launched a second investigation in May 2018 on the back of an influx of complaints and anecdotal evidence that not enough had changed.

What I found

My investigation found that although there had been some improvement following my 2016 report, it was short-lived and, if anything, had the effect of driving some practices ‘underground’. Some agent staff were told to be careful of what they put in writing in case the Ombudsman saw it. The unfair practices identified in the 2016 report were continuing; and new issues, such as agents’ use of surveillance on workers without adequate justification and unreasonable return to work practices, were identified.

As I had found previously, there were multiple examples of agents unreasonably terminating claims, including selectively using evidence, making decisions contrary to binding medical panel decisions, and acting unreasonably during conciliation.

While WorkSafe’s process for auditing the quality of agent decisions had improved, we found concerning examples of it passing questionable decisions and failing to properly exercise its powers.

It was evident that the piecemeal changes made to the WorkCover scheme following my 2016 report were unsuccessful, and more fundamental reform was needed. While the financial viability of the scheme was imperative, the balance between financial sustainability and fairness for injured workers has tilted too far away from the latter.

My recommendations therefore focussed on systemic reform: reviewing whether the agent model remained appropriate and addressing a critical shortcoming in the dispute resolution system – that only a lengthy and costly court process can deliver a binding outcome where other efforts to resolve a dispute, such as conciliation, have already failed.

Acknowledging that major reform will take time to implement, I also recommended that WorkSafe should intervene directly in appropriate cases, setting up a dedicated unit to review disputed decisions where agreement cannot be reached at conciliation.

What has happened since

I made two recommendations to the Government and 13 to WorkSafe, with the Government and Worksafe each starting to implement the recommendations.

The Government has commissioned an independent review into whether the current model for claims management is meeting the Workplace Injury Rehabilitation and Compensation Act 2013 (Vic) (WIRC Act). It will also introduce a new arbitration model for the Accident Conciliation and Compensation Service, which will enable binding decisions on disputes to be made and complement existing dispute resolution processes.
WorkSafe has made progress to implement each of the recommendations addressed to it and is on track to finalise implementation by the end of 2020. Most importantly, this includes establishing a unit to independently review a disputed decision following conciliation, with the power to make determinations.

Since my report was tabled, my office has referred several matters to WorkSafe for review. On the whole, we have observed and have been satisfied with the rigour of the reviews WorkSafe has undertaken to date, some of which resulted in agent decisions being overturned or further action taken.

Figure 7: Complaints made to the Ombudsman about the WorkCover scheme

Source: Victorian Ombudsman
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<tr>
<th>Status of my recommendations</th>
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<tr>
<td><strong>Recommendation 1 – to the Victorian Government</strong></td>
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<tr>
<td>Commission an independent review of the agent model to determine how and by whom complex claims should be managed, taking into account:</td>
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<td>• the need to ensure appropriate compensation is provided to injured workers, as well as the financial viability of the scheme</td>
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<td>• the experience of other accident compensation schemes, including Victoria's transport accident scheme (managed by the Transport Accident Commission) and other national and international workers compensation jurisdictions.</td>
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<tr>
<td>Accepted.</td>
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<tr>
<td>The Attorney-General advised that the Government has commissioned an independent review of the current model for claims management and whether it is meeting the objectives of the WIRC Act, in relation to complex claims.</td>
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<td>Peter Rozen QC has been engaged to undertake the review and will be supported by a dedicated team.</td>
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<tr>
<td><strong>Recommendation 2 – to the Victorian Government</strong></td>
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<tr>
<td>Introduce a new dispute resolution process which:</td>
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<td>• allows for binding determinations on the merits of claims decisions, including factual disputes; is inexpensive; and provides timely outcomes</td>
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<td>• complements the existing dispute resolution processes of conciliation and legal review at court.</td>
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<tr>
<td>Accepted.</td>
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<tr>
<td>The Attorney-General advised that the Government intends to introduce a new arbitration model for the Accident Conciliation and Compensation Service.</td>
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<td>Consultation with affected stakeholders has been undertaken to inform the development of a new dispute resolution model that responds to the objectives of this recommendation.</td>
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<tr>
<td>Recommendation 3 – to WorkSafe Victoria</td>
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<td>Establish a dedicated business unit to</td>
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<tr>
<th>Recommendation 4 – to WorkSafe Victoria</th>
<th>Accepted.</th>
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<tr>
<td>Amend its quality decision making audit procedure to ensure that:</td>
<td>WorkSafe commenced reviewing its quality decision making audit procedure to ensure that the audit criteria and process consider the sustainability of decisions, and that unsustainable decisions are overturned. This review was due to be operational by 31 May 2020.</td>
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<td>• only sustainable decisions pass</td>
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<tr>
<td>• unsustainable decisions identified through the audit process are overturned.</td>
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<th>Recommendation 5 – to WorkSafe Victoria</th>
<th>Accepted.</th>
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<tr>
<td>Establish a centralised complaints process which triages and provides a single point of contact for all complaints about the claims process, including agent decisions and Independent Medical Examiners (IME).</td>
<td>On 31 March 2020, WorkSafe launched its centralised complaints system which handles receipt, triage and acknowledgement of complaints, and manages the complaints process end-to-end, incorporating regular communication on progress to the complainant. WorkSafe states that by 29 May 2020, of the 339 complaints received into the new system 63% were resolved without further escalation, and that the time taken to resolve complaints had reduced from an average of 21 days to 13 days. Reporting and monitoring of trends in complaints received will drive continuous improvement.</td>
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**Recommendation 6 – to WorkSafe Victoria**

Update the Claims Manual, and provide training to agent staff, to:

- require that agents make sustainable decisions
- require that agents provide reasons in an adverse decision notice if they have disregarded or discounted any relevant evidence or information in making the decision
- clarify and expand the requirements about agents’ use of surveillance, including what constitutes ‘adequate evidence’, record keeping standards and the use of surveillance in mental injury claims
- clarify the circumstances in which agents should refer a worker to a psychiatrist IME for assessment of a potential secondary mental injury
- provide guidance on the appropriate IME specialty to assess workers with chronic pain syndrome or a pain disorder
- provide guidance on the rejection of mental injury claims under section 40(1) of the WIRC Act (reasonable management ground), including the evidence required to support a decision on this ground
- provide clarification and greater guidance regarding the circumstances in which it is appropriate to issue a return to work non-compliance notice, including assessment of whether a worker has made ‘reasonable efforts’ to comply with their obligations
- provide guidance on the evidence required to show a ‘material change’ in a worker’s condition since a previous Medical Panel examined them and provided an opinion.

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Accepted.

WorkSafe is reviewing its Claims Manual and will progressively update the information available to agents by May 2020. WorkSafe is committed to developing training to support agents implementing the revised information in the Claims Manual and will roll out mandatory training to all those responsible for making decisions about injured workers’ entitlements.
<table>
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<tr>
<th><strong>Recommendation 7 – to WorkSafe Victoria</strong></th>
<th><strong>Accepted.</strong></th>
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</table>
| Increase WorkSafe’s oversight of the following claims management activities by agents, through targeted ‘health checks’ or audits:  
  • agents’ use of surveillance  
  • mental injury claims rejected under section 40(1) of the WIRC Act (reasonable management ground)  
  • return to work non-compliance notices  
  • terminations of ‘top up’ weekly payments provided under section 165 of the WIRC Act (or section 93CD of the Accident Compensation Act 1985 (Vic)). | WorkSafe is strengthening requirements for the use of surveillance, including an annual assessment of the documented reasons and appropriateness of surveillance and a requirement to escalate approval of the use of surveillance.  
To address the recommendation, WorkSafe is increasing its oversight of claims management activities by introducing ‘health checks’ for:  
  • agents’ decisions to undertake surveillance  
  • return to work non-compliance warnings  
  • any decisions by agents that result in payments to injured workers being stopped.  
WorkSafe’s audit program will also include:  
  • increased audits of mental injury claims rejected under s40(1) of the WIRC Act  
  • audits on return to work non-compliance warnings. |

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<tr>
<th><strong>Recommendation 8 – to WorkSafe Victoria</strong></th>
<th><strong>Accepted.</strong></th>
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</table>
| Amend the ‘Injured Worker Survey’ measure so that it better targets complex claims, which may include:  
  • increasing the focus on complex claims in the current survey, or  
  • introducing a separate survey of workers with complex claims. | WorkSafe is elevating its monthly reporting of current survey results for injured workers with complex needs within WorkSafe. WorkSafe is developing a methodology for increasing focus on injured workers with complex needs. |

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<tr>
<th><strong>Recommendation 9 – to WorkSafe Victoria</strong></th>
<th><strong>Accepted.</strong></th>
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</table>
| Introduce a contractual requirement regarding the timeframe in which agents must respond to:  
  • requests for reinstatement of weekly payments  
  • requests for medical and like treatment. | WorkSafe has introduced a contractual requirement that decisions in relation to requests for reinstatement of weekly payments and requests for medical and like treatment must be taken within 28 days of receipt of the request, unless there are documented, exceptional circumstances. |
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<tr>
<th><strong>Recommendation 10 – to WorkSafe Victoria</strong></th>
<th>Accepted.</th>
<th>WorkSafe is analysing the most effective means to learn from trends in Medical Panel outcomes and to share these lessons. Information from trends will be incorporated into quarterly audits of agents’ quality decision making and IME quality reviews, providing a feedback loop for improvement.</th>
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<tr>
<td>Establish a mechanism enabling the regular review of Medical Panel outcomes to identify potential trends in: • IME opinions • agents’ use of IMEs • agent decision making.</td>
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<tr>
<th><strong>Recommendation 11 – to WorkSafe Victoria</strong></th>
<th>Accepted.</th>
<th>WorkSafe has amended both its Quality Assurance peer review and Clinical Panel desktop review processes, ensuring that reviewers are provided with all of the documentation that an IME considered to inform their examination of the worker and prepare their report. The changes to these work practices have been communicated to peer reviewers and relevant members of WorkSafe’s clinical panel.</th>
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<tr>
<td>Amend its IME Quality Assurance processes to ensure that reviewers are provided all of the documentation the IME considered to inform their examination of the worker and prepare their report.</td>
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<tr>
<th><strong>Recommendation 12 – to WorkSafe Victoria</strong></th>
<th>Accepted.</th>
<th>WorkSafe is amending the relevant template questions, requiring IMEs to detail how each factor in the definition has been considered in providing their opinion and is developing training to support IMEs’ understanding of the statutory meaning of ‘suitable employment’. Training will be delivered through multiple channels to WorkSafe’s 270 IMEs by September 2020.</th>
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<tr>
<td>Ensure IMEs consider the definition of ‘suitable employment’ in the WIRC Act when forming opinions about whether a worker has a current work capacity, by: • amending the relevant template question(s) so that IMEs are required to detail how they considered each factor in the definition of ‘suitable employment’ when providing their opinion, similar to the way in which Medical Panels address this • providing training to IMEs on what constitutes ‘suitable employment’.</td>
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<tr>
<th><strong>Recommendation 13 – to WorkSafe Victoria</strong></th>
<th>Accepted.</th>
<th>Work is in progress to implement the recommendation by July 2020.</th>
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<tr>
<td>Provide different time allocations for independent medical examinations of injured workers with ‘complex claims’ and remunerate IMEs for these accordingly.</td>
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</table>
| **Recommendation 14 – to WorkSafe Victoria** | Accepted.  
WorkSafe is developing a training package for IMEs. Training will be supported by guidance materials that will assist IMEs to determine what constitutes ‘material change’ in a worker’s condition and how surveillance materials should be considered when forming an opinion about work capacity. |
| **Recommendation 15 – to WorkSafe Victoria** | Accepted.  
WorkSafe has completed a further review, and an action plan for improvement is in place. |

Provide guidance and/or training to IMEs regarding:
- what constitutes ‘material change’ in a worker’s condition since a previous Medical Panel examined them and provided an opinion
- how surveillance material should be considered when forming an opinion about a worker’s work capacity.

Undertake a further review of the issues identified by the investigation regarding IME ‘Y’ and engage with them direct to ensure any necessary changes to their practices occur.
Revisiting councils and complaints

Why I investigated

Complaints about local councils are a significant proportion of my office’s work, not surprisingly, given the importance of their role in the community. Having identified in 2015 that one of the main causes of complaints against local councils was the way they dealt with complaints, I tabled a report into complaint handling by Victoria’s 79 local councils, along with a Good Practice Guide to encourage them to do it better.

Four years later it was time to see what had changed. I wanted to examine whether councils have improved their practices and what was still needed to ensure they make it easy to complain, respond to complaints effectively and learn from complaints to improve services.

What I found

As with my 2015 enquiry, I surveyed all 79 councils. The survey asked councils to comment on how they receive, record and respond to complaints, what they do with complaint data, and for examples of good practice and areas they felt they could improve. I also asked about the usefulness of guidance material, such as my 2015 Good Practice Guide and information provided by Local Government Victoria, the State Government agency responsible for overseeing local councils.

I found that while some councils had made significant improvements to their complaint handling processes, other councils still viewed complaints in a negative light, concerned that they may be used as a basis for criticism.

This resulted in some councils disguising their complaint figures, calling them ‘service requests’ or ‘matters with statutory rights of appeal’ instead of counting them as complaints. The lack of a consistent definition of complaint meant that data between councils could not be meaningfully compared, and councils were at risk of missing important information that could be used to improve services.

Other results were more encouraging. Compared with 2015, more councils now have complaint handling policies, including timeliness targets for responding to complaints and avenues for individuals to appeal decisions. Council staff are supported to deal with complaints through appropriate training, including on dealing with challenging behaviour. More public information is available, making it easier to make a complaint but there is still room to make this more accessible to people with specific communication needs.

As I concluded in my 2015 report, the State Government has an important role to play in driving improvements across all councils. In particular, there was an opportunity to encourage better practices through mandated obligations introduced by the Local Government Bill and by enhancing reporting requirements for complaints in the Local Government Performance Reporting Framework.

What has happened since

Since my report was tabled, the Local Government Act 2020 (Vic) was enacted on 24 March 2020, replacing the 1989 Act. The 2020 Act effectively implements the recommendations I made to the Minister for Local Government.
This includes establishing a definition of a complaint:

For the purposes of the complaints policy, complaint includes the communication, whether orally or in writing, to the Council by a person of their dissatisfaction with –
(a) the quality of an action taken, decision made or service provided by a member of Council staff or a contractor engaged by the Council; or
(b) the delay by a member of Council staff or a contractor engaged by the Council in taking an action, making a decision or providing a service; or
(c) a policy or decision made by a Council or a member of Council staff or a contractor.

It also includes the requirement for councils to establish a complaint handling policy and process, an internal review process that is independent of the original decision maker, and a discretion to deal with or decline a complaint which is otherwise subject to statutory review.

Work is underway to introduce an indicator for complaints in the Local Government Performance Reporting Framework. While this work has been delayed, due to the need to prioritise support for councils to implement the 2020 Act and respond to the COVID-19 emergency, it is planned to continue later in 2020. The State Government is also funding the use of a shared service provider for regional councils through a Rural Councils Transformation Program.
| Recommendation 1 - to the Minister for Local Government | Accepted.  
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<tr>
<td>For the 2019 Local Government Bill:</td>
<td>Section 107 of the Local Government Act sets out the complaints policy requirements of councils, adopting all elements of this recommendation.</td>
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<td>• Remove the definition of ‘decision’ as set out in clause 145 of the 2018 Bill.</td>
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<td>• Expressly include in the definition of ‘complaint’, complaints about ‘a policy or decision made by a council or a member of council staff or a contractor engaged by the council that is otherwise subject to statutory review’.</td>
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<td>• Provide councils with an express discretion to enable them to refuse to deal with a complaint that is otherwise subject to statutory review. In exercising this discretion, councils should consider whether it is reasonable in the circumstances to expect the complainant to exercise their rights under the relevant statutory review process.</td>
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<td>• Retain the requirement in the 2018 Bill that councils have:</td>
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<tr>
<td>• complaint handling policies and procedures</td>
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<td>• an internal review function for reviewing complaint decisions.</td>
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| Recommendation 2 – to the Minister for Local Government | Accepted.  
| In connection with the 2019 Local Government Bill, create regulations: | Section 107 of the Local Government Act includes provision for regulations relating to council complaints. The Minister for Local Government states that the development of relevant regulations is expected to commence in early 2021, as part of the staged commencement and implementation of the Act. This process will be managed by a project control board comprising Local Government Victoria, sector representatives and State Government bodies. |
| • addressing the process for managing and resolving complaints about a council | |
| • addressing the process for internally reviewing a complaint | |
| • requiring councils to report on complaint data in their Annual Report. | |
| **Recommendation 3 – to Local Government Victoria** | Accepted.  
The Minister advised that the Local Government Performance Reporting Framework Technical Working Group (TWG) will consider a complaints indicator. Delays to this have occurred due to the 2019-20 bushfires and the need to focus on the implementation of the new Local Government Act. |
| --- | --- |
| Following implementation of the recommendations above, develop an indicator for complaints in the Local Government Reporting Framework, including:  
  - if councils have a complaints policy, and  
  - complaints data collected in accordance with the recommended regulations in Recommendation 2. | |
| **Recommendation 4 – to Local Government Victoria** | Accepted.  
The Minister advises that the Government’s $20 million Rural Councils Transformation Program will support the implementation of this recommendation. Specifically, the program aims to create shared service delivery models to maximise the benefits of economies of scale and critical mass which rural councils would not have access to under other circumstances. Planning for the Program's implementation of four shared service arrangements is being finalised and is being introduced with the commencement of the Local Government Act. |
| Lead the development of strategies to improve rural councils’ ability to handle complaints and provide independent internal reviews, through the sharing of resources. | |
29. As the Ombudsman, I hold many functions and powers of a Royal Commission. I have significant powers of inquiry, including to compel the provision of information or evidence relevant to an investigation, and the Parliament can call on me to independently investigate matters of public importance. My independence is enshrined in and protected by Victoria’s constitution.

30. This mechanism for Parliament to refer matters to me for investigation has been used four times since the commencement of my term. In the forty years prior to my appointment, only two such referrals were made to the Ombudsman.

31. Such investigations can either condemn or exonerate; their purpose is to get to the truth, and to expose it for the public record.

32. Between 1 April 2018 – 31 March 2020, I completed three investigations triggered by referrals – one from a Government Department, and two from the Parliament:

- **Investigation into child sex offender Robert Whitehead’s involvement with Puffing Billy and other railway bodies**
- **Investigation of matters referred from the Legislative Assembly on 8 August 2018**
- **Investigation of allegations referred by Parliament’s Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria.**
For decades, young victims with valid complaints about sexual abuse were forced to seek justice for themselves, while steps were taken to protect the reputation of alleged offenders and the railway.

For the benefit of victims and others who were still seeking answers, my report provided a detailed chronology which set out, as far as we could determine on the evidence available, who knew what and when.

The investigation also raised many issues considered by the Royal Commission into Institutional Responses to Child Sexual Abuse, which made numerous recommendations for governments and institutions to better protect children and to respond to the needs of survivors.

**What has happened since**

On 27 November 2019, The Hon Martin Pakula MP, Minister for Tourism, Sport and Major Events, apologised in Parliament on behalf of the Victorian Government to the victims and survivors of the child sexual abuse at Puffing Billy between the 1960s and 80s. On the same day, the Emerald Tourist Railway Board issued a public apology which acknowledged senior staff of Puffing Billy Railway failed to stop or prevent the abuse that occurred at the time.

Today, with the members of the Victorian Parliament gathered here in this house, we acknowledge the devastating and ongoing impact of Robert Whitehead’s criminal acts and the cries for help that were ignored. The Victorian government sincerely apologises to victims, including Wayne Clarke, their families, their friends, their communities and anyone else who has been impacted by the abuse perpetrated at Puffing Billy. We apologise for the inaction of those who in the past failed to support those who spoke out.

– The Hon Martin Pakula MP, Minister for Tourism, Sport and Major Events

The current Board, established on 22 June 2018, accepted my recommendations at its first meeting and has taken significant steps, in coordination with the Department of Jobs, Precincts and Regions (which replaced the former Department), to implement them. The Department has commissioned a review of the Board’s governance and structure, and intends to amend its governing legislation to separate and clarify the roles of the Board and the Puffing Billy Preservation Society. The Board has established, published and is embedding Child Safe practices at Puffing Billy Railway. CCYP has been engaged to review Puffing Billy Railway’s implementation of the Victorian Child Safe Standards.
### Status of my recommendations

| Recommendation 1 - to the Minister for Tourism and Major Events | Accepted. On 27 November 2019, the Minister apologised on behalf of the Victorian Government to the victims for failing to protect them from child sexual abuse at Puffing Billy during the 1960s and 80s. Victims and families were present, as was I and members of the investigation team. |
| Recommendation 2 - to the Minister for Tourism and Major Events | Accepted. Just prior to the tabling of my report, all former members of the Board resigned, and a new Board was appointed on 22 June 2018. The Board’s appointment has now been extended to support continued stability and improvements, including the implementation of the recommendations. A review of the Board’s governance was commissioned in early 2019 and finalised in October 2019. The review considered the operation of the Emerald Tourist Railway Act 1977 (Vic) (ETRA), the composition and structure of the Board and the relationship between the Board and the Puffing Billy Preservation Society. The Department is undertaking work to ensure the Board operates with a clear and accountable governance structure and has commenced work on legislative amendments to ETRA. |
| Recommendation 3 – to the then Department of Economic Development, Jobs, Transport and Resources | Accepted. In June 2019, the Department engaged CCYP to review the Board’s progress in implementing the Victorian Child Safe Standards under the Child Wellbeing and Safety Act 2005 (Vic), in-lieu of the National Child Safe Standards referred to in the report not yet having been enacted in Victoria. The Board has received preliminary findings from CCYP (see recommendation 8) and is reporting its progress to the Department. The Minister has also issued, in his Statement of Expectations to the Board, that implementing the Child Safe Standards be a matter of priority this year. |

Apologise publicly to Wayne Clarke and any other victim of Robert Whitehead, for the current and historical actions of government agencies who individually or collectively failed to protect children from sexual abuse.

Review the current structure and composition of the Emerald Tourist Railway Board in light of its responsibility as a government agency, and the governance issues associated with its relationship with the Puffing Billy Preservation Society.

Ensure that the Child Safe Standards are implemented by the Emerald Tourist Railway Board and commission a review by the CCYP on the progress of implementation within 12 months of this report.
| Recommendation 4 – to the then Department of Economic Development, Jobs, Transport and Resources | Accepted.  
In June 2018, the Department established the ‘Puffing Billy Enquiries Team’ to assist members of the public who had experienced child sexual abuse. The team has received direct approaches and is working to support those individuals, and continues to provide assistance to survivors. |
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<tr>
<td>Establish a unit to assist members of the public who claim to have experienced child sexual abuse perpetrated by an adult member of Puffing Billy to seek redress in accordance with the principles established by the Royal Commission.</td>
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| Recommendation 5 – to the then Department of Economic Development, Jobs, Transport and Resources | Accepted.  
The Department has finalised a guideline for responding to document requests from survivors of institutional child sexual abuse. The Department has also published advice on its website to facilitate access to documents, including details of a dedicated email address and phone number for the public to contact. |
| Facilitate, as far as practicable and in accordance with law, access to any relevant documentation held by or accessible to the department, for members of the public who claim to have experienced child sexual abuse. | |
| Recommendation 6 – to the Emerald Tourist Railway Boards | Accepted.  
On 27 November 2019 the Board published its apology on its website. The apology addressed the victims and their families, and those impacted by Robert Whitehead’s activities, and acknowledged senior staff of Puffing Billy Railway failed to act at the time. In addition, the Board Chair met individual victims, on request, in 2018 and continues to make himself available to have such discussions. |
| Apologise publicly to any volunteer at Puffing Billy who became a victim of child sexual abuse perpetrated either by Robert Whitehead or any other adult member of Puffing Billy. | |
**Recommendation 7 – to the Emerald Tourist Railway Board**

Implement the Records and Recordkeeping Principles to ensure documents are preserved and individuals can access records about themselves.

<table>
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<th>Accepted.</th>
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<tr>
<td>The Director and Keeper of Public Records, Public Records Office Victoria (PROV), was appointed to the new Board. Puffing Billy Railway and the Board have planned and worked to implement archival storage and record keeping practices.</td>
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<td>In 2018, the Board engaged two external consultants which each provided a report to the Board. The Board have endorsed the 22 recommendations across the reports.</td>
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<td>In December 2019, the Board employed an Information Management and Archive Coordinator to lead implementation of the consultants’ recommendations.</td>
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<td>The Board has also established a governance structure for information management and, on 28 February 2020, approved an Information Management Policy and Corporate Archives Policy.</td>
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| Recommendation 8 – to the Emerald Tourist Railway Board | Accepted.  
Puffing Billy Railway has developed and published its Child Safe Policy, a Child Safe Code of Conduct and contact details for children and parents/carers to report concerns.  
In 2018, Puffing Billy Railway completed a review of its child safe practices with the assistance of a departmental staff member with expertise in the area.  
A Child Safe Standards Implementation plan was established in October 2018. Since this time significant progress has been made to complete a Child Safe Policy, a Code of Conduct and policies on volunteer commitment, whistleblowers, privacy, conflicts of interest, social media, diversity & inclusion, recruitment and selection, issues resolution (grievance), discrimination, and harassment and bullying.  
The Board received CCYP’s draft audit findings and recommendations on 20 April 2020. Since the audit was undertaken, the Board has introduced compulsory code of conduct training and acknowledgement, a central complaints register, risk mitigation strategies and increased oversight and reporting. Puffing Billy Railway is also preparing to address some ongoing requirements and additional recommendations identified from the audit, with oversight from the Board. |
| --- | --- |
| Recommendation 9 – to the Emerald Tourist Railway Board | Accepted.  
The former CEO of Puffing Billy was stood aside in April 2018, and resigned from his position in June 2018. |
| **Recommendation 8 – to the Emerald Tourist Railway Board** | Implement the Royal Commission’s Child Safe Standards to ensure that the best interests of children are a primary consideration. |
| **Recommendation 9 – to the Emerald Tourist Railway Board** | Review the continued suitability of the Chief Executive Officer of the Puffing Billy Railway. |
Why I investigated

On 8 August 2018, the Legislative Assembly of the Parliament of Victoria passed a resolution to refer a matter to the Ombudsman, requiring me to investigate allegations that 40 current or former Liberal Members of Parliament knew, or ought to have known, about invoicing fraud committed by a former Liberal Party State Director, and that another Member had requested invoice dates be altered to circumvent Parliamentary rules.

The fraud involving its former State Director had been detected by the Liberal Party in 2015, and he had pleaded guilty to obtaining financial advantage by deception for which he was sentenced in 2016. The Party also paid back the $175,446 then identified as having been paid from Parliamentary funds.

What I found

My investigation found no culpability on the part of any of the named Members of Parliament, who had paid for printed goods and distribution services, which they received, and although detail was lacking in many invoices, at a price they could not reasonably have been expected to query. Our investigation into alleged invoice fraud found no evidence of any wrongdoing.

I did however observe that the number of allegations being made in recent years about MPs’ expenses suggested broader concerns about a system being open to abuse.

It was difficult to see why the expenses of MPs should not be subject to the same robust scrutiny that applies to public servants and the broader public sector, who cannot simply self-certify their entitlements from the public purse. I therefore recommended a framework for the scrutiny of Member expenses in which Members do not self-certify their own expenses.

What has happened since

I addressed my recommendation to the Speaker of the Legislative Assembly and President of the Legislative Council as the Presiding Officers of Parliament, in consultation with the Clerks, the Department of Parliamentary Services (DPS) and the recently established Victorian Independent Remuneration Tribunal (VIRT), on the basis that policy in relation to member expenses emanated from one or more of these sources.

The Presiding Officers of Parliament advised that from 16 September 2019 a new framework, introduced by the Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019 (Vic), came into effect which effectively removed the ability for Members to self-certify their own expenses. This framework replaced the Members Guide that was in place at the time of my investigation.

Under the new framework, Members are required to submit invoices for expenses using a centralised system. Each expense claim is then independently assessed for compliance against relevant legislation and guidelines prior to approval, or rejected where compliance is not satisfied. Members can appeal a rejected claim through a legislated process.
### Status of my recommendations

<table>
<thead>
<tr>
<th><strong>Recommendation 1</strong></th>
<th><strong>Accepted.</strong></th>
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<tr>
<td>The Presiding Officers of the Parliament, in consultation with the Clerks of Parliament and DPS and/or the VIRT, should develop a framework for the scrutiny of Member expenses in which Members do not self-certify their own expenses.</td>
<td>The Speaker of the Legislative Assembly and President of the Legislative Council, as the Presiding Officers of the Parliament, jointly advised me of the new framework for submitting and approving Members’ expenses which took effect from 16 September 2019, shortly before my investigation report was tabled. The new framework established independent processes for setting rules and administering those rules relating to Members’ expenses. Under the framework, VIRT determines Members’ Electorate Office and Communications Budget and work-related allowances, which are, in turn, administered and enforced by the Secretary of DPS and the relevant Clerks of each House of Parliament. To further enhance transparency, allowances and expenses claimed by Members must be publicly published every three months. The Presiding Officers fully support the changes that have been made.</td>
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</table>
Investigation of allegations referred by Parliament’s Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria

Why I investigated
On 12 December 2017 the Legal and Social Issues Committee of the Victorian Parliament released an interim report on its inquiry into youth justice centres in Victoria, and in it, referred a matter to me for investigation.

The background to this referral was the riots at the Parkville Youth Justice Precinct in November 2016, as a result of which a number of young people were transferred to a hastily configured youth justice and remand centre inside a maximum-security adult prison. The lawfulness of that transfer was the subject of legal proceedings. In evidence to the inquiry the former Principal of Parkville College, a specialist Government school for students in custody, alleged that the Department of Education and Training’s most senior officials put pressure on him by telling him what the Department would like him to say in those proceedings, with the implied threat that funding for Parkville College would not be renewed in the event of an adverse court outcome.

Further allegations were subsequently made, that information provided by the Department in the legal proceedings was misleading, and that the Principal was investigated in reprisal for his evidence.

What I found
Ultimately, the allegations were not substantiated. Those against whom the allegations were made denied them in the strongest terms. There was little common ground between the accounts and evidence that each person involved, in at least some respects, was wrong or mistaken in their account. I observed that the judgement of all involved could be called into question, but that it was not surprising that human judgments made in the heat of the moment were questionable.

What has happened since
I provided my report to the Committee with the recommendation that the matter be closed with no further action.
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<tr>
<th>Year</th>
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| 2020 | Investigations into allegations of nepotism in government schools  
      May 2020 |
| 2020 | Investigation of alleged improper conduct by Executive Officers at Ballarat City Council  
      May 2020 |
| 2020 | Investigation into three councils’ outsourcing of parking fine internal reviews  
      February 2020 |
| 2019 | Investigation of matters referred from the Legislative Assembly on 8 August 2018  
      December 2019 |
| 2019 | WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims  
      December 2019 |
| 2019 | Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust  
      November 2019 |
| 2019 | Revisiting councils and complaints  
      October 2019 |
| 2019 | OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people  
      September 2019 |
| 2019 | Investigation into Wellington Shire Council’s handling of Ninety Mile Beach subdivisions  
      August 2019 |
| 2019 | Investigation into State Trustees  
      June 2019 |
| 2019 | Investigation of a complaint about Ambulance Victoria  
      May 2019 |
| 2019 | Fines Victoria complaints  
      April 2019 |
| 2019 | VicRoads complaints  
      February 2019 |
Investigation into the imprisonment of a woman found unfit to stand trial
October 2018

Investigation into allegations of improper conduct by officers at Goulburn Murray Water
October 2018

Investigation of three protected disclosure complaints regarding Bendigo South East College
September 2018

Investigation of allegations referred by Parliament’s Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria
September 2018

Complaints to the Ombudsman: resolving them early
July 2018

Ombudsman’s recommendations – second report
July 2018

Investigation into child sex offender Robert Whitehead’s involvement with Puffing Billy and other railway bodies
June 2018

Investigation into the administration of the Fairness Fund for taxi and hire car licence holders
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Investigation into Maribyrnong City Council’s internal review practices for disability parking infringements
April 2018

Investigation into Wodonga City Council’s overcharging of a waste management levy
April 2018

Investigation of a matter referred from the Legislative Council on 25 November 2015
March 2018

Investigation into the financial support provided to kinship carers
December 2017

Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre
November 2017

Investigation into the management of maintenance claims against public housing tenants
October 2017

Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus
September 2017

Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system
September 2017

Investigation into Victorian government school expulsions
August 2017

Report into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board
June 2017

Apologies
April 2017

Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board
March 2017

Report on youth justice facilities at the Grevillea unit of Barwon Prison, Malmsbury and Parkville
February 2017

Investigation into the Registry of Births, Deaths and Marriages’ handling of a complaint
January 2017
## Victorian Ombudsman’s Parliamentary Reports tabled since April 2014

### 2016

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<td>Investigation into the transparency of local government decision making</td>
<td>December 2016</td>
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<td>Ombudsman enquiries: Resolving complaints informally</td>
<td>October 2016</td>
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<td>Investigation into the management of complex workers compensation claims and WorkSafe oversight</td>
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<td>Report on recommendations</td>
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<td>Investigation into Casey City Council’s Special Charge Scheme for Market Lane</td>
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<td>Investigation into the misuse of council resources</td>
<td>June 2016</td>
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<td>Investigation into public transport fare evasion enforcement</td>
<td>May 2016</td>
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### 2015

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<tr>
<td>Reporting and investigation of allegations of abuse in the disability sector: Phase 2 - incident reporting</td>
<td>December 2015</td>
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<tr>
<td>Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations</td>
<td>November 2015</td>
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<tr>
<td>Investigation into the rehabilitation and reintegration of prisoners in Victoria</td>
<td>September 2015</td>
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<tr>
<td>Conflict of interest by an Executive Officer in the Department of Education and Training</td>
<td>September 2015</td>
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<tr>
<td>Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight</td>
<td>June 2015</td>
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<td>Investigation into allegations of improper conduct by officers of VicRoads</td>
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<td>Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service</td>
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<td>Councils and complaints – A report on current practice and issues</td>
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<td>Investigation into an incident of alleged excessive force used by authorised officers</td>
<td>February 2015</td>
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Investigation following concerns raised by Community Visitors about a mental health facility
October 2014

Investigation into allegations of improper conduct in the Office of Living Victoria
August 2014