

Report on recommendations  
June 2016

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# 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**

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my *Report on recommendations*.



Deborah Glass OBE

**Ombudsman**

22 June 2016

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# Foreword

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*Yesterday Mum received the ex gratia payment from Health Department Victoria ...*

*It has been a long and tortuous journey but from all bad comes good. The work of your Team will now ensure that the Victorian Health Department will provide a better service for future Victorians and particularly vulnerable Victorians.*

*Words alone cannot adequately describe what the kindness of your staff, the acceptance of our concerns, and the willingness to act on injustice meant to us ... Mum says to you all "I thank you from the bottom of my heart. I can now live without worry and enjoy living till 104 years like my mother."*

Email from daughter of 102-year-old former resident of Mentone Gardens

What difference do Ombudsman reports make?

It's a question I am often asked, especially when I explain to audiences that while I can make recommendations, I cannot enforce them. This is true of all parliamentary ombudsmen in Australia: we investigate administrative unfairness and recommend improvements to address the shortcomings or injustices we find. But the Ombudsman Act allows me not only to make any recommendations I see fit, but also to monitor the steps being taken to implement them, and to report to Parliament on them.

This is my first report to Parliament on the recommendations I have made since my appointment on 30 March 2014, and covers the period until 30 March 2016. In that time I have tabled 11 reports, making 61 recommendations – all of which have been accepted.

The 11 reports cover diverse subjects such as use of excessive force by ticket inspectors on public transport, abuse in the disability sector and rehabilitation in prisons. The 61 recommendations range from the specific – making *ex gratia* payments to residents affected by the financial collapse of the Mentone Gardens aged care home – to the broad: a whole-of-government approach to reducing criminal reoffending.

Four of the reports were the result of investigations of “protected disclosure” or whistleblower complaints involving allegations of improper conduct in the public sector. Recommendations in these cases included disciplinary action, training and stronger oversight.

It is pleasing that all recommendations have been accepted, and that those which are more easily implemented have been, or are in process. I congratulate the government and heads of agencies on the positive response I have seen in the vast majority of cases.

Some recommendations, however, require a change in the law or a significant injection of funding. These have been accepted in principle and I will continue to monitor their implementation. In one case, the report on abuse in the disability sector, my systemic recommendations were deliberately high level, acknowledging the Victorian Government parliamentary inquiry into these matters and the safeguards being developed at Commonwealth level.

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It is truly gratifying when implemented recommendations make a real and immediate difference to people's lives: the \$4.33 million paid to the former residents of Mentone Gardens, to allow them to recover their dignity and independence in old age; or the change in the law allowing Aboriginal and Torres Strait Islander people to retain the proceeds of artwork created in prison, to assist their rehabilitation.

Some recommendations will, I hope, have a long-lasting effect on good public administration. My report into local councils' handling of complaints included developing a practical guide to assist local councils to do it better. Over 50 local councils are actively using this guide; this should make a real difference to the way they respond to their communities.

A few recommendations – noted in this report as “accepted in principle” or “under consideration” – require political will to achieve real long-term change. The public debate that followed the release of my report into rehabilitation in prisons highlighted what many in the criminal justice community have been saying for years: that prisons do not always make us safer, that we need to focus on the causes of crime rather than its consequences. The onus is now on the government to take a long-term view on reducing reoffending.

Similarly, reform of political donations is not a subject generally embraced by governments, and a bi-partisan approach acknowledging the public interest in this area will be key to achieving change. I will continue to follow up and report on these issues.

I cannot enforce my recommendations, and rightly so; I am not responsible for government policy or how the State apportions its budget. But the very high take-up rate of recommendations is testament to the “persuasive powers of the Ombudsman” as they were described by the Attorney-General introducing the Ombudsman Bill in 1973. It is also testament to the fact that my reports are a means to an end, not an end in themselves.

The recommendations are evidence-based and capable of being implemented – a matter on which I set great store.

These reports are important as investigations of issues that matter to our community, and as an expression of the standards we expect of our public sector. The recommendations hold government to a high bar – no less than the people of Victoria deserve.

Deborah Glass

**Ombudsman**

# At a glance

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## Key changes made

- \$4.33 million in *ex gratia* payments to former residents of Mentone Gardens supported residential service or their estates (pages 8-9)
- The Office of Living Victoria abolished (pages 12-13)
- Disciplinary action taken against 20 VicRoads employees who claimed or approved exemptions from speeding infringements (pages 14-15)
- Aboriginal and Torres Strait Islander people allowed to sell artworks created in prison, with proceeds held in trust until their release (pages 28-33)

## Key changes in progress

- New training for authorised officers on Victoria's public transport network (pages 24-25)
- Over 50 local councils improving policies and practices for responding to complaints from the community (pages 26-27)
- Review of the advocacy needs of people with disability (pages 34-38)
- New system for reporting serious incidents involving Department of Health and Human Services clients (pages 34-38)

## Key changes under consideration

- Whole-of-government approach to reduce offending and recidivism and to promote rehabilitation of offenders (pages 28-33)
- Single independent oversight body for the disability sector (pages 34-38)

# Introduction

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1. This report outlines the impact of my reports and recommendations since I became Ombudsman in 2014.
2. My office's effectiveness depends not just on the number and quality of these reports and recommendations. It also depends on whether authorities act on the recommendations, and whether they make a lasting difference to the fairness and integrity of public administration in Victoria.
3. Like other parliamentary ombudsmen, my recommendations are not binding on the government. However, the Ombudsman Act gives me the power to ask authorities, ministers and mayors about the steps they have been or are taking to give effect to my recommendations. It also makes authorities accountable by giving me the power to report to the Parliament if appropriate steps are not taken within a reasonable time.<sup>1</sup>
4. The report is divided into three chapters that reflect my office's main functions:
  - resolving complaints about administrative actions of authorities
  - investigating protected disclosure complaints about improper conduct referred to me by the Independent Broad-based Anti-corruption Commission (IBAC)
  - fostering systemic improvement in public administration.
5. Each chapter provides an overview of the impact of my reports to date, followed by case studies on each of the reports and what has happened since they were tabled. I have included information about the status of each recommendation so it is clear what action is being taken.
6. Fifty-three recommendations were made to government authorities, of which 100 per cent were accepted.<sup>2</sup> A further eight recommendations were made to the government as a whole, all of which were accepted when I tabled my reports (including some accepted "in principle") or are now advised to be "under consideration".
7. There has already been significant change in some cases. In others, particularly my more recent recommendations about systemic reform in prisons and the disability sector, work has started but there is more to be done.
8. I will continue to monitor and report to the Parliament about these issues so the Parliament and community can judge progress for themselves.

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<sup>1</sup> *Ombudsman Act 1973* sections 23(4), (5) and (6).

<sup>2</sup> For reporting purposes, my office classifies a recommendation as 'accepted' if the authority agrees or partially agrees to the recommendation or agrees to consider the recommendation.

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Figure 1: Recommendations March 2014 – March 2016 – acceptance

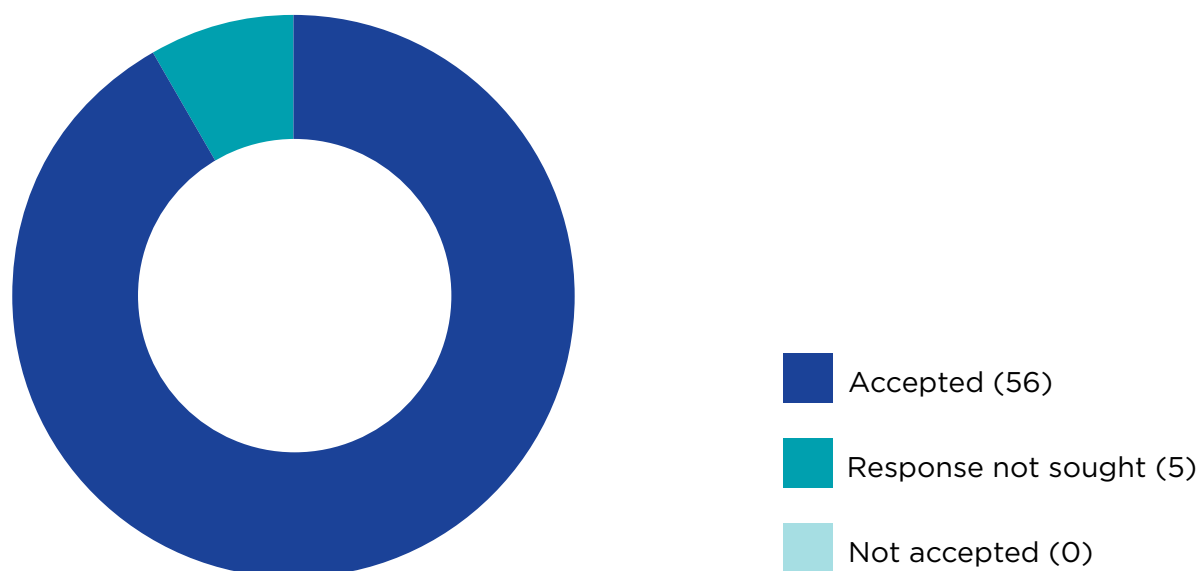
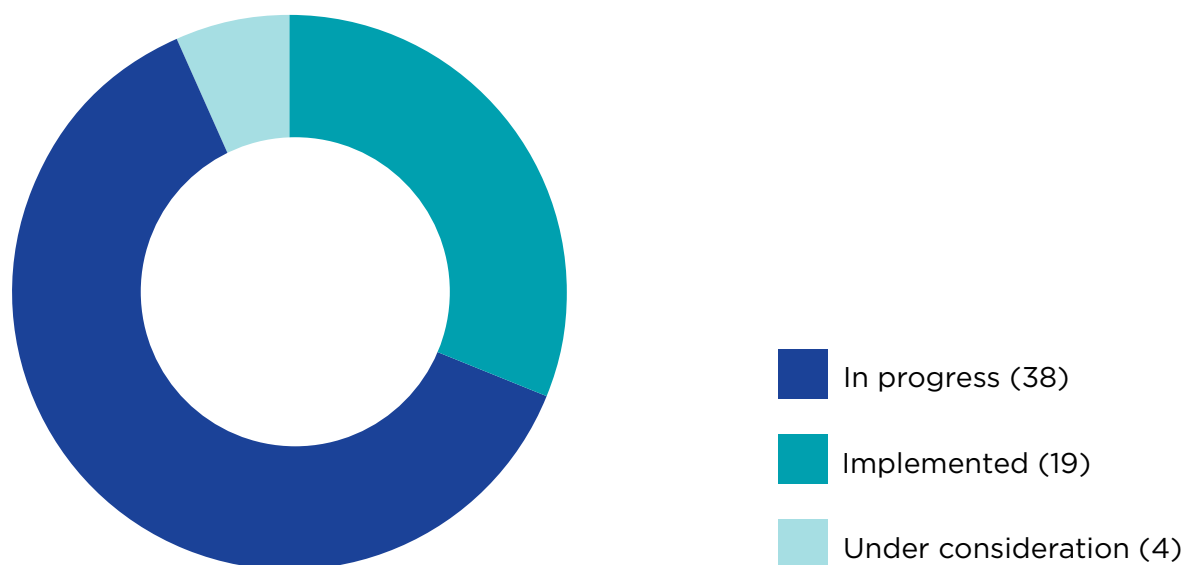


Figure 2: Recommendations March 2014 – March 2016 – implementation





# Resolving complaints – ensuring fairness

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9. My investigation into the former Department of Health's oversight of Mentone Gardens supported residential service shows what can be achieved by complaints from the community.
10. The investigation responded to complaints from elderly former residents or their family members, who lost their bond or deposit money when Mentone Gardens' proprietor went into liquidation.
11. In response to my recommendations, the responsible minister has now approved \$4.33 million in *ex gratia* payments to former residents or their estates.
12. The Department of Health and Human Services is also strengthening its regulatory oversight of services like Mentone Gardens (case study on pages 8-9). These changes will benefit the thousands of other Victorians who rely on these services for care and accommodation due to age, illness or disability.
13. The letters I received from former residents and their families show the impact of my recommendations in this case.

*Yesterday was a signal day for my wife ... and myself, with receipt of advice from the Department of Health and Human Services, about the remittance of our ex gratia payments ...*

*... I wish to thank you especially for enabling [my wife] and myself to eventually retrieve our losses ...*

Letter from former resident of Mentone Gardens

*Your comprehensive report was crystal clear and brought tears to our eyes as we read each word. Thank you for continuing to dig into this matter to reveal the truth. Thank you for listening to our words ... and for filling us with hope for a more just and fair system for the future of elderly Victorians.*

Email from granddaughter of former resident of Mentone Gardens

14. The complaints from the Mentone Gardens residents and their families were just some of the 13,000–14,000 complaints about authorities I receive each year.
15. Where an authority has acted unfairly or unreasonably, my office can often resolve the problem informally, without any need to investigate or table findings in Parliament. The authority might apologise, provide an explanation, change its decision or agree to change its practices for the future.

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## Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service

### Why I investigated

In late 2013 I received a complaint from Mr Allan Lorraine about the Department of Health's financial oversight of Mentone Gardens, a government-registered supported residential service (SRS) that was home to 39 elderly residents. Mr Lorraine and his wife lost the \$400,000 "bond" they had paid to the company that ran Mentone Gardens, after it went into liquidation.

After I announced the investigation publicly, another 17 former residents or their family members approached my office having lost their bonds or deposits.

### What I found

The Department of Health (now the Department of Health and Human Services) regulates SRS. It registered and monitored the operation of Mentone Gardens from 1991 to 2013. The department's legislation required its Secretary to be satisfied that the company that ran Mentone Gardens had the financial capacity to operate as an SRS.

My investigation found that the department failed in its regulatory role, missing opportunity after opportunity to identify the company's precarious financial position.

It also identified broader problems with the department's regulation of SRS including failure to take enforcement action and address non-compliance; incomplete or unclear policies, procedures and guidelines; and inadequate training of departmental staff involved in regulating SRS.

### What has happened

The responsible minister has approved *ex gratia* payments to 34 former residents or their estates. The payments total \$4.33 million, with individual payments varying according to the circumstances of each claim.

The department is also strengthening its oversight of SRS in Victoria including:

- compliance review audits of all SRS regarding management of residents' money and trust accounts in 2015-16
- an external review of the department's audit tools and regulatory framework
- training to improve the capabilities of the department's authorised officers, who monitor SRS compliance with minimum service standards.

Status of my recommendations	
<p><b>Recommendation 1</b></p> <p>That the State Government make <i>ex gratia</i> payments to people, or their estates, who lost bonds, deposits or unspent fees paid in advance as a result of Parklane Assets Pty Ltd being placed in liquidation. That the payment be made by 30 June 2015, subject to the provision of those people of the necessary evidence of their loss, in accordance with the guidance on <i>ex gratia</i> payments under the <i>Financial Management Act 1994</i>.</p>	Accepted and implemented
<p><b>Recommendation 2</b></p> <p>That the State Government amend the <i>Supported Residential Services (Private Proprietors) Act 2010</i> to require proprietors of an SRS to:</p> <ol style="list-style-type: none"> <li>provide an audited set of financial accounts to the department every two years to confirm financial capacity to operate</li> <li>... have those trust accounts audited by a registered CPA or Chartered Accountant and produce a copy of that report to the department for inspection.</li> </ol>	<p>Accepted in principle and in progress</p> <p>In March 2016 the Secretary of the department advised me that the department is considering options, including using the current Act, to determine what documentation can be requested.</p>
<p><b>Recommendation 3</b></p> <p>That the department develop comprehensive procedures for the regulation of SRS to include:</p> <ol style="list-style-type: none"> <li>guidelines for implementing and escalating enforcement action ...</li> <li>a centrally managed repository of legislation, policies and procedures, tools and instruments ...</li> <li>an updated complaints handling manual</li> <li>a policy for analysis of complaint data at both a regional and central office level to identify trends and patterns in complaints and factor this into the risk assessment framework ...</li> <li>ongoing training for staff on the above.</li> </ol>	Accepted and in progress

# Investigating improper conduct – ensuring accountability

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16. Three of my reports about improper conduct by public officers led to:
  - those involved being held accountable for their actions
  - stronger systems to prevent improper conduct in future.
17. Sometimes change was achieved simply by exposing the improper conduct. In the case of the former Office of Living Victoria, the government abolished it a week after I sent a draft report outlining poor governance and administration to the responsible Secretary and Chief Executive Officer (case study on pages 12-13).
18. In other cases, authorities have taken action to address concerns I raised. VicRoads' response to my report about employees who claimed exemptions from speeding infringements shows what can be achieved when authorities act decisively (case study on pages 14-15). Five months after my report was tabled, it had:
  - taken disciplinary action against two employees investigated by my office
  - audited all claims for infringement exemptions by employees over a three year period and taken action against a further 18 employees
  - changed internal work instructions for infringement exemptions.
19. VicRoads' Chief Executive thanked me for the investigation "which has assisted VicRoads to deal effectively with this improper conduct".
20. The Department of Education and Training has strengthened its conflict of interest reporting in response to my report about a conflict of interest by a senior officer (case study on pages 16-17).
21. At the time this report was prepared, 10 of 11 recommendations had been implemented or were in progress, with one still under consideration.
22. In November 2015 I reported to Parliament about allegations that a local government councillor had offered, or had been involved in offering, favourable planning application committee decisions in return for donations from property developers to his state election campaign funds (case study on pages 18-19).
23. While I did not substantiate the allegations, I was concerned that current regulation of political donations in Victoria creates an environment in which allegations of improper conduct can flourish. I recommended that the government consider the issues raised in the report, including possible restrictions on donations by property developers and earlier public reporting of all donations.

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24. In December 2015 the Special Minister for State informed me that:

the Victorian Government's preference is to consider reform of political donation laws through the Council of Australian Governments framework. This is consistent with the Victorian Parliamentary Electoral Matters Committee report on political donations and disclosure in 2009, and also consistent with the NSW Panel of Experts report on political donations in December 2014.

The Victorian Government will pursue consideration of political donations laws through COAG. In the event that COAG consideration does not lead to federal harmonisation, the Government will consider reform options to address deficiencies in political donations regulation in the remainder of its term.

25. In May 2016 in response to the draft report, the Minister informed me:

The Draft Report indicates that, at the time of its preparation, COAG's website did not record any discussions about political donations. However, I note that this issue was scheduled for informal discussion at COAG in December 2015. The Government hopes to further such discussions through COAG following the upcoming Federal election.

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## **Investigation into allegations of improper conduct in the Office of Living Victoria**

### **Why I investigated**

In 2013 the IBAC Commissioner referred a complaint about the Office of Living Victoria (OLV) to my predecessor. The disclosure alleged three instances of improper conduct by officers at OLV regarding procurement of services.

OLV was established as an Administrative Office in 2012 to drive reforms to integrate planning of Melbourne's water system into the urban planning framework, and to change the way water services were managed in Victoria.

At the time my investigation concluded, it had a budget of \$32.5 million.

### **What I found**

The investigation substantiated the allegations. It also uncovered other cases of poor governance and administration including breaches of government procurement policies, poor contract and project management and failure to manage conflicts of interest. Examples included:

- OLV paying over \$1.3 million to a contractor and his company for multiple contracts, none of which were subject to competitive tender to ensure value for money
- excessive use of the Staffing Services State Purchase Contract, which allows hiring of staff outside usual public sector recruitment processes. OLV's Head of Office had hired a former colleague to a senior position at a cost of \$233,000 for 10 months' work. The salary for an equivalent public sector employee at the time was \$131,139 per year.

I concluded that senior management at OLV had lost sight of its obligations to comply with government procurement policies and procedures and to be accountable for expenditure of public money.

### **What has happened**

A week after I provided a draft report setting out my findings to the Secretary and Chief Executive Officer responsible for OLV, OLV was abolished as a separate Administrative Office. Its Chief Executive Officer and Head of Office departed in the following month.

The report made four recommendations aimed at determining the extent of the problems at OLV, and ensuring they are not repeated. Two subsequent reviews identified additional concerns with OLV's procurement, contract management and grants administration. The Secretary of the Department of Treasury and Finance has confirmed that all Administrative Offices are bound by Victorian Government Purchasing Board policies, which aim to ensure value for money.

Status of my recommendations	
<b>Recommendation 1</b>  That the Department of Treasury and Finance (DTF) and the Victorian Government Purchasing Board (VGPB) review the operation of the Staffing Services State Purchase Contract arrangements ...	Accepted and implemented  The Secretary of DTF advised in May 2016 that the new Staffing Services State Purchase Contract implements efficiencies including stronger operating terms and conditions “for greater transparency and clarity”.
<b>Recommendation 2</b>  That DTF and the VGPB consider options to ensure that all Administrative Offices are obliged to adhere to VGPB supply policies.	Noted and implemented  The Secretary of DTF has confirmed that VGPB policies apply to all Administrative Offices.
<b>Recommendation 3</b>  That the Secretary of the Department of Environment and Primary Industries (DEPI) clarify the arrangements relating to the intellectual property rights associated with the Integrated Water Cycle Management model.	Accepted and implemented  In December 2014 the Secretary of DEPI advised that DEPI had investigated the contracts in question. It determined that there was no need for ongoing access to the model or materials developed by the contractor and terminated the contracts.
<b>Recommendation 4</b>  That the Victorian Auditor-General undertake an audit of OLV’s financial management, including its grants assessment and approval processes.	Agreed to consider and implemented  The Victorian Auditor-General Office’s 2014 annual financial audit of DEPI included a review of OLV’s financial management and governance. It plans to undertake a performance audit on “meeting future water security challenges” in 2017–18. OLV’s activities will only be considered as necessary in assessing the state’s current water reform program.  The department and minister responsible for OLV commissioned their own further reviews: <ul style="list-style-type: none"> <li>• a 2014 ‘due diligence review’</li> <li>• a 2015 review by former Victorian Auditor-General Mr Des Pearson.</li> </ul> The reviews identified additional concerns with procurement, contract management and grants administration at OLV.

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## Investigation into allegations of improper conduct by officers of VicRoads

### Why I investigated

In 2014, the IBAC Commissioner referred a complaint about VicRoads to my office. The disclosure raised three allegations that staff in VicRoads' Transport Safety Services (TSS) area were improperly claiming or approving exemptions from speeding infringements incurred when driving VicRoads enforcement vehicles.

TSS authorised officers are responsible for improving road safety by ensuring vehicles comply with legislation.

Under Victoria's *Road Safety Road Rules 2009*, vehicles engaged in enforcement activity are exempt from the speeding rule if the driver is taking reasonable care, it is reasonable the rules should not apply and the vehicle is displaying lights and sirens.

### What I found

My investigation substantiated the allegations. It found that one officer, Officer A, had repeatedly exceeded the speed limit without displaying lights and sirens in breach of the road rules. Another officer, Officer B, had done so once.

I also found that VicRoads' process for investigating speeding infringements received by employees was seriously deficient and exemptions were approved where staff were not eligible.

The responses of employees interviewed during the investigation highlighted a culture of entitlement in TSS to breach the legislation they were responsible for administering. This was particularly troubling given their responsibility was for road safety.

### What has happened

VicRoads took disciplinary action against Officers A and B following my report. They are no longer employed at VicRoads.

Eighteen other VicRoads officers were subsequently found to have improperly claimed or approved infringement exemptions. Twelve of those officers are no longer employed at VicRoads; three officers were reprimanded and three officers received a reduction in pay.

VicRoads has also taken steps to strengthen its internal policies on speeding infringements. In November 2015, VicRoads' Chief Executive provided a copy of its new work instruction on Regulatory Services officers and traffic infringements. VicRoads' Chief Operating Officer now approves any infringement exemptions for employees.



<b>Status of my recommendations</b>	
<b>Recommendation 1</b> <p>That VicRoads take appropriate disciplinary action against Officer A and Officer B for breach of the Victorian Public Sector Code of Conduct.</p>	Accepted and implemented
<b>Recommendation 2</b> <p>That VicRoads create an investigation policy and review the procedure for consideration of infringement exemptions, including that infringement exemptions are to be approved at the Executive Director level.</p>	Accepted and implemented
<b>Recommendation 3</b> <p>That VicRoads provide training to all VicRoads officers, including in particular enforcement officers, on the new investigation policy.</p>	<p>Accepted and implemented</p> <p>VicRoads' Chief Executive advised me that authorised officers have provided written confirmation that they have read and understood the policy.</p>
<b>Recommendation 4</b> <p>That VicRoads audit all infringement exemptions for the three-year period between May 2012 and May 2015. In accordance with section 23(4) of the Ombudsman Act, I request that VicRoads report the results of the audit and any action taken to my office within six months.</p>	<p>Accepted and implemented</p> <p>The Chief Executive provided me with the results of the audit in November 2015. It showed that:</p> <ul style="list-style-type: none"> <li>• 253 infringements were issued to vehicles registered to VicRoads from 1 May 2012 to 1 May 2015</li> <li>• Regulatory Services officers claimed exemptions for 25 of those infringements</li> <li>• There was no or insufficient evidence to support the exemption claim in 80 per cent of those cases.</li> </ul> <p>As noted earlier, action was taken against officers who improperly claimed exemptions or approved the improper claims.</p>

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## **Conflict of interest by an Executive Officer in the Department of Education and Training**

### **Why I investigated**

In 2014, the IBAC Commissioner referred a complaint to my office alleging a conflict of interest by an Executive Officer in the Department of Education and Early Childhood Development (now the Department of Education and Training).

The Executive Officer worked in an area that oversaw \$1.2 billion of government funding for vocational education and training.

The disclosure alleged that, while employed at the department, the Executive Officer:

- considered, negotiated and accepted a high-level managerial job within the BAWM group of companies, which was involved in the training sector
- dealt with a complaint about BAWM.

### **What I found**

The investigation substantiated the allegations. It found that the Executive Officer accepted an executive role and a directorship with one of the companies in the BAWM group while employed by the department. He also acquired a 10 per cent shareholding in the company using a \$234,090 loan provided by another company in the group.

The Executive Officer subsequently resigned from the department. While serving out his notice period he received dividends of \$30,000, which he failed to declare in accordance with the department's conflict of interest policy.

### **What has happened**

The Executive Officer was no longer working at the department at the time of my investigation and was beyond the reach of public service disciplinary measures.

In response to my recommendations, the department commissioned an audit of his involvement and influence on decisions regarding BAWM and related registered training organisations. At the time this report was prepared, the department was considering the draft audit report.

The department has implemented new conflict of interest arrangements for employees whose work involves providing funding and managing contracts in the training sector. The new arrangements require employees to sign an annual conflict of interest declaration and declare conflicts as they arise. The department has commissioned a probity action plan and handbook and is providing training to employees.

The department is also looking at ways to improve organisation-wide processes for employees to declare private interests, including work on an audit methodology for identifying anomalies in declarations.

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Status of my recommendations	
<b>Recommendation 1</b>  That the Department of Education and Training arrange an independent audit of BAWM and related registered training organisations (RTOs) contracted by the department from 1 October 2012 until 31 August 2013 to identify the involvement and influence of the Executive Officer, if any, on decisions regarding those RTOs.	Accepted and in progress
<b>Recommendation 2</b>  That the Department of Education and Training require that officers responsible for the provision of funding to, and the management of funding contracts with private companies, sign statutory declarations regarding their personal interests and any conflicts of interest, on a quarterly basis. The same requirement should apply more broadly to all officers of the Victorian Public Service who have similar responsibilities.	Accepted and implemented

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## **Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations**

### **Why I investigated**

In 2014 the IBAC Commissioner referred a complaint to me regarding four councillors at Casey City Council.

The disclosure alleged that a councillor had offered, or had been involved in offering, favourable planning application committee decisions in return for financial donations from relevant property developers to his state Liberal Party election campaign funds. It was alleged that three other councillors had been complicit in these matters.

### **What I found**

My investigation did not substantiate any of the allegations.

Nevertheless, I decided to table a report to highlight issues of public interest that arose in the course of my investigation. Those issues were whether it is appropriate to allow property developers to make donations to the campaigns of political candidates, and whether there is a need for greater transparency in Victoria's political donation disclosure laws.

As I stated in my report, there can be little doubt that the lack of transparency in political donations and the lack of limitations on who can make those donations in Victoria creates an environment in which allegations of improper conduct can flourish. They create a perception that politicians can be bought, which reduces public trust in government.

I recommended that the Victorian Government consider the issues raised in my report, in particular whether there should be restrictions on political donations to candidates and political parties by property developers, and disclosure of political donations.

### **What has happened**

In December 2015, I wrote to the Special Minister of State about the government's response to my recommendation.

The Special Minister of State advised me that the government's preference is to consider reform of political donation laws through federal harmonisation via the Council of Australian Governments (COAG) framework.

If COAG consideration does not lead to federal harmonisation, the Minister stated that the government would consider reform options to address deficiencies in political donations regulation in the remainder of its term.

The Minister has since advised me that the issue was scheduled for informal discussion at COAG in December 2015, and that the government hopes to further such discussions through COAG after the July federal election.

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Status of my recommendations	
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<b>Recommendation 1</b>	Under consideration
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That the Victorian Government consider the issues raised in this report, in particular:	Under consideration
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- |  |                     |
|--|---------------------|
| <ul style="list-style-type: none"><li>a. whether there should be restrictions on donations to candidates and political parties by property developers</li><li>b. whether details of all donations to a candidate or political party should be required to be published on a publicly available register within 30 days of the relevant election.</li></ul> | Under consideration |
|--|---------------------|

# Tackling systemic problems – fostering improvement

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26. Six of my reports to Parliament used my own motion powers to report on systemic problems in public services and administration in Victoria:
- care of patients in mental health facilities
  - use of excessive force by authorised officers on public transport
  - handling of complaints by local councils
  - rehabilitation and reintegration of prisoners
  - reporting and investigation of abuse in the disability sector (two reports).
27. The response from authorities and community groups has been positive.
28. In particular, many local councils welcomed my office's good practice guide on complaint handling in local government (case study on pages 26-27).

*I take this opportunity to thank you for developing and providing the good practice guide. It is documents like this that greatly assist our sector in developing best practice processes and procedures. This in turn gives me confidence, as Council CEO, that Council is supporting its community to the best of its ability.*

Letter from council CEO

*Council appreciates the opportunity to be involved in developing better ways to understand, report on and manage complaints and to ensure that it is providing a service that meets the expectation of our community.*

Letter from council governance manager

*... the guide has been a very useful document for the Council and has led to the re-evaluation and refinement of a number of complaints-related processes.*

Letter from council customer service executive

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29. There is also considerable activity underway in authorities to consider and respond to my recommendations:
- Over 50 councils have or are improving policies and practices for responding to complaints from the community (case study on pages 26-27).
  - The government has announced several initiatives aligned with my recommendations on rehabilitation and reintegration of prisoners (case study on pages 28-33). These include expansion of the Drug Court to the Melbourne Magistrates' Court.
  - The Department of Health and Human Services is developing a new system for reporting serious incidents involving its clients (excluding hospitals) (case study on pages 34-38).

30. At the time of writing, most of the recommendations were still in progress, with further work required before they will be fully implemented. This is to be expected. Many of the recommendations involve long-term change, and some require responsibilities to be transferred between agencies. Some require additional budget funding or changes to legislation and policy. A number of recommendations, including those concerning authorised officers, local government complaints and the disability sector, have been awaiting the outcomes of other government or parliamentary reviews.
31. Time will ultimately tell whether this activity leads to real change, and whether that change resolves the problems identified by my investigations.

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## Investigation following concerns raised by Community Visitors about a mental health facility

### Why I investigated

My predecessor initiated this investigation in 2013 after Community Visitors reported concerns in their 2012-13 annual report about the care of mental health patients in a number of mental health facilities, including a major provider of mental health care in regional Victoria.

Community Visitors are volunteers managed by the Office of the Public Advocate who visit accommodation facilities operating under mental health, disability or supported residential services legislation. They play a significant role in scrutinising services provided to particularly vulnerable groups in our community.

Their report included concerns that:

- patients had complained they suffered injuries as a result of staff using excessive force to restrain them
- the provider refused to give Community Visitors full access to incident reports related to patient injuries, despite patients given written authorisation.

### What I found

The investigation found that the provider was taking a narrow and overly legalistic view of the law at the time, and that Community Visitors were entitled to access incident reports.

Poor documentation of incidents at the provider showed a general under-reporting of injuries to patients related to restraint by staff. A random audit of patient files showed that only half contained treatment plans, which give patients an understanding of how their treatment will be managed and their recovery goals.

### What has happened

The provider took several steps to resolve issues identified by the investigation before my report was finalised.

I was concerned, however, that the same issues could be repeated in similar facilities. I made recommendations for all mental health facilities about auditing treatment plans and Community Visitors' access to information.

There is clear evidence that the recommendations have resulted in significant improvement. Completion of treatment plans at one of the provider's centres improved from 14 per cent to 96 per cent in the six months following the tabling of my report. In May 2016 the Secretary of the Department of Health and Human Services advised that all mental health services have to ensure they have processes for reviewing management plans – which includes treatment plans – as part of national accreditation requirements. She also advised me that in 2015 all mental health services were made aware that under the *Mental Health Act 2014*, Community Visitors have access to incident reports concerning consumers receiving treatment in designated mental health services.

I note that, in their 2014-15 annual report, Community Visitors reported that access to incident reports had improved in many regions, but there were still instances where hospitals resisted providing them or the reports had redactions that limited their usefulness. I encourage the department to monitor the issue and work with Community Visitors to resolve any outstanding problems.



Status of my recommendations	
<p><b>Recommendation 1</b></p> <p>If any mental health facility should refuse to provide incident reports to Community Visitors upon request, I recommend that the Secretary of the Department of Health give directions as necessary to clarify the scope of section 217 of the <i>Mental Health Act 2014</i> to resolve this issue definitively.</p>	<p>Accepted and implemented</p> <p>As noted earlier, the department provided advice on this to all mental health services in 2015.</p> <p>The provider involved in my investigation advised that it now gives Community Visitors a full report of incidents that have occurred between their visits, as well as a monthly report.</p>
<p><b>Recommendation 2</b></p> <p>All mental health facilities should conduct regular random audits of treatment plans to ensure they are completed in a timely manner.</p>	<p>Accepted and implemented</p> <p>The provider involved in the investigation advised my office in May 2015 that it had been auditing its treatment plans. It found that failure to complete the plans was confined to one centre. As noted above, that centre's completion of treatment plans improved from 14 per cent just after my report was tabled to 96 per cent.</p> <p>The provider now conducts a biannual program of random audits, as well as regular annual auditing, and reports results to senior management.</p>

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## **Investigation into an incident of alleged excessive force used by authorised officers**

### **Why I investigated**

In December 2013 a Member of Parliament released footage of an authorised officer restraining a 15-year-old girl at Flinders Street Railway Station, using what the media described as a “spear tackle” and “body slam”. She was suspected of being a fare evader, resisting arrest and assaulting the officer.

The Member of Parliament also released footage of the young woman’s friend being arrested and restrained by a second authorised officer.

Authorised officers have a statutory role to deter fare evasion, vandalism and anti-social behaviour on public transport, and to report ticketing and behavioural offences. They have legislative powers to arrest suspected offenders.

My predecessor had previously tabled two reports on incidents of excessive force by authorised officers. While this incident was not the subject of a complaint, he decided to start an own motion investigation.

### **What I found**

I concluded that the force used by the authorised officer in the first incident was neither reasonable nor proportionate in the circumstances, and that officers breached the young woman’s rights under *Victoria’s Charter of Human Rights and Responsibilities Act 2006*. The restraint in the second incident appeared to be rough but was not an excessive use of force.

I concluded that training of authorised officers in the use of force remains insufficient and inadequate, despite previous reports and recommendations from my predecessor highlighting training as a significant factor. I was also critical of the Department of Economic Development, Jobs, Transport and Resources’ (DEDJTR) own investigation into the incident.

### **What has happened**

In response to my recommendations, DEDJTR began work on legislative change to transfer responsibility for authorised officers to Public Transport Victoria (PTV), the agency that manages Victoria’s train, tram and bus services.

In August 2015 PTV consultants completed a review of training for authorised officers, in consultation with Victoria’s Public Transport Ombudsman, operators and disability groups. The proposed new training approach includes information about de-escalating incidents and a new mechanism for reviewing incidents involving authorised officers.

Further work had been on hold pending a government review of ticketing compliance and enforcement on the public transport network. That review was released in May 2016, and made more recommendations about training and support for authorised officers.

DEDJTR advised that it will now conduct a further internal review to determine the resources and governance arrangements required for these functions. It advised that PTV is coordinating implementation of revised training for authorised officers, in conjunction with the recommendations from the government review.

<b>Status of my recommendations</b>	
<b>Recommendation 1</b> <p>That DEDJTR transfer the responsibility for all functions concerning authorised officers including recruitment, training, accreditation and authorisation to PTV.</p>	Accepted and in progress
<b>Recommendation 2</b> <p>That PTV review the training of authorised officers in light of the Ombudsman's report and global best practice, with particular emphasis on customer service, defusing and de-escalating conflict, and provide me with a report within 12 months.</p>	Accepted and implemented
<b>Recommendation 3</b> <p>That PTV seek the assistance of the Public Transport Ombudsman in conducting a review of previous complaints to its office to assist PTV in its assessment of authorised officer training ...</p>	Accepted and implemented
<b>Recommendation 4</b> <p>That PTV establish robust review mechanisms to address incidents involving authorised officers conduct, including the use of an external agency to review serious incidents.</p>	Accepted and in progress

## **Councils and complaints – A report on current practice and issues**

### **Why I started the enquiry**

I started this project in response to trends in complaints to my office about local government.

Complaints about local councils have been one of the highest categories of complaint to the Ombudsman for many years. This is not surprising given the types of services councils provide. For many people, their main interaction with government is with their local council.

Staff in my office identified that one of the main causes of complaint was the way councils dealt with complaints. All too often complaints were seen as a nuisance or provoked a defensive, bureaucratic or unhelpful response.

### **What I did**

Instead of using my powers to investigate councils, I decided my office would develop a good practice guide to help them improve their complaint handling practices. My officers surveyed all 79 councils in Victoria and consulted a wide range of people and organisations. One of the findings was that the definition of “complaint” varied across local government, which led to inconsistent recording and reporting of complaints by councils. My team developed a draft guide based on the survey responses and circulated it to councils for comment.

I tabled a report on the project and the good practice guide in Parliament in February 2015. I made three recommendations to the Minister for Local Government and Local Government Victoria for legislative change and information for councils to support better practices.

### **What has happened**

Over 50 councils have told my office that they are using the good practice guide to improve the way they deal with complaints from their communities. Many already have or will review their complaint handling or customer service policies based on the guide. Some were making other changes, such as:

- information on websites on how to provide feedback
- investing in better systems to record, track and report on complaints
- regular reporting to managers about complaints to drive service improvements.

These changes build a solid foundation for good complaint handling. I remain hopeful that they will lead to more engaged, responsive local government and fewer substantiated complaints about councils to my office.

My office will continue to engage with councils on these issues. Some of my officers have spoken at events organised by LGPro, the peak body for local government professionals in Victoria, and we continue to offer workshops on good complaint handling for council and other government officers.

The government's current review of the *Local Government Act 1989* is considering the legislative changes I recommended, including a definition of “complaint”. Recent feedback from councils suggests there are still inconsistencies in how councils define complaints. To resolve this problem, I encourage the review to adopt the definition I recommended.

### Status of my recommendations

#### Recommendation 1

That the Minister for Local Government consider including within the *Local Government Act 1989*, a definition of “complaint” as follows:

A complaint is an expression of dissatisfaction with:

- the quality of an action taken, decision made, or service provided by a council or its contractor
- a delay or failure in providing a service, taking an action, or making a decision by a council or its contractor.

Accepted in principle and in progress

#### Recommendation 2

That the Minister for Local Government consider including within the *Local Government Act 1989*, a requirement that councils have a complaint handling policy and procedures, and an internal review function for reviewing council complaint handling decisions.

Accepted in principle and in progress

#### Recommendation 3

That Local Government Victoria develop, or coordinate the development of, standard fact sheets or advice for local councils relating to issues bound by legislation – such as rates, infringements and planning.

Accepted and implemented

In May 2016 the Secretary of the Department of Environment, Land, Water and Planning advised me that Local Government Victoria has and continues to provide circulars to councils on common issues such as the new rates system.



**Smart Justice @SmartJusticeAus**

Here in Vic we have pockets of good practice eg the Drug Court, NJC, JLTC. We just need to do more of it, and do it smarter

**@VicOmbudsman**



**Homeless Law @Homelesslaw**

**@VicOmbudsman** explains that not having a roof over your head is a ‘script for recidivism’

**#unlockyourthinking**

## **Investigation into the rehabilitation and reintegration of prisoners in Victoria**

### **Why I investigated**

This investigation was prompted by the growth in prisoner numbers in Victoria, concerns with the rate of reoffending and the spiralling cost to the Victorian community.

Evidence showed that the prison population in Victoria had grown by 25 per cent in the three years from 2012 to 2015 and the budget for correctional services had risen to over \$1 billion. At the same time, Victoria's recidivism rate (the rate of return of prisoners discharged from prison following a sentence who return within two years) had increased, and the correctional system was the subject of more complaints to my office than any other government agency.

### **What I found**

The investigation concluded that the current system is not sustainable. The significant increase in prisoner numbers has resulted in many prisoners not being able to access rehabilitation programs or adequate support while in prison, and less than a quarter were receiving post-release support.

Problems included waiting lists for offending behaviour and alcohol and drug programs; unmet demand for mental health services; education and training service providers failing to meet benchmarks; problems with support for prisoner groups with particular needs; and a need for a whole-of-government approach to transition and pre- and post-release support in areas like housing, health and employment.

My report identified a number of alternative justice and sentencing approaches in specific Victorian courts that were achieving positive

results in reducing reoffending, as well as international examples that Victoria could examine.

### **What has happened**

The Department of Justice and Regulation (DOJR), which is responsible for Victoria's prison system, accepted all of my recommendations. In May 2016 its Secretary advised that four had been implemented and 21 others were in progress.

At the time of writing, my principal recommendation – for a whole-of-government strategy to reduce offending and recidivism and to promote rehabilitation of offenders – was under discussion between departments.

The government has announced several initiatives aligned with my recommendations including:

- funding to expand the “Communities That Care” pilot program, which targets the root causes of crime
- funding for new projects to address unemployment and youth disengagement
- expansion of the Drug Court to the Melbourne Magistrates’ Court
- changes to the Corrections Regulations 2009 to allow participating Aboriginal and Torres Strait Islander people to sell artworks created in prison, with proceeds held in trust until their release
- new contracts for delivering education programs in prisons
- flexible operating hours for Community Correctional Services, helping offenders and former prisoners who have gained employment.

My office will continue to monitor progress on the recommendations and the impact on recidivism rates in Victoria.

<b>Status of my recommendations</b>	
<b>Recommendation 1</b> <p>That the Victorian Government adopt a whole-of-government approach to reduce offending and recidivism and to promote rehabilitation of offenders ...</p>	<p>Accepted in principle and in progress</p> <p>DOJR advised that it was liaising with the Department of Premier and Cabinet.</p>
<b>Recommendation 2</b> <p>That DOJR, using justice reinvestment methodology, pilot and evaluate local approaches to crime prevention and community safety in disadvantaged Victorian communities with the aim of reducing reoffending and increasing community safety ...</p>	<p>Accepted in principle and in progress</p> <p>In addition to the funding noted earlier, DOJR is considering ways to coordinate and evaluate other “place-based” projects.</p>
<b>Recommendation 3</b> <p>That DOJR and Court Services Victoria seek further investment to expand the current court-based interventions to operate as required for offenders, regardless of their location. This should build on ... the Drug Court of Victoria, the Court Integrated Services Program, the Neighbourhood Justice Centre, the Assessment and Referral Court List, the Criminal Justice Diversion Program and the CREDIT/Bail Support Program and the Koori Court ...</p>	<p>Accepted in principle by DOJR, subject to additional funding, and in progress</p> <p>DOJR advised that it was liaising with Court Services Victoria.</p> <p>As noted earlier, the government has announced the expansion of the Drug Court to the Melbourne Magistrates’ Court.</p>
<b>Recommendation 4</b> <p>That DOJR review current practices and procedures for identifying and screening prisoners with a cognitive disability, including an acquired brain injury, to ensure that these functions are carried out by staff with specialist knowledge.</p>	<p>Accepted in principle and in progress</p> <p>A literature review to identify the most suitable screening tool was completed in October 2015 and is under consideration.</p>
<b>Recommendation 5</b> <p>That DOJR pilot and evaluate alternative case management structures and approaches that do not solely rely on prison officers to perform this role ...</p>	<p>Accepted in principle, subject to additional funding, and in progress</p> <p>DOJR is proposing to include a more integrated case management approach in its service delivery model for the new Karreenga Annexe at Marngoneet Correctional Centre.</p>

<p><b>Recommendation 6</b></p> <p>That DOJR develop systems and processes to provide greater continuity of, and stronger emphasis on, prisoner case management, including ensuring that case managers are able to meaningfully contribute to, and receive feedback from case management meetings.</p>	<p>Accepted in principle and in progress</p> <p>DOJR advised that the proposed model required more staff and had budget implications. Forms have been revised so officers must sign that case workers' notes have been considered by case management committees, and that case workers have noted the committee's minutes.</p>
<p><b>Recommendation 7</b></p> <p>That DOJR increase the availability of offending behaviour programs to ensure that the needs of the prison population, including those on remand, are met in a timely fashion.</p>	<p>Accepted and in progress</p> <p>DOJR has established a new panel of preferred providers and let new contracts to deliver 500 screenings and 500 assessments to meet demand, starting in May 2016.</p>
<p><b>Recommendation 8</b></p> <p>That DOJR continue the work already commenced to evaluate offending behaviour programs and provide an update to my office by December 2016 ...</p>	<p>Accepted and in progress</p> <p>DOJR proposes to appoint an external expert to evaluate the programs, with "first phase outcomes" expected in December 2016.</p>
<p><b>Recommendation 9</b></p> <p>That DOJR ensure that alcohol and drug treatment programs are available in all Victorian prisons, including minimum security prisons.</p>	<p>Accepted and implemented</p> <p>Health programs have been operating at all prisons since July 2012. Criminogenic programs, which aim to reduce the risk of substance-related re-offending, have been available for sentenced prisoners at all but two locations since 1 July 2015.</p>
<p><b>Recommendation 10</b></p> <p>That DOJR review whether the residential drug treatment program at Marngoneet is meeting its objectives, and whether the effectiveness of the program is being compromised by the current prisoner placement process.</p>	<p>Accepted and in progress</p> <p>DOJR has engaged independent evaluators to evaluate all alcohol and drug treatment programs, with a report expected by mid-2016.</p>
<p><b>Recommendation 11</b></p> <p>That DOJR monitor completion rates of in-prison education programs, not just enrolment or one off attendance, either through an amended Service Delivery Outcome measure or alternative regular measurement.</p>	<p>Accepted and in progress</p> <p>New contracts for delivery of education programs were finalised in November 2015 and include new key performance indicators. DOJR is considering changes to Service Delivery Outcome measures for 2017.</p>



<p><b>Recommendation 12</b></p> <p>That DOJR, when recontracting for the provision of in-prison education programs, introduce more consistent performance measures for providers across the prison system.</p>	<p>Accepted and implemented</p> <p>See above.</p>
<p><b>Recommendation 13</b></p> <p>That DOJR trial the introduction of controlled and monitored online learning for suitable prisoners, review the success of the trial and consider the results for expansion to a wider group of approved prisoners.</p>	<p>Accepted in principle subject to additional funding and in progress</p> <p>DOJR will begin trialling a new IT platform in May–June 2016 that will give eligible prisoners access to an intranet-based teaching and learning platform.</p> <p>In-cell access to education services is included in the specifications for the new Ravenhall prison. Intranet computers with mock search engines were recently introduced in the prisoner education centre at Fulham Correction Centre.</p>
<p><b>Recommendation 14</b></p> <p>That DOJR undertake a review of the Aboriginal Wellbeing Officer / Aboriginal Liaison Officer positions ...</p>	<p>Accepted and in progress</p> <p>A review is underway, with an expected completion date of September 2016.</p>
<p><b>Recommendation 15</b></p> <p>That DOJR examine the current delivery of cultural programs to Aboriginal and Torres Strait Islander prisoners ...</p>	<p>Accepted and in progress</p> <p>DOJR stated that it was continuing to monitor demand for programs against availability. A new cultural grants program, Kaka Wangity Wangin-Mirrie, will enable a “more sustainable and long term approach to contracting and accessing Aboriginal Culture Programs”. Programs are expected to start in July 2016.</p>
<p><b>Recommendation 16</b></p> <p>That DOJR continue the recently funded art program for Aboriginal and Torres Strait Islander prisoners, with consideration to the proceeds of sale of artwork supporting the prisoner’s transition to the community.</p>	<p>Accepted and implemented</p> <p>Approval was given in March 2015 to continue the program to March 2018, with a grant of \$758,000.</p> <p>As noted earlier, the <i>Corrections Regulations 2009</i> have been amended to allow additional deposits into prisoner trust accounts where prisoners in the program are paid for artworks.</p>

<p><b>Recommendation 17</b></p> <p>That DOJR investigate and provide options to government for replicating the services available in the Judy Lazarus Transition Centre for women prisoners.</p>	<p>Accepted and in progress</p> <p>DOJR stated that it was considering enhancing transitional options for women.</p>
<p><b>Recommendation 18</b></p> <p>That DOJR consider new and/or expanded accommodation options and practices for young adults in prison, along the model developed by the Youth Unit in Port Phillip.</p>	<p>Accepted in principle and in progress</p> <p>DOJR stated that it was exploring options for accommodating and managing young people across prisons, which will be considered against other factors to assess feasibility.</p> <p>A young adult prisoners accommodation model is under consideration for the new Karreenga Annexe at Marngoneet Correctional Centre.</p>
<p><b>Recommendation 19</b></p> <p>That DOJR explore options for additional dedicated facilities similar to the Marlborough Unit in Port Phillip to address the specific needs of [prisoners with cognitive disability].</p>	<p>Accepted in principle and in progress</p> <p>DOJR stated that it was exploring options for accommodating and managing prisoners with a cognitive disability across prisons, again noting the need to test options against factors to assess feasibility.</p>
<p><b>Recommendation 20</b></p> <p>That DOJR, in consultation with relevant stakeholders as necessary, explore options to provide the services available in the Judy Lazarus Transition Centre to a larger number of prisoners.</p>	<p>Accepted and in progress</p> <p>DOJR stated that it was considering transition options for a larger number of prisoners, and was drafting an internal discussion paper.</p>
<p><b>Recommendation 21</b></p> <p>That DOJR, in consultation with relevant stakeholders as necessary, investigate options to address post-release housing for former prisoners ... This approach should also ensure that the specific needs and vulnerabilities of women are recognised and addressed.</p>	<p>Accepted and in progress</p> <p>DOJR stated that it was working with the Department of Health and Human Services to review the current housing model. The Australian Institute of Criminology completed a literature review in September 2015 to inform practice and policy development. A further report on practices and models in other jurisdictions is expected by mid-2016.</p>

<p><b>Recommendation 22</b></p> <p>That DOJR, in conjunction with the Department of Health and Human Services, investigate a “throughcare” model from prison to community health services, to address the health needs, in particular mental health, alcohol and drug, and disability, of prisoners being released into the community.</p>	<p>Accepted and in progress</p> <p>DOJR stated that it was working with the Department of Health and Human Services to investigate how to improve the current throughcare model. A Continuity of Aboriginal Health Care pilot “is likely to offer insights into throughcare service delivery to all prisoners”, with early findings of the pilot expected in 2017.</p>
<p><b>Recommendation 23</b></p> <p>That DOJR establish a project with relevant stakeholders ... with a view to creating stronger employment pathways in prison and more options for employment post prison.</p>	<p>Accepted and in progress</p> <p>A new pilot employment support program with Jobactive providers in five Victorian prisons began in March 2016. The pilot will be evaluated in 2017.</p>
<p><b>Recommendation 24</b></p> <p>That DOJR consider the introduction of paid employment for prisoners in transition that requires a percentage of wages paid to go to victims of crime support.</p>	<p>Accepted in principle and in progress</p> <p>DOJR stated that it was obtaining legal advice on a draft proposal.</p>
<p><b>Recommendation 25</b></p> <p>That DOJR explore options to introduce more flexible parole reporting conditions, particularly in relation to former prisoners who have secured employment post-release.</p>	<p>Accepted and implemented</p> <p>As noted earlier, Community Correctional Services began a flexible opening hours model in March 2016. This is expected to offer more flexibility for offenders to complete the requirements of orders.</p>

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## Reporting and investigation of allegations of abuse in the disability sector

### Why I investigated

I initiated this investigation in response to community concern about abuse of people with disability in care. Media coverage in late 2014 detailed allegations of abuse in one of Victoria's best-known providers of disability services. At the same time, data from my office and other organisations showed continuing concerns with the way incidents of abuse were reported and handled.

Due to the impending introduction of the National Disability Insurance Scheme (NDIS), I decided to conduct the investigation in two phases:

- The first phase looked at effectiveness of oversight arrangements, so I could prioritise issues relevant to imminent decisions about the shape of the NDIS and a Victorian parliamentary inquiry.
- The second phase examined the processes for reporting and investigating abuse.

### What I found

My investigation found that we do not have a clear picture of the scale of abuse in the disability sector in Victoria. There is no single source of information or common framework for reporting abuse.

Despite areas of good practice and strong oversight compared to other states, the oversight arrangements in Victoria are fragmented, complicated and confusing. The result is lack of ownership of the problems around reporting abuse, legislative barriers to sharing information in some cases and inadequate funding for advocacy services.

The investigation also identified problems with the current system of incident reporting and investigation. They include a system that is not person-centred; failures to report abuse for reasons including fear and intimidation; gaps in reporting in areas such as supported residential services; failure to provide feedback to services; and an inadequate departmental investigations framework.

### What has happened

The key recommendation in my reports was for a single independent oversight body for the disability sector in Victoria.

In October 2015, the Minister for Housing, Disability and Ageing wrote to me welcoming my Phase 1 report and recommendations. He advised me that the government would consider the recommendation in the context of:

- the report of the Victorian parliamentary inquiry into abuse in disability services, which was tabled in Parliament in May 2016
- development of an NDIS quality and safety framework.

In the meantime, the Department of Health and Human Services (DHHS) is taking steps to implement some of my more specific recommendations:

- assessing the Victorian Disability Advocacy Program
- implementing new incident management arrangements
- new training on incident reporting.

Status of my recommendations	
<b>Recommendation 1</b> <p>... That:</p> <ul style="list-style-type: none"> <li>a. the Victorian Government either establish, or transfer responsibility to an existing agency, for a single independent oversight body ...</li> <li>b. that the Victorian Parliament Family and Community Development Committee further examine the logistics of a single independent oversight body ...</li> </ul>	Under consideration
<b>Recommendation 2</b> <p>That the government:</p> <ul style="list-style-type: none"> <li>a. undertake a comprehensive assessment of the advocacy needs of people with disability</li> <li>b. transfer sufficient funding provision from DHHS, and responsibility for administering advocacy services, to the Office of the Public Advocate ...</li> </ul>	<p>In progress</p> <p>DHHS advised that it would consider recommendations arising from its assessment of the Victorian Disability Advocacy Program in line with the outcomes of the review of the program.</p>
<b>Recommendation 3</b> <p>That the government, as part of the reforms being undertaken to implement a single independent oversight body (whichever option is chosen):</p> <ul style="list-style-type: none"> <li>(a) introduce a mandatory reporting requirement to that body of all serious incidents relating to people with disability by all service providers, regardless of the regulatory regime under which they fall</li> <li>(b) consider the benefit of extending mandatory reporting by third parties along the child protection models in Victoria and NSW.</li> </ul>	Under consideration
<b>Recommendation 4</b> <p>That DHHS amend the <i>Critical client incident management instruction</i> to ensure client wellbeing is the primary purpose of incident reporting and management.</p>	<p>Accepted and in progress</p> <p>As noted earlier, DHHS is working on a new incident management system that will operate across the department (excluding hospitals). Implementation will be staged from July 2016.</p>

<p><b>Recommendation 5</b></p> <p>That DHHS ensure the new incident report form and system:</p> <ul style="list-style-type: none"> <li>• is person-centred</li> <li>• records accountability for, and completion of, follow-up actions; the outcome of the response to the incident; and feedback to service providers on incident reporting and management.</li> </ul>	<p>Accepted and in progress</p>
<p><b>Recommendation 6</b></p> <p>That the government ensure that all workers across the disability sector are covered by protected disclosure legislation in order to support a culture of reporting.</p>	<p>Under consideration</p> <p>DHHS advised that the government would consider this recommendation in the context of the Victorian parliamentary inquiry report and development of the NDIS quality and safeguarding framework.</p>
<p><b>Recommendation 7</b></p> <p>That DHHS examine opportunities to achieve cultural change in the reporting of abuse, including through:</p> <ul style="list-style-type: none"> <li>• introducing mandatory training for disability workers in Disability Accommodation Services (DAS) [provided by DHHS] and community service organisations (CSO) [funded by DHHS], with a focus on incident reporting, identifying abuse and respect for human rights</li> <li>• developing guidance to service providers on learning from incidents, including timely debriefing with staff involved.</li> </ul>	<p>Accepted and in progress</p> <p>DHHS stated that:</p> <ul style="list-style-type: none"> <li>• its mandatory induction program had been updated to strengthen training about reporting abuse</li> <li>• it was working with its training provider for community service organisations to ensure programs met industry standards</li> <li>• it had funded an online learning program, "Abuse Identification and Response", which is being developed</li> <li>• it launched three e-learning modules about client incident reporting for frontline staff in March 2016.</li> </ul>
<p><b>Recommendation 8</b></p> <p>That DHHS develop an investigation framework and guidance for investigation of incidents in DAS, CSO and Supported Residential Services (SRS) [privately owned residential services] ...</p>	<p>Accepted and in progress</p> <p>DHHS stated that it would consider the recommendation as part of its new incident management system.</p>

<p><b>Recommendation 9</b></p> <p>That DHHS develop guidance on reviews, including when, how and what type of incident requires review, and extend the application as appropriate to client-to-client assault, dangerous behaviour, self-harm and suicide.</p>	<p>Accepted and in progress</p> <p>DHHS stated that it would consider the recommendation as part of its new incident management system.</p>
<p><b>Recommendation 10</b></p> <p>That DHHS perform an active role in supporting service providers to investigate incidents ...</p>	<p>Accepted and in progress</p> <p>DHHS stated that it would consider the recommendation as part of its new incident management system.</p>
<p><b>Recommendation 11</b></p> <p>That DHHS subject incidents in SRS to the same level of scrutiny as those in DAS and CSO to ensure consistent protections for people with disability across the sector ...</p>	<p>Accepted and in progress</p> <p>DHHS has developed a <i>Prescribed reportable incident instruction</i>, which clarifies the department's role regarding reportable incidents in SRS. It formalises requirements for the department to:</p> <ul style="list-style-type: none"> <li>• adopt the investigation and review principles established as part of its new incident management system</li> <li>• identify non-compliance and risks to resident safety and wellbeing</li> <li>• undertake appropriate enforcement responses</li> <li>• undertake quarterly analysis of prescribed reportable incidents with the aim of preventing reoccurrence.</li> </ul> <p>The instruction will be reviewed after DHHS's new incident management system is implemented.</p>

**Recommendation 12**

That DHHS and the Transport Accident Commission (TAC) implement an information-sharing protocol and extend this to incidents in SRS.

Accepted (in principle in the case of DHHS) and in progress

DHHS stated that information sharing guides were being revised and strengthened to incorporate reporting management and review of incidents for all agencies that use SRS, including TAC clients.

TAC advised that it delivered a draft protocol to DHHS in April 2016. It will meet with DHHS in June 2016 to discuss the draft and the process to finalise the protocol.

**Recommendation 13**

That the TAC provide for access by Community Visitors to TAC registered providers.

Noted and in progress

In its response to my draft report, TAC said it would welcome inspections by Community Visitors.

In May 2016, the TAC advised me that it had met with the Office of the Public Advocate (which coordinates the Community Visitors program) in April 2016 to discuss how they could work to facilitate access.



**AFI Policy Team** @Adv4l\_Policy

“We must support the independence and decision making of people with disability”

@VicOmbudsman  
#disabilitydisrupt



**NSWCID** @nswcid

Spot on @VicOmbudsman  
Gr8 lessons 4 @NDIS  
safeguards systems



# Appendix

Summary of status of recommendations				
	Number of recommendations	Recommendations implemented	Recommendations in progress	Recommendations under consideration
Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service	3	1	2	-
Investigation into allegations of improper conduct in the Office of Living Victoria	4	4	-	-
Investigation into allegations of improper conduct by officers of VicRoads	4	4	-	-
Conflict of interest by an Executive Officer in the Department of Education and Training	2	1	1	-
Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations	1	-	-	1
Investigation following concerns raised by Community Visitors about a mental health facility	2	2	-	-
Investigation into an incident of alleged excessive force used by authorised officers	4	2	2	-
Councils and complaints – A report on current practice and issues	3	1	2	-
Investigation into the rehabilitation and reintegration of prisoners in Victoria	25	4	21	-
Reporting and investigation of allegations of abuse in the disability sector (two reports)	13	-	10	3
<b>Total</b>	<b>61</b>	<b>19</b>	<b>38</b>	<b>4</b>

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