

Ombudsman's recommendations – fourth report

September 2022

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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

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973* (Vic), I present to Parliament my *Fourth report on recommendations*.



Deborah Glass OBE

Ombudsman

28 September 2022

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Foreword

This report covers Ombudsman recommendations spanning two years when the impacts of the COVID-19 pandemic undoubtedly contributed to inequality, disadvantage and vulnerability. Two years when human rights came sharply into focus for every Victorian, as we lost our liberties in multiple ways – sometimes for good reasons, but not always.

The pandemic triggered change in many aspects of life, not least the relationship between citizen and state. The Victorian Ombudsman has, for nearly 50 years, sought to redress power imbalances, and so the role of Ombudsman has become more important than ever.

This report summarises the outcomes and improvements following 11 Ombudsman reports tabled in Parliament in between May 2020 and December 2021, as well as updating progress from some earlier reports.

It is also intended to respond to a perennial question I am asked – if you can't enforce your recommendations, what is the point of them? The point is that Ombudsman reports deliver tangible results.

The vast majority of my recommendations are not only accepted but implemented. They drive systemic change and improvements. They reassure people their government is listening to their grievances. Some of these outcomes are monumental.

The response to my investigation into the Business Support Fund – an economic lifeline during the pandemic – resulted in more than 4,200 rejected applicants collecting \$42 million in financial support. It also showed how it is possible for a large department to learn and improve. I commend the Department of Jobs, Precincts and Regions, who engaged constructively with my investigation, resolving many complaints and improving its processes along the way.

The vast majority of my recommendations are not only accepted but implemented. They drive systemic change and improvements. They reassure people their government is listening to their grievances. Some of these outcomes are monumental.

Similarly, the City of Melbourne responded positively during and after my investigation into its parking fines, especially those involving people unfairly fined for confusing O and zero on its PayStay app. More than 2,000 fines issued to motorists were reversed, and systemic changes implemented.

My investigation into how local councils respond to ratepayers in hardship is not only improving outcomes for homeowners who fall into debt, it also demonstrated how our practical advice supports better public administration. Recommendations from my report were recently enshrined in law.

Another of my reports has resulted in major reforms to the child protection residential care system to improve the welfare and safety of children. The full impact of the reforms will take some time to flow through, and will hinge on important funding decisions. The work to date is encouraging, and I will continue to monitor progress.

This report follows up on a subject I have canvassed extensively in the past – the Victorian workers compensation system. An independent review commissioned in response to my 2019 report underscored my finding that systemic change was desperately needed. The 22 recommendations from that review, together with my previous recommendations, represent substantial reforms which will significantly improve the experience of many injured workers.

While such large-scale change can take time to flow through to workers, one key reform is already legislated: a new arbitration function, which will enable timely and inexpensive binding decisions on disputes rather than workers having to resort to the courts.

I commend all the Ministers, departments and agencies who have embraced and driven these changes in the public interest.

Sometimes, however, my recommendations are not accepted. In such cases it is the role of this biennial report to reflect on why, and to hold agencies to account for their inaction.

About 3,000 residents of nine inner-Melbourne public housing towers are still waiting for the apology I recommended for the harm and distress caused by the immediacy of their July 2020 lockdown. It still matters: we have been told residents felt disheartened and let down by the lack of an apology, and that it remains a barrier to rebuilding trust with the Government.

Sometimes, however, my recommendations are not accepted. In such cases it is the role of this biennial report to reflect on why, and to hold agencies to account for their inaction.

The official response was the Government made no apology for saving people's lives. I did not investigate or criticise the six statewide lockdowns, despite receiving multiple complaints about them. But the public housing towers remain the only lockdown, before or since, that took place on no notice whatsoever to affected people.

I based my recommendation for an apology on evidence that there was an alternative to the immediacy of the lockdown that would have respected people's rights without compromising public safety.

My report into the Victorian border closure in 2021 did not recommend a formal apology, largely because there seemed little point. Instead, I recommended that the Government publicly acknowledge the narrow exercise of discretion in granting exemptions resulted in unjust outcomes, and consider measures to alleviate this, such as ex gratia payments.

Once again, the response sidestepped the issue and focused on the number of times Victorians were warned to come home. But not all those locked out were holidaymakers who could have done so. Many had no choice; people were dealing with urgent, sometimes desperate, personal circumstances. I criticised an exemption system which put more effort into keeping people out than finding safe ways of bringing them home.

The official response to my recommendation was both slow and lukewarm, appearing months later on the Department of Health's website.

It is encouraging that governments are increasingly comfortable apologising for historical wrongs, such as the powerful apology delivered in the Victorian Parliament in 2019 to the victims of historical sex abuse at Puffing Billy Railway, and clearly recognise the benefits these bring. But it seems difficult for them to acknowledge, let alone apologise for, recent wrongs.

In neither of those reports did I criticise the actual decision to lock down, or to lock out. Yet the immediate official responses, focusing on saving lives, pointedly avoided the evidence that lives could still have been saved while respecting people's rights and making fair decisions.

While saying sorry may be difficult, if done well, the results are worth all the effort – and more. The act of recognition, accompanied by responsibility and regret, can provide comfort and release. It is never too late to do so.

It is possible to find silver linings in the storm clouds of the pandemic. As we take stock of our lives after two years of disruption, so too do we find opportunities for decision makers to reshape and improve 'old' ways. Improvement and innovation were keys to surviving the pandemic, and we need to carry forward the willingness to embrace new, better ways of doing things.

Fairness – a core Ombudsman value – is more important than ever, given the deep divides that emerged during the crisis, and the learnings from my investigations should make for fairer decisions. Integrity and accountability also came under the microscope in councils and schools, reinforcing how crucial a strong underlying culture is, especially as we move to rapid decision making with fewer guardrails.

And during two years of being stripped of individual liberties, my reports illustrated the importance of Victoria's Human Rights Charter. It gives us a practical framework for dealing with the balancing act that decisions often present, and a reminder that people should always be at the heart of decision making.

Some things, sadly, have not changed for the better, and Victoria's apparent inability to make progress implementing the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('OPCAT') is one of them. I have tabled two reports exploring both the policy and operational needs to implement this important international treaty to improve our treatment of people in detention.

I do not make large numbers of recommendations and I make none of them lightly. I am proud of what they have achieved in collaboration with public sector leaders, in pursuit of better administration and ultimately, public confidence in government and its services.

Some states and territories have now designated the body or bodies who will perform the inspection role, but despite the years we have had to prepare, Victoria has not yet done so. The Department of Justice and Community Safety says it is waiting on a funding agreement with the Commonwealth. Yet the cost of establishing an independent inspection function – which we calculated in our 2019 report – represents a fraction of 1 per cent of the current prison budget.

I do not make large numbers of recommendations and I make none of them lightly. I am proud of what they have achieved in collaboration with public sector leaders, in pursuit of better administration and ultimately, public confidence in government and its services. And I note with regret that trust and confidence are the likely losers when they are – even if rarely – ignored.

Deborah Glass

Ombudsman

At a glance – key impacts



Major structural reform to improve the experience of injured workers navigating the compensation system, especially for disputed decisions



\$42 million paid to more than 4,200 business owners after an investigation showed systemic failings in a grant scheme



Improved processes for administering government grant programs, including clear paths for applicants to complain and seek a review



New laws to boost access to advocacy for children and young people in out-of-home care, to improve their safety and wellbeing



Laws ensuring councils implement fairer financial hardship policies to support struggling ratepayers



Law changes to introduce review rights and improve information flows for people detained in future pandemic outbreaks



Better guidelines and training for City of Melbourne parking officers, ensuring motorists fined in the CBD and surrounds can be more confident of a fair review



Reversal of 2,446 parking infringements and costs valued at almost \$209,000 following the City of Melbourne's inflexible approach to applying discretion



Tighter recruitment, procurement, conflict of interest, and anti-fraud and corruption policies and procedures at several local councils



More thorough vetting of external candidates for school principal roles, including extra probity and professional competency checks

Introduction

Monitoring how public bodies respond to the recommendations arising from my investigations is a vital part of the Ombudsman role. Regularly following up with authorities enables me to see if they have acted to address issues as they said they would, and whether this is making a difference.

Every two years I publish a report on the progress made by authorities in implementing my recommendations. This report covers my investigations tabled in Parliament between May 2020 and December 2021. It is divided into four sections, reflecting the key values that guide the work of my office.

Ensuring fairness

- *Investigation into decision-making under the Victorian Border Crossing Permit Directions*
- *Investigation into review of parking fines by the City of Melbourne*
- *Investigation into good practice when conducting prison disciplinary hearings*

Enhancing integrity and accountability

- *Investigation of alleged improper conduct by Executive Officers at Ballarat City Council*
- *Investigation of protected disclosure complaints regarding the former Principal of a Victorian public school*
- *Investigation into corporate credit card misuse at Warrnambool City Council*
- *Investigation into Melton City Council's engagement of IT company, MK Datanet Pty Ltd*

Supporting improvement and innovation

- *Investigation into the Department of Jobs, Precincts and Regions' administration of the Business Support Fund*
- *Investigation into how local councils respond to ratepayers in financial hardship*

Protecting human rights

- *Investigation into the detention and treatment of public housing residents arising from a COVID-19 'hard lockdown' in July 2020*
- *Investigation into complaints about assaults of five children living in Child Protection residential care units*

Each section includes an overview of the theme, short summaries for each report, and information from the relevant authorities outlining their actions. My office has assessed the status of the implementation of each recommendation, based on the updates and evidence provided by the relevant agencies.

Figure 1: Agency responses to recommendations May 2020 – December 2021

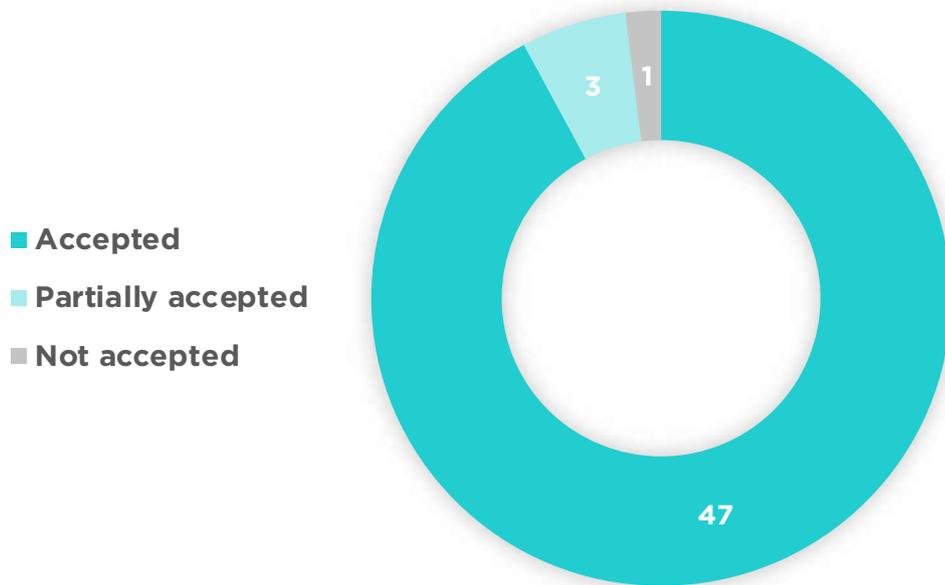
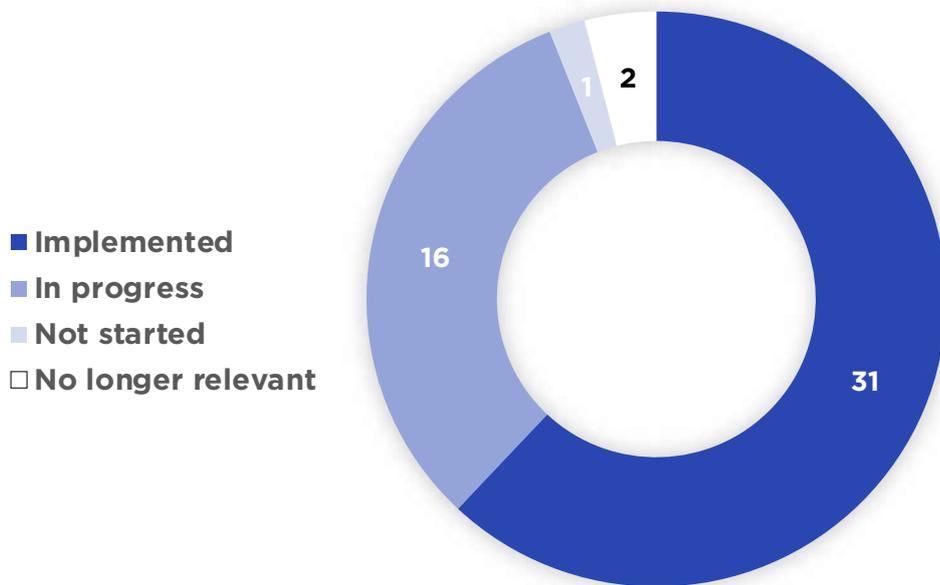


Figure 2: Action taken on accepted recommendations May 2020 – December 2021



Source: Victorian Ombudsman

While my recommendations are not legally binding, I am pleased to report almost all were fully or partially accepted. Similarly, some action has been taken on almost all of the accepted recommendations. Many agencies report significant progress toward positive change. Where further work is necessary, the will is often there but factors such as a lack of funding, competing policy priorities or pressures flowing from the pandemic are delaying progress.

Not all investigations result in recommendations. I only make them where they will result in meaningful action to fix errors and prevent similar issues in future. For example, recommendations are not usually necessary when an agency has already taken action to address an issue, or when an agency's actions are found to be reasonable.

My public reports without formal recommendations are still valuable as they concern matters of public interest. The Western Highway report, for example, confirmed the Government's actions were reasonable. Other reports highlight risks, problems and consequences for public administrators to be aware of and learn from.

I have tabled five public reports without recommendations in the relevant period:

- *Investigation into allegations of collusion with property developers at Kingston City Council*
- *The Ombudsman for Human Rights: A Casebook*
- *Outsourcing of parking fine internal reviews – a follow-up report*
- *Investigation into the planning and delivery of the Western Highway duplication project*
- *Investigations into allegations of nepotism in government schools.*

In eight instances between May 2020 and December 2021, I made private recommendations to departments, agencies, councils or other bodies following investigations that were not made public. Reports are kept private to protect either individual privacy or the public interest. These recommendations still drive change and I monitor progress made on them too.

While this report collates details of progress only against my recent recommendations, my office continues to monitor recommendations dating back many years, recognising it can take time to see the benefits.

Occasionally it becomes evident, usually through complaint trends, that underlying issues continue to exist despite an authority's acceptance of recommendations, and that further investigation might be required. For example, my 2019 report *WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims* revisited a 2016 investigation. As discussed later in this report, keeping a keen eye on progress from the 2016 recommendations enabled me to identify persistent failings and to propose further important reforms. Given ongoing complaints about other aspects of the workers compensation scheme, I have recently launched a third investigation, this one into decision making by employers who manage their own workers compensation claims.

The cycle of investigation and monitoring has benefits for my office, as well as for the public and broader public sector. By better understanding which recommendations influence effective change, we maximise the chances of our future work making a difference for the benefit of all.

Ensuring fairness

A key principle guiding the work of my office is ensuring fairness through independent and impartial complaint resolution, and by encouraging fair and reasonable decision making within the public sector. My office often helps resolve problems involving unfair decisions quickly and informally, with authorities offering an explanation, an apology or a promise to do things differently next time. Sometimes, a deeper examination is required to uncover improvement opportunities.

The need to keep fairness in mind and retain public confidence when making decisions was especially evident during peaks in the COVID-19 pandemic. Our investigation into the border crossing permit scheme showed that failures to exercise discretion fairly, give reasons for decisions or offer the right of review resulted in unjust outcomes for many people.

Our investigation into parking fines issued by the City of Melbourne uncovered a similar lack of fairness. As with the border permits scheme, these faulty decisions not only affected individuals but, given the glare of publicity, also damaged public trust in government.

At the other end of the spectrum, far away from the public eye, we investigated disciplinary hearings in Victorian prisons. We found they are largely carried out 'in the dark' with insufficient scrutiny or transparency, and the potential for unfairness is rife. Fairness for prisoners attracts fewer media headlines than free citizens stranded across a border or angry motorists with parking fines. But fairness is essential for all in a civilised society.

Ultimately, the recommendations flowing from these investigations aim to lower the risk of arbitrary decision making. They introduce openness and transparency into processes to ensure public officers and authorities act fairly when making decisions that affect the rights and interests of all people.



Investigation into decision-making under the Victorian Border Crossing Permit Directions

Tabled 7 December 2021

Why I investigated

In January 2021, in response to the COVID-19 public health crisis, Victoria introduced a 'traffic light' border permit scheme for people entering the state. Travellers grew used to a system which, even at its most restrictive, allowed them to return home from interstate COVID-19 risk zones, subject to self-quarantine and testing requirements. This model changed at short notice in July 2021 and the border with New South Wales was shut.

Thousands of people were suddenly locked out – unable to enter Victoria unless they had an exemption for a specified reason or were considered an 'excepted person'. By early September 2021, my office had received more than 80 complaints from people refused exemptions to enter Victoria.

What I found

Amid challenging circumstances, the decision to close Victoria's border was not unreasonable as it was based on public health advice and human rights implications were considered.

However, the discretion available to approve exemptions was exercised too narrowly and resulted in unjust outcomes. The Department of Health ('DoH') granted just 8 per cent of more than 33,000 exemption applications lodged between July and September 2021. Most applications were not specifically rejected but 'closed for other reasons'. The senior and busy officials who granted exemptions had limited time to dedicate to individual applications. DoH did not provide reasons for refusals and there was no appeal process for denials.

The applications required extensive evidence which was sometimes onerous or impractical to collect, such as statutory declarations, proof of residence, letters from medical professionals or bank statements. Many people found themselves stranded, unable to farewell loved ones at funerals, attend vital medical appointments, care for sick family members, start jobs or simply return home. Overall, the investigation found DoH put significant resources towards keeping Victorian residents out rather than facilitating safe ways for them to return.

What's happened since

In October 2021 travel restrictions began to ease and in November Victoria's borders reopened. Shortly before I tabled my report, the Minister for Health introduced the *Public Health and Wellbeing Amendment (Pandemic Management) Bill 2021*. It sought to refine the *Public Health and Wellbeing Act 2008 (Vic)* 'in light of what the government has learned responding to the COVID-19 pandemic'.

While many of these amendments are welcome, the Government's response to some of my recommendations on this matter suggest it has missed some of the lessons to be taken.

The Government made no formal response when the report was tabled but DoH has since acknowledged the 'distress and disruption the border restrictions generally created'. It stopped short, however, of acknowledging the unjust outcomes so many Victorians suffered as a result of the border permit decisions or making any effort to lessen the disadvantage caused.

It has accepted my recommendation to consider amending the *Charter of Human Rights and Responsibilities Act 2006 (Vic)* ('Charter of Rights Act') to give greater clarity on freedom of movement. DoH said facilitating the return home of Victorians where it can be achieved safely 'will continue to be a key component' of its response to future pandemics. It will not guarantee financial supports to people unable to return home as a result of border closures, though will consider financial impacts 'as part of any guidance developed in this area'.

DoH reported that it issued 25 infringements for entering Victoria as an 'excepted person' without meeting the criteria. Fifteen people sought a review independently, resulting in 13 infringements being withdrawn. DoH reviewed the remaining 10 cases, resulting in eight further withdrawals and two infringements upheld. It is worth noting police also fined people for entering Victoria from restricted areas. In light of DoH's action, I invited Victoria Police to consider reassessing their infringements. In response, Victoria Police advised 222 fines for entering Victoria 'without excuse or reason' were appropriately issued for 'blatant, deliberate and obvious breaches of the CHO directions' and none would be withdrawn.

The Government and DoH published an update online in late May 2022 detailing the steps taken to implement my recommendations.

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To the Victorian Government:

Publicly acknowledge that the narrow exercise of discretion under the Border Directions while NSW and the ACT were ‘extreme risk zones’ resulted in unjust outcomes, and consider measures to alleviate this, such as ex gratia payments on application to help cover the financial cost of not being able to travel home.

Partially accepted | Implemented

DoH advised:

While the Victorian Government is not considering making ex gratia payments for those Victorians who were unable to travel home during this period, it does acknowledge the distress and disruption that the border restrictions generally created. It also acknowledges the frustration and challenges that people experienced when attempting to obtain an exemption in these difficult circumstances, when the risks presented to the public health of Victorians by COVID-19 were constantly evolving.

Recommendation 2 - To the Victorian Government:

To provide greater clarity, consider amending section 12 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) to reflect the equivalent provision in the *Human Rights Act 2004* (ACT) as follows.

12 Freedom of movement

Every person has the right to move freely within Victoria and to enter and leave it and has the freedom to choose where to live.

Accepted | In progress

DoH advised:

The Victorian Government has accepted the recommendation to consider amending the Charter of Rights Act to give greater clarity on freedom of movement, with changes now under consideration.

Recommendation 3 – To the Secretary to the Department of Health:

As a matter of priority, develop and implement policy under the amended *Public Health and Wellbeing Act 2008* (Vic) to:

- a. assure Victorians that their ability to return home safely will be a key component of future public health directions or pandemic orders that require the closure of Victoria's interstate borders
- b. ensure that if, as a result of interstate border closures, a Victorian resident is unable to return home safely, appropriate financial assistance will be provided so the person is not unfairly disadvantaged
- c. provide guidance for the implementation of future public health directions or pandemic orders that allow people to apply to be exempt from any or all requirements, to ensure discretionary decision-makers:
 - i. consider each applicant's individual circumstances
 - ii. take reasonable steps to engage directly with the applicant
 - iii. prioritise factors that mitigate risk to public health
 - iv. consider whether additional conditions may be reasonably imposed on the applicant to mitigate risk to public health and allow the exemption to be granted
 - v. provide reasons for any adverse decision
 - vi. provide details of internal and external review rights, including the Ombudsman.

Partially accepted | In progress

DoH advised:

- a. In the event of any future pandemic orders relating to border closures, the objective of facilitating the return home of Victorians where it can be achieved safely and without imposing excessive risk on the wider community will continue to be a key component. This will form part of the guidance material developed by DoH for relevant exemption processes.
- b. DoH is not able to guarantee financial assistance to any residents unable to return home as a result of any future interstate border closure. However, DoH will consider financial impacts as part of any guidance developed in this area.
- c. DoH is developing guidance for the implementation of future pandemic orders that allow people to apply to be exempt from any or all requirements. It is expected this will address:
 - establishing and scaling up exemption processes in the context of a pandemic, including resourcing, systems, procedures
 - communicating with the public and individual applicants about the exemptions process
 - balancing the public health risks with the applicant's individual circumstances, including prioritising factors that mitigate the risk to public health and considering conditions that might enable an exemption
 - fairness in decision-making, including providing reasons for adverse decisions, and internal and external review rights.

Recommendation 4 – To the Secretary to the Department of Health:

Noting DoH could not provide certainty to people on their status as an ‘excepted person’ under the Border Directions, invite those who received an infringement for entering or attempting to enter Victoria as an ‘excepted person’ to have their infringement reviewed and withdrawn where they believed on reasonable grounds they were an ‘excepted person’.

Accepted | Implemented

DoH advised:

Between March-November 2021, DoH issued 25 infringement notices to ‘excepted persons’. Fifteen individuals requested a review, resulting in (as of 1 September 2022):

- 3 withdrawn with an official warning issued
- 10 withdrawn with no further action taken
- 1 confirmed following internal review
- 1 request made for Magistrate’s Court determination.

The Department undertook to reassess the remaining 10 infringements on its own initiative for possible withdrawal and to advise affected persons of the outcome in due course. This exercise is now complete with the following outcomes:

- 8 infringements were withdrawn and the matters abandoned.
- 2 infringements were not withdrawn (and the infringements are to proceed).

Recommendation 5 – To the Secretary to the Department of Health:

Report publicly on steps taken to implement recommendations 1-4 above, on or before 31 March 2022.

Accepted | Implemented

DoH published on its website its progress report in late May 2022.



Investigation into review of parking fines by the City of Melbourne

Tabled 16 September 2020

Why I investigated

I received a complaint from the Independent Broad-based Anti-corruption Commission ('IBAC') alleging improper conduct by officers from the City of Melbourne's parking branch. It alleged two senior staff had misused their powers when reviewing and deciding to prosecute infringement notices, with the aim of raising revenue. The complaint included several examples where the Council continued to pursue fines that were unfair. The alleged conduct appeared to show poor administrative decision making.

What I found

My investigation found the City of Melbourne acted unfairly in upholding fines against drivers who had paid the correct fee and parked legally but made a simple mistake. The motorists had confused the number zero with the letter O when entering their car registration details in the PayStay app which resulted in a fine being issued.

Drivers who requested a review and had their fines unfairly upheld had to go to court to object. The investigation also found the Council had reworded its Penalty Reminder Notice despite their own legal advice suggesting the wording was wrong and misleading.

While the original complaint alleged improper conduct by two senior Council staff, the evidence did not support this. The investigation found an inflexible approach generated or endorsed by senior management of the Council was at the heart of the issue, with officers using a 'Decision Matrix' which simply did not allow for any discretion.

What's happened since

The City of Melbourne responded commendably during and after my investigation. It agreed with our recommendations to reverse the fines issued to the individual motorists, and to implement systemic changes. It identified almost 2,500 infringements caused by the PayStay zero/O error. Many have now been withdrawn and refunded. The remaining affected motorists have until May 2023 to arrange their refund from the Council before the money is transferred to the State Revenue Office's Unclaimed Monies Register.

The Council expects the total amount reversed as a result of our investigation to be almost \$209,000 when court costs are included. The Council has also engaged external consultants to more broadly improve its approach to making decisions and exercising discretion. New guidelines and training more clearly outline conduct standards, the purpose of internal reviews and the principles of good decision making and administrative law.

Parking fines are a perennial source of complaint to my office and this is likely to continue. It is hoped that Victorian motorists fined in the CBD and surrounds will now more likely receive a fair review.

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To the City of Melbourne:

That Council's Chief Legal Counsel undertake a review of the 21 October 2019 Decision Matrix to ensure consistency with the principles of administrative law and decision making.

Accepted | Implemented

Council advised:

Council's Chief Legal Counsel reviewed the Decision Matrix in October 2020 and also engaged external solicitors to conduct an independent review. They both thought the document was beneficial as a supporting and secondary tool to assist decision makers in making their independent decisions. The title 'Decision Matrix' was changed to 'Infringement Processing Guidance' to clearly convey its intended use.

The Chief Legal Counsel considered there needed to be a set of internal review guidelines (Guidelines) that sat between the Attorney-General's guidelines to the *Infringements Act 2006* and the renamed Infringement Processing Guidance. External solicitors were also commissioned to prepare the Guidelines in advance of providing training on the principles of sound administrative decision making.

Recommendation 2 - To the City of Melbourne:

That the Council provide training to relevant staff on the principles of administrative decision making and use of the revised Decision Matrix.

Accepted | Implemented

Council advised:

Our Infringement Review and Prosecutions Teams attended two workshops presented by the external solicitors. The first presentation covered the principles of administrative law in respect to decision making. The second presentation was to consider real and hypothetical scenarios.

All currently employed Infringement Review Officers have now completed the training on use of the Internal Review Guidelines and the Infringement Processing Document. Training for new recruits is included in their induction - Infringement Review Training Plan.

In addition to the above and prior to the external solicitor's work, from August 2020 to October 2020, an internal review of decisions occurred on a daily basis. The process involved the General Manager Community and City Services and Director On-street Support and Compliance meeting with decision makers daily to discuss decisions where the decision maker was unsure. The process was intended to provide feedback to and empower the decision makers to feel comfortable in making their decisions. We continue to support our Infringement Review Officers to exercise their discretion when dealing with infringement review objections.

Recommendation 3 – To the City of Melbourne:

That the Council establish an arrangement under which it undertakes a review of all PayStay zero/O error fines during the period 1 July 2017-1 July 2018 and 1 November 2018-30 October 2019 where an internal review was rejected and refund the infringement where the Council now considers the infringement would have been withdrawn if the revised Decision Matrix had been in place at the time of the review.

Accepted | Implemented

Council advised:

Our review and analysis identified 2,446 relevant Parking Infringement Notices for withdrawal and refund.

Customers were initially contacted by letter explaining their right to a refund and were asked to make contact and provide bank details to have their infringement payment refunded. A follow up email was provided to 925 customers who did not respond to the letter. In 345 cases where there was still no response, phone calls were made. Fines Victoria supported the City of Melbourne by dealing directly with those matters that were registered with them.

Customers yet to arrange their refund can contact the City of Melbourne until May 2023 when any amount yet to be refunded will be handed over to the State Revenue Office Unclaimed Monies Register.

Recommendation 4 – To the City of Melbourne:

That the Council conduct an independent review of the behaviours, processes, systems, reporting structures and governance of the Branch, including implementing a process to monitor the use of discretion in reviewing infringements.

Accepted | Implemented

Council advised:

The City of Melbourne engaged consultants to conduct an Effectiveness and Efficiency Review of the On-street Support and Compliance Branch which commenced in late 2020.

The review made 26 findings covering strategy and service delivery through to processes, people, and business enablers.

The City of Melbourne has also:

- expanded its internal reporting tools to monitor both the reasons for infringement withdrawals and infringements upheld
- commenced monitoring customer feedback for comments relating to the use of discretion.



Investigation into good practice when conducting prison disciplinary hearings

Tabled 6 July 2021

Why I investigated

Within Victoria's 14 prisons, about 10,000 disciplinary hearings a year are conducted dealing with prisoners accused of breaking prison rules. Those found guilty can lose privileges such as telephone calls and out-of-cell time and can have their parole impacted. The transparency of these hearings is limited, and the only option for prisoners to challenge an outcome is to apply to the Supreme Court for judicial review. Despite improvements made following a 2011 Ombudsman investigation, my office continued to receive about 60 complaints a year about the prison disciplinary process. I decided to investigate the fairness of the current process to ensure it respects prisoners' rights to humane treatment.

What I found

While I found improvements in some areas since 2011, disciplinary hearings in Victorian prisons are still carried out 'in the dark' with insufficient oversight or transparency. I also found that greater discretion could be used to divert some prisoners from the disciplinary hearing process entirely. While I observed some good practices and decisions, the potential for unfairness was still rife. One example of an unnecessary hearing was a suicidal prisoner with mental health conditions who resisted a strip-search while being moved to a safe cell. He was charged despite apologising a day later.

Good decision making routinely provides written reasons for outcomes and allows for internal reviews. Neither of these were available to prisoners. Record-keeping was at times poor or inaccurate. Anecdotal evidence suggested undocumented pre-hearing discussions were common.

Prisoners had limited access to information and support, especially those with mental health issues or cognitive impairment. Sometimes prisoners were not given enough information about the charge, leading to procedural unfairness. There was also a perception of bias identified in some cases.

What's happened since

The recommendations from this report aimed to increase fairness and transparency in a largely opaque process. Corrections Victoria has formed a Disciplinary and Hearing Officers Working Group to assist with implementing the recommendations. Some progress has been made including developing an audit tool and some learning modules to boost knowledge and consistency. Reporting requirements for hearing outcomes have also been strengthened and alternatives to deal with minor offences have been developed.

However, the Department of Justice and Community Safety ('DJCS') has reported COVID-19 impacts have somewhat stalled activity on several important fronts. Funding decisions are also delaying a centralised record-keeping system for hearings.

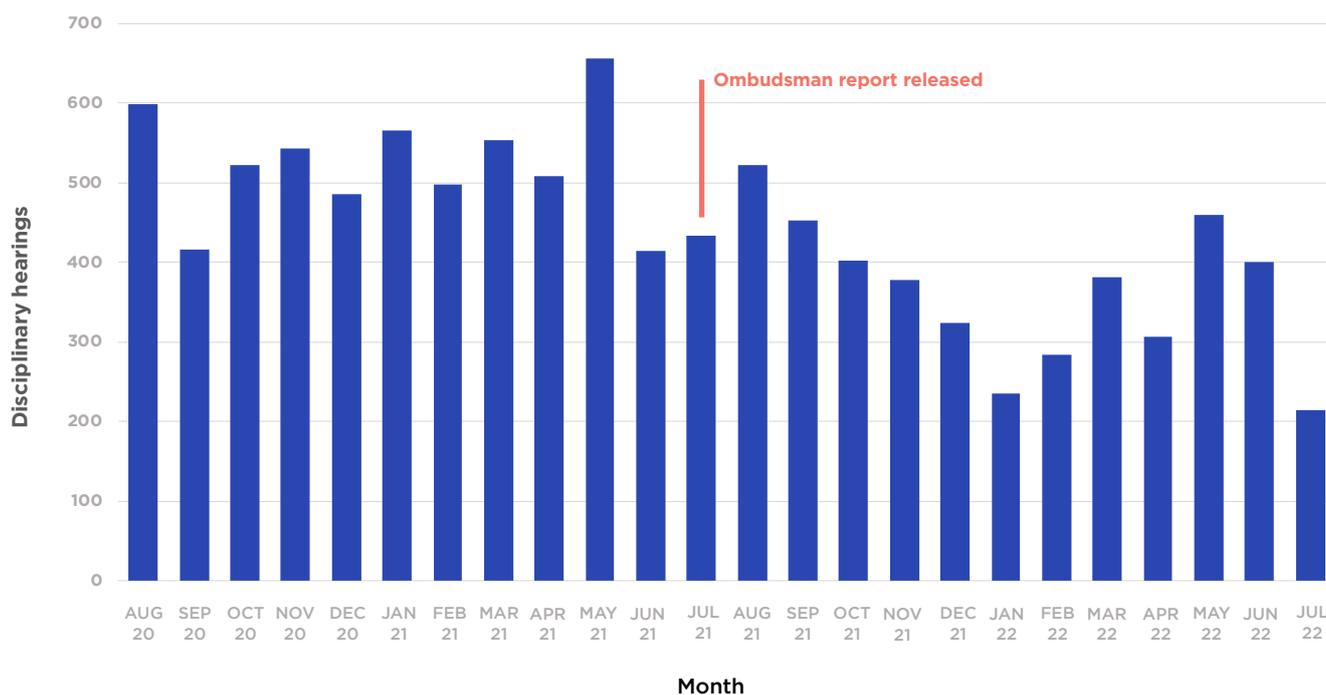
In May 2022, the Office of the Public Advocate ('OPA') advised more work was needed to improve the awareness and use of its support officers. In response, DJCS attributed the decline in support officer use to lower prisoner numbers and fewer hearings as a result of my recommendations, and stated data showed the number of hearings involving prisoners with an intellectual disability had halved since 2020.

While I welcome DJCS's initiative to provide more training for Disciplinary and Hearing Officers, an internal review mechanism and a dedicated team of hearing experts are crucial to reducing the risk of unjust hearing outcomes. My office will continue to monitor DJCS's efforts as the effects of the pandemic subside.

As expected, there was an increase in complaints to my office about disciplinary hearings following the tabling of the report in Parliament.

Pleasingly, the number of complaints has since reduced. DJCS data indicates the number of disciplinary hearings held has also reduced. This may be due to a notable reduction of the prison population and COVID-19 restrictions, in conjunction with Corrections Victoria's efforts to manage disciplinary matters without resorting to disciplinary hearings. As the report noted, sensible changes should see fewer matters proceed to a formal disciplinary process, reducing the burden on prisons, prison officers and prisoners alike.

Figure 3: Prison disciplinary hearings held August 2020 – July 2022



Source: Victorian Ombudsman, based on data from Corrections Victoria

Observations from Dr Colleen Pearce AM, Office of the Public Advocate

Regarding Recommendation 5, 'to develop and implement measures to improve prisoner understanding and experiences of the disciplinary hearing process and available supports', recent experience in our Corrections Independent Support Officer ('CISO') program indicates there has been no substantial change.

However, it is important to note that there have been considerable operational barriers for both prisons and our CISO program in making the necessary improvements due to the COVID-19 pandemic. Over the past two years, CISO volunteers were only able to attend hearings [online]. Few requests were received from prisons for CISOs over that time. Now that CISO volunteers are resuming in-person attendance, requests from prisons have begun to increase.

"[R]ecent experience in our Corrections Independent Support Officer ('CISO') program indicates there has been no substantial change."

Other observations on the program include:

- Measures to improve prisoner understanding of the disciplinary hearing process and available supports have been delayed. My office developed a plain English poster to promote understanding of disciplinary hearings and the role of CISOs, which we did not distribute during the pandemic as we had only limited ability to attend remote hearings. However, the materials will be distributed shortly. We are not aware of any materials that have been developed by [DJCS].
- While CISO program staff were invited to attend a Prison General Managers Meeting in December 2021, other opportunities to promote the CISO program within prisons and relevant specialists units have not been provided.
- There have been only occasional requests for CISOs for prisoners with other forms of cognitive impairment.
- There has been no change in the integration of the CISO program into pre-hearing processes, including during the notification of charge.

Status of my recommendations

Implemented

0

In progress

5

Not started

1

Not accepted

0

Recommendation 1 - To the Department of Justice and Community Safety:

Recognising that robust merits review of decisions is likely to substantially mitigate the risk of unfair outcomes, develop and implement an internal review mechanism for disciplinary hearings, including, if necessary, through amendment to the *Corrections Act 1986* (Vic).

Accepted in principle | In progress

DJCS advised:

Work is being done to implement a review mechanism for General Manager Disciplinary Hearing decisions, including a review to determine if any policy amendments are required.

Corrections Victoria ('CV') has developed an audit tool to identify areas for focus, training and procedural development in relation to the hearings. The audit tool will capture the outcome of ten randomly selected hearings.

Recommendation 2 - To the Department of Justice and Community Safety:

Establish and invest in a dedicated team within DJCS to be responsible for conducting prison disciplinary hearings and related internal reviews, including staff with relevant operational and administrative decision-making expertise.

Accepted in principle | Not started

DJCS advised:

Two online learning modules have been developed for Disciplinary and Hearing Officers to strengthen their knowledge and consistency of practice. However, the roll out is on hold due to current demands and COVID impacts.

Relevant policies and documentation continue to be reviewed and strengthened including updating the General Manager's Disciplinary Hearing Training Manual.

Prison staff are continuing to refer matters centrally to the CV Operations Directorate for advice.

Recommendation 3 – To the Department of Justice and Community Safety:

Recognising the benefits in prisons conducting fewer and better-quality disciplinary hearings, develop and implement a strategy to reduce the number of minor offences that proceed to the hearing stage, including through a formalised and consistent minor offence process, behaviour management plans and other alternatives to disciplinary hearings.

Accepted in principle | In progress

DJCS advised:

CV has issued amendments to the Commissioner's Requirements (CR) and Deputy Commissioner's Instructions (DCI), providing alternatives to formal discipline, including a warning system, introducing behavioural management plans for repeat offenders, and strengthening minor offence processes.

Progress on a new incident category to record minor offences is underway but on hold due to the operational demands in prisons due to COVID.

Recommendation 4 – To the Department of Justice and Community Safety:

Amend Commissioner's Requirement 2.3.3 and related materials to require that Hearing Officers record brief written reasons for disciplinary hearing outcomes and penalties and make these available to prisoners upon request.

Accepted in principle | In progress

DJCS advised:

The CR and related materials have been amended. The yet-to-be rolled out training reiterates requirements.

The current Schedules populated by Disciplinary and Hearing Officers are already available for prisoners to view upon request and this messaging has been included in the June 2021 policy changes.

Further amendments of the CR and DCI are planned in relation to the process for a prisoner requesting a review of a disciplinary hearing.

Recommendation 5 – To the Department of Justice and Community Safety:

In consultation with the Office of the Public Advocate, develop and implement measures to improve prisoner understanding and experiences of the disciplinary hearing process and available supports, including through:

- a. development of plain English materials explaining the disciplinary hearing process and available supports
- b. expansion of the CISO program to provide assistance to prisoners with other forms of cognitive impairment
- c. improved integration of the CISO program into pre-hearing processes, including during the notification of charge
- d. identification of further opportunities to promote the CISO program within prisons and relevant specialist units.

Accepted in principle | In progress

DJCS advised:

- a. In July 2021, an easy English poster was distributed to prisons. A reminder was sent to staff to include this material in prison orientation and reception processes and in response to disciplinary matters. It has been reiterated that Disciplinary Officers and Hearing Officers must document all communication about CISOs.

On 1 July 2022 DJCS updated its policy to require staff to provide the Plain English Fact Sheet to prisoners with an intellectual disability when being charged with a prisoner offence.

A new Schedule will be developed to provide for greater record keeping, which will also capture refusals. CV will further review the accessibility of plain English materials and promotional strategies in consultation with OPA.

- b. The expansion of the CISO program is dependent on available funding and the support of OPA.
- c. Both the CR and DCI will be amended to include the requirement that a Disciplinary Officer provide prisoners with a recorded intellectual disability the poster on disciplinary hearings at the time a prison charge is issued. This is so that these prisoners are aware of the option to have a CISO attend their disciplinary hearing and the assistance that can be provided.

These amendments will also include the requirement that the OPA must be notified of every instance when charges are issued to a prisoner with a recorded intellectual disability, as opposed to the current requirement that notification must be made prior to the hearing date being confirmed.

- d. CV has promoted the previous expansion of the scope of the CISO program by including in the DCI that staff can engage with OPA to discuss cases where a prisoner has significant cognitive impairment, an Acquired Brain Injury or mental impairment, to ensure all consideration has been given to prisoner circumstances.

Further opportunities will be explored for CV to collaborate with the Prisoner Disability Support Initiative so that prisoners who may not previously have been identified as having a cognitive impairment are made aware of OPA and the CISO program.

Recommendation 6 – To the Department of Justice and Community Safety:

Recognising the significant record-keeping issues identified in this report, investigate opportunities to integrate disciplinary hearing processes and files into a centralised electronic records system.

Accepted in principle | In progress

DJCS advised:

In July 2021, amendments to CR and DCI have been reissued, reinforcing record keeping and communication between prisons and options to use video or telephone hearings.

Work continues towards the development of electronic record keeping as part of the Chisholm Road (now Western Plains) Prison project.

Funding is required to implement a centralised electronic record-keeping system. However, the implementation of the Prisoner Information Management System Minor Offence module will allow the centralised collection of a range of information relating to minor prison offences.

The current due date for implementing this recommendation is June 2022, subject to funding being secured.

Enhancing integrity and accountability

A central function of my office is to enhance integrity and accountability across the public sector. We do this by independently investigating serious matters and reporting on improper conduct and poor administration. The pandemic reinforced how crucial a strong underlying culture of accountability is. Whether in an emergency, or in 'normal' times, Victorians are entitled to expect public officials will act with honesty and transparency, manage resources appropriately and use power responsibly.

However, not all public sector employees put the public interest first. The *Public Interest Disclosures Act 2012* (Vic) provides for a broad range of conduct to be reported and investigated. While I do not publish the outcomes of most investigations of these disclosures, there are instances where the integrity breaches are so significant or cautionary that tabling a report in Parliament is in the public interest. These reports send an important signal to potential disclosers that reporting inappropriate behaviour is an essential part of safeguarding integrity. The reports are also a warning to those public sector employees who fall short of the high standards of conduct expected of them.

The recommendations from four such investigations are contained in this report – three relating to council staff, and one a school principal. Between them they covered themes examined all too often by our investigations. These include nepotism in recruitment processes, using public positions for personal or financial gain and misusing public money. In each case, disregard was shown for the processes and procedures intended to ensure accountability. In some cases, opportunities to spot and fix the problematic conduct were missed. Implementing the recommendations from these cases is important to restore and sustain public trust.

Victorians are entitled to expect public officials will act with honesty and transparency, manage resources appropriately and use power responsibly.



Investigation of alleged improper conduct by Executive Officers at Ballarat City Council

Tabled 14 May 2020

Why I investigated

I received eight whistle-blower complaints raising integrity concerns about two senior staff at the City of Ballarat, one of Victoria's largest regional councils. Most of these complaints alleged that the CEO and a Director gave friends or former colleagues preferential treatment in employment decisions.

What I found

Not all allegations raised in the eight complaints were substantiated. The investigation found the Director of Infrastructure and Environment was improperly involved in recruiting three former colleagues to senior roles. His conduct included changing a position description to better suit one of his associates after Human Resources raised concerns about their suitability for the original role.

The Director's tender practices were also inconsistent with the *Local Government Act 1989* (Vic) and he exercised poor judgement when making some purchases on his council card.

The investigation found the CEO's conduct was less serious, though she was involved in decisions regarding two staff which were unwise at best, and possibly improper.

Senior officers must lead by example. They set a culture in which accepting poor practice can become the norm. Poor management of conflicts of interest – actual or perceived, deliberate or otherwise – leaves an organisation vulnerable to accusations that can fundamentally damage its integrity.

What's happened since

This investigation produced some valuable lessons for the entire local government sector. It serves as a warning for all senior officers to be more mindful of conflicts of interest – be they actual or perceived – and of managing them appropriately.

Since I tabled my report on 14 May 2020, the CEO and the Director have left the Council. In response to my report, the Council commissioned a procurement audit report and a review of governance and culture. The Council has advised these informed revised policies and procedures, and a cultural change program.

Status of my recommendations

Implemented

1

In progress

0

Not started

0

No longer relevant

1

Recommendation 1 - To City of Ballarat:

Establish an arrangement by June 2020 under which Council consider the findings of this report in respect of Council's CEO, and take such action, if any, in respect of those findings as it determines is appropriate.

Accepted | Implemented

The CEO's employment was terminated following a resolution in Council on 18 May 2020.

Council advised it:

- engaged an external consultant to conduct an in-depth review of procurement and supplier management issues
- prepared treatment plans to address identified risks
- developed and implemented a new Procurement Policy that outlines the procurement framework for purchasing of all goods, services and materials ... including: detailed procurement controls for whole-of-lifecycle procurement; quoting; tendering; conflicts of interest and acquisition of gifts and assets
- undertook an in-depth independent review of project management methodology that will inform the development of enhanced procurement practices consistent with best practice with business cases including whole of life costing, staged approval processes and verification for all projects over an identified value within Procurement Policy
- updated and implemented a revised Corporate Purchase Card Procedure including monthly review of delegation limits, enforced education prior to issuing cards; and removal of clause permitting Chief Executive Officer exemptions enabling personal transactions
- updated and implemented the Gifts and Hospitality Procedure and included education on registering items received within the procedural guidelines modelled on industry best practice
- engaged an external consultant to conduct a Governance and Culture Assessment Review
- revised its Recruitment and Selection Procedure. The changes ensure that recruitment and selection decisions, including promotion, are transparent and based on merit. Additional changes included development of an independent panel member register, to be used where internal staff are involved in recruitment process, additional training for staff involved in recruitment panels on best practice interview techniques, and a revised approach to capture and record conflicts of interest identified during the recruitment process.

Recommendation 2 - To City of Ballarat:

That the Council CEO consider whether to take disciplinary action or management action in respect of Council's Director, Infrastructure and Environment.

Accepted | No longer relevant

The Director tendered his resignation to Ballarat City Council on Monday 18 May 2020.



Investigation of protected disclosure complaints regarding the former Principal of a Victorian public school

Tabled 15 February 2021

Why I investigated

A complaint about a Principal using school funds for private purposes was referred to me by IBAC. School staff were allegedly asked to co-sign cheques made out to 'cash', with the Principal collecting the proceeds. The complaint also alleged the Principal failed to follow procurement and recruitment processes.

These allegations raised questions about lingering weaknesses in the financial governance of our schools, despite significant reforms introduced by the Department of Education and Training ('DET') since 2016.

What I found

My investigation found the Principal misused cash cheques to deposit thousands of dollars into his personal bank account, effectively using school funds as a line of credit. The Principal had not disclosed his past bankruptcy during the hiring process and the selection panel was unaware of it, despite the role overseeing a \$10 million budget.

The Principal also failed to comply with procurement policies by 'invoice splitting' for a \$280,000 shade sail project and \$300,000 of other building works. Invoice splitting spreads the cost of one project across multiple invoices to avoid reaching a threshold where a tender process would be required.

The school's business manager lacked the qualifications and experience to challenge the Principal, as did the school council. DET also missed some red flags which might have uncovered the problems sooner.

What's happened since

My recommendations aimed to improve the ability of school councils and DET to hold Victorian principals to account. They built on good progress DET had already made toward strengthening financial controls in schools following previous Ombudsman and IBAC investigations.

DET reports it has tightened guidance on financial vetting of external candidates for principal roles, including extra probity checks. It has also introduced a professional competency assessment into its principal recruitment process.

DET has updated its school governance training materials and annual school certification checklist to increase awareness among school councils of the relevant policies, procedures and training available to support them in holding principals to account more effectively.

Status of my recommendations

Implemented

3

In progress

0

Not started

0

Not accepted

0

Recommendation 1 - To the Department of Education and Training:

That DET consider further auditing the Principal's financial activities when he was Principal at the School and decide whether to formally refer his conduct to Victoria Police.

Accepted | Implemented

DET advised:

DET carefully considered whether any further audit of the now former Principal's financial practices was warranted and ultimately decided not to take any further action. In forming this view, DET took into account the considerable efforts by the Ombudsman to forensically examine cash cheque transactions, and the lack of records or information relating to transactions available in the investigation.

DET assessed that further auditing of possible invoice splitting could be undertaken. However, as the Ombudsman investigation did not find misappropriation, but rather policy non-compliance, on balance an audit was not considered to be likely to offer further value to DET. DET provided Victoria Police with a copy of the Ombudsman's report. Victoria Police has not advised that their initial assessment to take no further action has changed.

Recommendation 2 - To the Department of Education and Training:

That DET introduce into principal recruitment material, guidance on making probative financial enquiries in relation to preferred principal candidates, to enable DET to reasonably assure itself of the candidates' financial management capability.

Accepted | Implemented

DET advised:

DET has made changes to the Principal Selection Guide to include additional probity requirements, particularly Australian Securities and Investment Commission and Association of Superannuation Funds Australia checks, for external applicants and employees of registered Victorian non-government schools.

DET considers the current controls in place for existing employees being appointed into principal roles are adequate. The Victorian Aspiring Principal Assessment (VAPA) has been introduced as a qualification requirement for appointments to principal positions. New appointments are now required to have completed this assessment, (if they are not a substantive principal of a registered school in Victoria) which includes consideration of the applicant's capacity to lead the management (including financial management) of the school. DET is therefore satisfied that completion of the VAPA will enable it to reasonably assure itself of the candidates' financial management capability.

In relation to those who are already a principal in a government school, DET considers a selection panel is likely able to more effectively assess demonstrated capacity in management of financial resources for internal and already substantive principal candidates.

Recommendation 3 – To the Department of Education and Training:

That DET introduce into its governance material for school council members, a requirement for school council members to attest to their knowledge and awareness of the policies and procedures that apply to their roles and that they are aware of the online training and support available from DET.

Accepted | Implemented

DET advised:

In implementing this recommendation, DET sought to strengthen existing systems, processes and assurance mechanisms to ensure that school council members are made aware of the policies and procedures that apply to their roles, and the training and support available to them. This has been done by:

- updating training materials in relation to school council governance to note that principals are required to remind school councillors in the first meeting of the new council each year about their financial responsibilities and the policies and procedures that need to be followed, in addition to providing councillors with information about the support and training available
- issuing correspondence to principals early in Term 2, 2022 which notified them of the requirement set out above and the obligation to table the correspondence in the first instance at the next school council meeting
- updating the annual Schools Certification Checklist, to require principals to attest to having reminded school council members of the policies, procedures, training and support relevant to their roles.



Investigation into corporate credit card misuse at Warrnambool City Council

Tabled 9 October 2020

Why I investigated

IBAC referred to me multiple allegations of credit card and other financial misuse at Warrnambool City Council. Local media had also featured these claims in reports with headlines such as *Eye fillet, pork belly and seafood linguine – your rates at work*, a reference to overly generous hospitality spending. Given the widespread community speculation raising integrity and accountability concerns, I started an ‘own motion’ investigation.

What I found

My investigation found a Council manager misused his corporate credit card to claim at least \$8,000 worth of goods and services which were excessive or for his personal benefit. The manager had submitted some invoices that concealed the true nature of the goods and services obtained.

Based on the records reviewed, the investigation concluded credit card misuse at the Council was limited to one individual and not widespread. However, there was evidence of lax practices by staff and poor judgement by some senior managers. The failure to order an audit when problems first surfaced meant further inappropriate transactions went unidentified and left the Council exposed to further fraud.

The investigation also found public confidence in the integrity of Council officers was undermined by a strategy which encouraged staff to hold work-related meetings at local cafes and restaurants. While this was well-intentioned, poor adherence to process, and insufficient oversight fed negative community perceptions.

What’s happened since

The manager resigned from the Council after repaying \$8,200. The Council has implemented all recommendations from two audit reports, resulting in strengthened policies, greater oversight and increased staff awareness of fraud and corruption risks. Fewer credit cards are now in use, and staff with cards must complete an online training course.

It is notable that in 2021, a further instance of alleged credit-card misuse was identified by Council staff. The Council attributes the identification of this apparent misuse to an improved culture and awareness resulting from the formal corruption training provided to credit card holders following the completion of my investigation.

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To Warrnambool City Council:

Council consider the findings of this report, make further enquiries as necessary regarding the manager’s credit card use, and consider referring the matter to Victoria Police.

Accepted | Implemented

Council advised:

The matter was considered and referred to Victoria Police, Warrnambool Criminal Investigation Unit on 26 October 2020.

Recommendation 2 - To Warrnambool City Council:

Council reconsider the number of corporate credit cards in use and the rationale of the issuing of cards.

Accepted | Implemented

Council advised:

In August 2021, the number of credit cards held by council staff was 65 compared to 81 held in November 2019 at the time of the previous internal audit.

Council has implemented a business case form that employees must complete when they apply for a credit card. This form includes a statement that the credit card holder has read and understands the credit card policy. The form is approved by the relevant Director. They are also required to complete an online training session each year.

Council also reports on the compliance and timeliness of cardholders and cardholder approvers on a quarterly basis to the Executive Team with recommendations for warnings or suspensions of cards for non-compliance. There is an annual review conducted by each Director to determine whether the cardholder has an ongoing business need for the card and whether the credit limit is appropriate for the role.

These measures that have been introduced provide Council with comfort that the number of cards within the organisation is appropriate and matched to the business need within each area.

Recommendation 3 - To Warrnambool City Council:

Council implements the recommendations of the two audit reports and report their progress to the Ombudsman within six months.

Accepted | Implemented

Council has implemented all recommendations of the two audit reports.



Investigation into Melton City Council's engagement of IT company, MK Datanet Pty Ltd

Tabled 9 June 2021

Why I investigated

IBAC referred to me a disclosure about a City of Melton officer failing to declare a conflict of interest with a company awarded a three-year contract to provide about \$1.3 million in IT services. The disclosure also raised concerns about whether the company was delivering the work it was contracted to do.

What I found

City of Melton officer 'Mr M' misused his position to recommend a company he effectively owned, MK Datanet, for a major IT contract. Mr M did not disclose any conflicts of interests despite helping to prepare the tender submission he later evaluated. He also used two other IT companies he controlled to provide fake quotes to give the appearance proper processes were followed.

The investigation identified multiple failings that allowed Mr M to get away with his deception. These included layers of contractual arrangements helping mask his associations, limited oversight of his work and a worrying lack of due diligence in the Council's tender and procurement processes.

What's happened since

The investigation raised important questions about proper procurement oversight and controls which are relevant to other councils and agencies. The City of Melton undertook significant work in response to my recommendations.

The Council referred Mr M's conduct to Victoria Police and the Australian Securities and Investments Commission. It considered the integrity risks raised in the report, including conflicts of interest, transparency in labour hire arrangements and tender practices. It has strengthened its practices in these areas. The Council states that staffing changes in the IT and procurement areas will improve its oversight. The Council invested in probity, procurement and contract management training, and now ensures non-permanent staff also complete mandatory induction modules. The Council reviewed the adequacy of MK Datanet's services and is in the final phase of its plan to address identified deficiencies.

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To the City of Melton:

That the Council consider the integrity risks identified in this report relating to conflict of interest and transparency in labour hire arrangements when developing and reviewing its policies and procedures as part of the implementation of the *Local Government Act 2020 (Vic)* and advise the Ombudsman of the steps taken to address these risks by 31 December 2021.

Accepted | Implemented

Council advised:

In relation to recruitment processes:

- A statement by all candidates acknowledging, understanding and committing to an undertaking to adhere to the following was introduced for all labour hire/fixed term candidates prior to commencement: the Code of Conduct, Child Safe Policy and Procedure, Discrimination, Harassment & Bullying Policy and Procedure, Privacy and Occupational Health and Safety Policies.
- Council's People and Culture team have provided a manager's induction guide and checklist for engagement of labour hire and fixed term staff – reminders on aspects of the Code of Conduct including Conflict of Interest requirements are communicated to staff by email.
- From late 2020, Council's LEARN Melton licence was extended so that compulsory online induction modules deployed to direct employees are also required to be completed by labour hire and fixed term staff.

In relation to Procurement/Tendering compliance:

- Recruitment of a Procurement Co-ordinator so the Procurement Manager can fully focus on the higher-level risk and strategic elements of the role.
- Transitioning from a decentralised procurement model to a centre led model in order to provide increased support and oversight of procurement activities across the organisation.
- Engaged a consultant/the Municipal Association of Victoria to conduct an external desktop review of Council's procurement maturity and opportunities.
- Invested in a more comprehensive online training programme with modules in the areas of probity, procurement and contract management.
- Providing training workshops for all council departments involved in procurement outlining procurement better practice principles.
- Increased oversight of purchasing and procurement activities through data analytics tests in the areas of Accounts Payable and Purchasing/Procurement.

Improvements to management and oversight of staff in the Information Management department include:

- Implementation of a new Information Technology departmental structure that will best support the organisation in being able to meet its objectives, including moving all procurement/tendering processes inhouse.
- Creating an IT supplier position and Professional Services Panel to ensure all procurement of related services are from suppliers that have been assessed for 'best value', selected through a transparent process to avoid conflict of interest issues.
- Transitioning to a whole of local government panel of providers that has been established by the Municipal Association of Victoria and Procurement Australia.
- The Information Technology department participated in the Municipal Association of Victoria Specification to Evaluation Training implemented by the organisation to improve organisational procurement.
- Introduction of a Procurement Process declaration to be completed before any tender is presented to Council.

Recommendation 2 - To the City of Melton:

That the Council, within six months of receipt of the Ombudsman's report, advise the Ombudsman of any steps taken to address the concerns raised in relation to Allegation 2 about the adequacy of the services provided to the Council by MK Datanet.

Accepted | Implemented

Council reported to the Ombudsman on its three-phase approach to addressing this recommendation. The first two phases are complete, with a further update to be provided.

Recommendation 3 - To the City of Melton:

That the Council consider referring the issues raised in this report in relation to Mr M's conduct, to Victoria Police and the Australian Securities and Investments Commission.

Accepted | Implemented

Council advised:

The matter has been referred to the Victorian Police and the Australian Securities and Investment Commission who will review the matter.

Supporting improvement and innovation

An important part of our work is fostering improvement by assisting public agencies to learn from complaints. We do this by investigating systemic issues and identifying solutions. A lot of behind-the-scenes effort is devoted to engaging widely across the public sector. We run education programs on good complaint handling and managing conflict of interest risks. Our team also works with departments and agencies to informally and efficiently resolve thousands of complaints every year.

Our activities are valuable learning opportunities to help public service providers improve their programs and services. Even a single complaint has the potential to help identify pressure points citizens are encountering, identify staff training and development needs, and strengthen quality assurance processes.

Though much effort goes toward preventing small issues from growing into larger ones, systemic issues do arise. An example is the influx of complaints we received about the Victorian Government's Business Support Fund, a \$10,000 grant aimed at providing short-term relief for those affected by COVID-19 lockdowns. To their credit, the Department of Jobs, Precincts and Regions ('DJPR') engaged constructively with us throughout our investigation, resolving large numbers of complaints and improving its processes along the way.

Similarly, our investigation into how councils respond to ratepayers in hardship is not only improving outcomes for struggling homeowners who fall into debt, it also demonstrated how our practical advice supports better public administration.



Investigation into the Department of Jobs, Precincts and Regions' administration of the Business Support Fund

Tabled 26 April 2021

Why I investigated

A flood of complaints from struggling business owners denied \$10,000 grants from a COVID-19 support package prompted this 'own motion' investigation. DJPR set up the Business Support Fund to provide critical and fast financial support in the early stages of the pandemic. For many, the scheme worked well. However, for too many others it did not. By September 2020, more than 600 people had complained to my office about the fund. The high volume of business owners denied a financial lifeline as they fought to stay afloat pointed to systemic failings.

What I found

DJPR had just nine days to implement the program after it was announced. This time pressure to make grants available quickly meant the fund was launched with an untested system. An initially under-staffed contact centre could not handle the queries. Extra staff hired to help did not have access to DJPR's case management system. Business owners had trouble getting information about the status of their application or were given incorrect, conflicting or generic responses.

The complexity of the application process and the inflexibility of DJPR's initial decision making also caused confusion and frustration. Compounding matters was the lack of a publicly accessible complaints and review process, with DJPR effectively outsourcing the complaints process to my office.

To its credit, DJPR made some changes even as the investigation was ongoing, including reassessing some applications, improving the online application process, and more actively assisting business owners.

What's happened since

My report made six recommendations. Implementing my first two recommendations led to thousands of rejected applicants being invited to reapply. More than 4,200 have done so successfully, collecting a combined \$42 million in financial support. The other recommendations aimed to improve processes for future grant schemes.

The vital lesson from my investigation is the need for effective communication and a robust internal review and complaints process. These are crucial for good public administration, especially in a time of crisis. To this end, DJPR is working with other departments to review the whole-of-government *Better Grants by Design* guidelines.

On an operational front, DJPR reports that changes to the Business Victoria hotline will improve responses to future peaks in demand. They have increased the information people answering calls have access to so they can respond directly to customer enquiries. DJPR has also developed a set of principles and service expectations for grant program administration and made Business Victoria's complaint and review options more transparent.

It is worth noting that beyond the initial support fund complaint spike in 2020, my office received an increase in complaints shortly after my report was tabled and during a further lockdown in the second half of 2021.

People complained about Business Victoria's policy decisions, receiving conflicting advice, delayed outcomes and deficient internal review decisions.

Given the unprecedented number of grants processed by Business Victoria, it is key that it works efficiently at scale and delivers good administration regardless of volume. We have written to DJPR about these issues, which I continue to monitor.

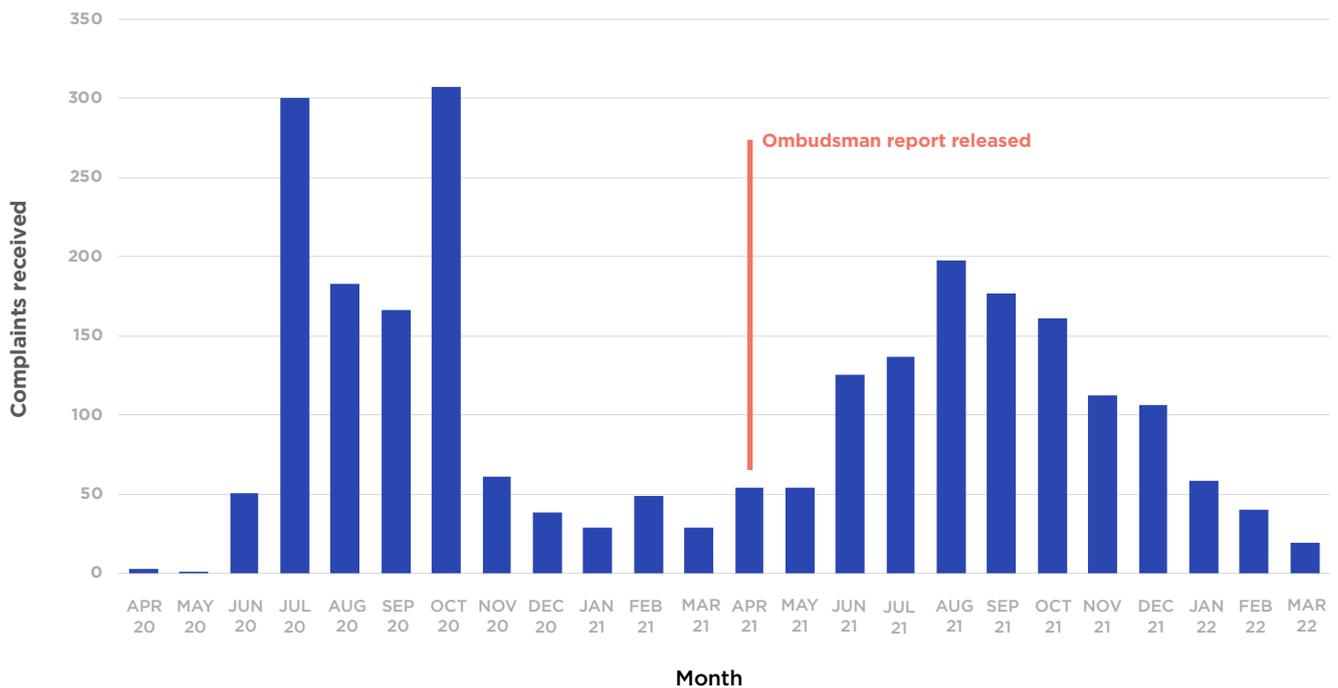
[Business Victoria] said it was only the escalation team who will deal with me ... but I can't contact the escalation team. So, I waited six months and I decided to lodge the complaint [with the Ombudsman] and within a couple of weeks someone from Business Victoria called me and resolved the issue.

- A business owner, on correcting the ABN on their grant application

I appreciate your efforts in whatever happened behind the scenes. It makes a huge difference to us.

- A business owner, after \$47,000 of grants were approved

Figure 4: Complaints to the Ombudsman about the Business Support Fund, April 2020 - March 2022



Source: Victorian Ombudsman

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To the Department of Jobs, Precincts and Regions:

Invite business owners from the following classes to reapply to the Business Support Fund - First Round:

- a. those whose applications were returned for revision and placed back into 'draft', who did not complete the application before the Fund closed
- b. those who were assessed as ineligible for Stream One of the Fund based on their ANZSIC class, who did not apply for Stream Two and who were enrolled in JobKeeper
- c. those who made typographical errors when applying which affected the outcome of their application
- d. those who provided JobKeeper information but not via the link in the email from DJPR.

DJPR should advertise its willingness to reconsider applications from these business owners on the Business Victoria website.

Accepted | Implemented

DJPR advised:

DJPR invited 10,680 businesses to apply for a reassessment of their Business Support Fund application.

In addition to invitations to the applicants, DJPR widely publicised the opportunity for unsuccessful Business Support Fund applicants in the above categories to have their application reassessed.

DJPR devoted specific webpages on the Business Victoria website to alert applicants of its willingness to reconsider applications. Approximately 397 businesses requested a reassessment though completing an expression of interest form on the website.

DJPR also reviewed all complaints where the applicant referenced a typographical error affecting the outcome of their application.

There were 5,337 unique applications resubmitted and 3,472 (65 per cent) were found to be successful.

Recommendation 2 – To the Department of Jobs, Precincts and Regions:

Communicate with business owners whose applications were rejected because they were not registered with Australian Securities and Investment Commission ('ASIC'), inviting them to reapply if they:

- a. subsequently had their ASIC registration backdated
- b. applied with business entity details with which DJPR could not establish ASIC registration and who can now provide evidence of registration or exemption from a requirement to be registered.

DJPR should advertise its willingness to reconsider applications from these business owners on the Business Victoria website.

Accepted | Implemented

DJPR advised:

DJPR invited 1,175 businesses to be reassessed. There were 827 unique applications for reassessment submitted and 733 (89 per cent) of these were found to be successful.

Recommendation 3 – To the Department of Jobs, Precincts and Regions:

Work with the Department of Treasury and Finance to update its *Better Grants by Design* framework to include guidance on administering time critical grants.

Accepted | In progress

DJPR advised:

DJPR is working with the Department of Treasury and Finance ('DTF') and the Department of Premier and Cabinet in relation to a review of the whole of Victorian Government *Better Grants by Design* guidelines.

DJPR has provided a consolidated list of recommended changes to DTF and we expect to have this recommendation acquitted by mid-late 2022, dependent on DTF's internal processes. DTF has indicated that it is likely the document would be updated by approximately the end of the 2021/22 financial year.

Recommendation 4 – To the Department of Jobs, Precincts and Regions:

Develop service delivery principles for grant program administration which includes:

- a. timelines for acknowledging applications and communicating outcomes
- b. information about how to complain
- c. processes for seeking a review of the outcome.

Accepted | Implemented

DJPR advised:

DJPR has developed a specific set of principles and service expectations for grant program administration that directly address this recommendation and has embedded these into relevant guidance material for future grant programs.

DJPR's service principles include that:

- Program Guidelines must set a clear timeline for acknowledging receipt of applications, with a commitment to acknowledge the receipt of applications within 2 business days
- Program Guidelines must set a clear timeline for communicating the outcome of an application
- DJPR must have in place clear processes for applicants to be able to request a review of their outcome
- DJPR must have in place a clear process for applicants to be able to lodge a complaint
- Information must be provided to all applicants advising how to request a review and/or lodge a complaint.

Recommendation 5 – To the Department of Jobs, Precincts and Regions:

Update the complaint handling process now published on the Business Victoria website to include detail about internal and external review avenues, including the Victorian Ombudsman.

Accepted | Implemented

DJPR advised:

The complaints page on the Business Victoria website has now been updated to include information on internal and external review processes. This information is available in the FAQs under the heading *What other review or complaint options are available to me?*

Recommendation 6 – To the Department of Jobs, Precincts and Regions:

Provide external contractors in its call centre with information that will allow them to provide detail about an application’s status and other relevant details to ensure responsive service to businesses.

Accepted | Implemented

DJPR advised:

DJPR has increased the capacity and capability of the Business Victoria Hotline to respond to peak demand.

Improved information (particularly about reasons for an applicant being assessed as unsuccessful) is being provided to all Hotline staff to help them respond directly to customer enquiries and minimise the need for calls to be escalated.

In line with the Ombudsman’s recommendation, DJPR has provided read-only access to its database to the Business Victoria Hotline. This required a substantial amount of systems development to protect the privacy of businesses and ensure that only relevant grant and assessment information was displayed.

An initial trial of access for 20 senior Hotline staff commenced on 13 August 2021 was successful and is now being expanded. This will ensure that the Hotline is able to more effectively respond to enquiries from applicants for all current funding programs.



Investigation into how local councils respond to ratepayers in financial hardship

Tabled 5 May 2021

Why I investigated

In recent years, I had heard concerns from ratepayers, financial counsellors and community lawyers about the way local councils treat people who cannot afford their council rates. With the COVID-19 pandemic threatening to increase financial hardship, I decided it was timely to commence an 'own motion' investigation.

What I found

All Victorian councils offered financial relief to ratepayers in the early stages of the COVID-19 pandemic, and some had good approaches to financial hardship generally. However, common underlying problems meant that as a whole council hardship practices compared poorly with sectors such as banking and utilities.

Many people struggling to pay rates were told their only option was a payment plan to reduce debt over time. Laws gave councils the power to defer or waive rates, but some were not telling people about these options or had a blanket policy to refuse. Councils relied too heavily on debt collectors which can be stressful and frightening. People in hardship were also charged high penalty interest on top of existing debts. Some councils took legal action over unpaid rates, including against victims of family violence and those with mental health issues.

What's happened since

To better protect ratepayers, my report recommended changing the *Local Government Act 2020* (Vic) and regulations to set minimum standards for rate hardship relief for all councils.

It also proposed capping penalty interest rates, improving oversight of debt collectors and providing better public information about people's rights and options.

My report was released as the Victorian Government began to introduce reforms in response to the *Local Government Rating System Review*. That review involved an in-depth analysis of Victoria's rates system which extended well beyond financial hardship. As with our investigation, it recommended improvements to help those struggling to pay, along with many other changes to the broader system.

Pleasingly, the *Local Government Legislation Amendment (Rating Reform and Other Matters) Bill 2022* (Vic), introduced into Parliament to address my recommendation of legislative reform, received royal assent on 9 August 2022.

The observations from WEstjustice and Financial Counselling Victoria, both received before the Bill was announced, indicated some improvement in the wake of my report in the handling of hardship by local councils, although this remains an area we will continue to monitor. Outcomes flowing from the amendments to the Local Government Act will further assist councils and ratepayers, particularly given the increasing concern surrounding the cost of living and the ongoing impacts of COVID-19. I look forward to progress updates and welcome any opportunity for my office to comment on the Regulations and Ministerial Guidelines as they are developed.

Observations from WEstjustice, Western Community Legal Centre

Over many years WEstjustice has raised concerns that local councils have not kept up with the evolving understanding and community expectations around financial hardship and consumer vulnerability, especially with respect to economic abuse and family violence. Having the Ombudsman investigate how local councils respond to ratepayers in financial hardship ensured that our concerns were heard and taken seriously. And while the findings in the Ombudsman's report were no surprise to consumer advocates, seeing them reported by the Ombudsman validated the issues that community legal centres and financial counsellors have long been raising.

Whilst it is too early to notice any significant changes at local government level yet, the Ombudsman's report has been the catalyst in sparking significant future changes. Real changes will flow on from this reform, such as changes to hardship policies, family and domestic violence policies and limiting the use of courts to sue ratepayers.

“Whilst it is too early to notice any significant changes at local government level yet, the Ombudsman's report has been the catalyst in sparking significant future changes.”

Observations from Dr Sandy Ross, CEO, Financial Counselling Victoria

There has been a generally reduced level of concern amongst financial counsellors about the ways in which local councils respond to ratepayers experiencing hardship, but it is unclear how much of this is due to the pandemic, and temporary changes in council processes, especially the suspension of pursuit of debts.

Councils that have a good approach to hardship continue to do well and garner respect from financial counsellors for their compassion and respectful approach. There is some evidence that your report (and perhaps other advocacy) has had some impact on Councils that have historically had a more problematic approach. Generally speaking, financial counsellors have felt encouraged by the report and noticed shifts here and there in local council attitudes. However, this is not entirely easy to be confident about.

For example, I spoke with financial counsellors in a regional town who commented that, following the report, the local council ... had established a policy on responding to hardship. This council had not previously had such a policy, and this represented a clear, positive impact. That said, interactions with the council in recent weeks suggest the policy might be more window dressing than representative of real change. Ratepayers in hardship approaching that council have apparently been 'required to see' a financial counsellor to 'be assessed', with the council suggesting it will then act on financial counselling recommendations ...

From our perspective, there is a way to go with local councils [with regard to financial hardship], which is not entirely surprising given the complexity and depth of changes needed to both procedures and culture in many of them.



Case study: Penalty interest pain adds to ratepayers' financial hardship

For more than a decade Dorothy and Henry* struggled to pay their annual council rates. Over that time, almost \$9,000 in penalty interest accrued on top of their original bills.

The ratepayers told their financial counsellor they had faced hardship for many years as they grappled with the impact of bushfires, physical and mental illness, and other difficult personal circumstances.

They said they had negotiated various payment arrangements with the Council to reduce the outstanding rates, however the penalty interest kept growing. After multiple missed payments in 2019, the Council referred the matter to a debt collector.

For the first time, Dorothy and Henry submitted a formal hardship application in writing to the Council. They continued making payments, offering up to \$300 per fortnight toward their debt, however this was prolonging their hardship.

After reviewing their situation in late 2021, their financial counsellor asked the Council to waive the entire penalty interest component.

The Council offered to waive about \$1,250 in interest accrued since 2019 when the first formal hardship application was received. It also suggested contacting a councillor to put forward a motion at a council meeting to have the entire interest debt waived.

The financial counsellor rejected the council's offer and approached my office in March 2022.

When my Early Resolution team contacted the Council, it acknowledged striking multiple payment arrangements with the ratepayers since 2008. It said hardship was first raised as an issue in discussions with Dorothy and Henry in 2016 but that paperwork it sent them to complete was not returned.

We suggested to the Council that given its knowledge of the pair's long-term payment difficulties, its approach did not seem reasonable. We noted the suggestion to ask a councillor to raise a motion at a council meeting seemed too onerous.

As my 2021 investigation into rates hardship concluded, penalty interest is meant to punish people who do the wrong thing, not to drive people in hardship further into debt.

As my 2021 investigation into rates hardship concluded, penalty interest is meant to punish people who do the wrong thing, not to drive people in hardship further into debt.

After the enquiries by my office to informally resolve the matter, the council agreed to waive all penalty interest accrued by Dorothy and Henry since 2010.

* not their real names

Figure 5: Media announcement of financial hardship reforms

Media Release

The Hon Shaun Leane MLC
Minister for Local Government
Minister for Suburban Development
Minister for Veterans



Wednesday, 8 June 2022

GIVING RATEPAYERS A FAIR GO

The Andrews Labor Government is ensuring people struggling to pay their rates are not being driven further into debt or out of their homes.

Minister for Local Government Shaun Leane will today introduce legislation into Parliament which will support Victorian property owners by ensuring councils implement fairer financial hardship policies.

The Local Government Amendment (Rating Reform and Other Matters) Bill 2022 will explicitly define financial hardship and require early engagement from councils with ratepayers.

Councils will also no longer be able to use debt collectors or pursue legal action - which can result in homes being sold to pay back debts to council - unless ratepayers refuse to engage and all other options have been exhausted.

During the pandemic many councils expanded their hardship policies to provide relief to those doing it tough and started engaging earlier with ratepayers who fall into debt – this Bill ensures councils do not revert to past practices.

It comes following the release of the Local Government Rating System Review and the Ombudsman’s ‘Investigation into how local councils respond to ratepayers in financial hardship’ report, with recommendations relating to greater support for ratepayers in financial hardship.

The Ombudsman’s report found that people who were struggling to pay their rates were often meet with debt collectors, high penalty interest and in some cases costly litigation.

This creates more stress and fear for those who are already struggling financially and or dealing with a range of compounding issues, including family violence and mental health.

The Bill will allow the Minister, in consultation with the Essential Services Commission, to set a maximum amount of interest levied on unpaid rates and charges, and Ministerial Guidelines to assist ratepayers experiencing financial hardship will be developed for councils to follow.

Councils will also be limited in using Magistrate’s Court orders for recovering unpaid rates in situations where rates or charges have not been paid for two years or more.

For more information on the Local Government Rating System Review visit localgovernment.vic.gov.au.

To view the ‘Investigation into how local councils respond to ratepayers in financial hardship’ report visit ombudsman.vic.gov.au/our-impact/investigation-reports.

Quotes attributable to Minister for Local Government Shaun Leane

“We know that many Victorians are doing it tough and that’s why we are working to reform the rating system.”

“Good hardship relief schemes strike a balance where the rate burden is shared while ensuring people in hardship are not driven further into debt or out of their homes.”

Source: Premier of Victoria Media centre

Status of my recommendations

Implemented



In progress



Not started



Not accepted



Recommendation 1 - To the Minister for Local Government and the Assistant Treasurer:

Stronger laws and standards

Seek changes to relevant local government legislation and regulations to:

1. ensure a clear, consistent definition of 'financial hardship'
2. empower the Essential Services Commission and the Minister for Local Government to issue standards (in the form of a code of practice or guidelines) for rates hardship relief, including where rates debts are associated with family violence
3. require councils to have a rates hardship policy. The policy should include provisions related to economic abuse associated with family violence
4. require councils to include hardship relief information on their websites and rates notices
5. give councils discretion to waive or defer rates and interest for individual ratepayers without an application
6. recognise payment plans or arrangements as one of the statutory options for responding to ratepayers in financial hardship, along with waivers and deferrals
7. provide for the Minister for Local Government and the Essential Services Commission to set a maximum interest rate that may be charged by councils where a ratepayer is complying with the conditions of a payment plan or arrangement or a deferral
8. require councils to make reasonable efforts to contact a ratepayer before taking legal action to recover unpaid rates
9. require councils to report data on rates hardship relief through the Local Government Performance Reporting Framework (or another appropriate reporting mechanism).

Accepted | In progress

The Minister for Local Government advised:

In consultation with the Assistant Treasurer, the Minister for Local Government is developing new arrangements for unpaid local government rates and charges and the treatment of ratepayers facing financial hardship.

These new arrangements will seek to:

- define the circumstances or conditions that result in hardship, including family violence or loss of employment
- set out standards for council financial hardship policies
- improve practices by councils with regard to the collection of unpaid rates and charges, including the use of debt collection agencies
- waive interest on unpaid rates and charges for those on payment plans or subject to a deferral
- make legal action a last resort.

The Essential Services Commission will have a key role in providing advice on standards and maximum interest rates under the new arrangements.

These reforms are being developed in conjunction with reforms recommended and accepted by the Government in the *2020 Local Government Rating System Review* final report.

Recommendation 2 - To Local Government Victoria:

Building knowledge and skills

Work with the Essential Services Commission, councils and local government professional associations to develop training and guidance material (such as model hardship policies) on dealing with rates hardship applications and debt recovery, including in relation to the following matters:

1. identifying indicators of financial hardship
2. assessing financial hardship applications and determining the most appropriate relief options
3. identifying indicators of family violence and responding to ratepayers who have disclosed family violence.

Accepted | In progress

Local Government Victoria advised:

DJPR is supporting the Minister for Local Government to develop new arrangements for the treatment of unpaid rates and charges and ratepayers facing financial hardship.

DJPR has also commenced work with local government sector peak bodies on improving financial hardship practices and will continue this work more broadly with the sector through future iterations of the *Local Government Better Practice Guide for Revenue and Rating*. A new edition is to be developed and published this year.

This ongoing work will be informed by the Victorian Government's response to the *2020 Local Government Rating System Review* final report.

The government has committed to ensuring that the rating system is set out in primary legislation and provides transparent and flexible ways for councils to treat ratepayers facing financial hardship fairly. Support and guidance to the local government sector will also be aligned with the best practices of the State Revenue Office and Australian Taxation Office wherever possible, alongside the advice of stakeholders such as the Essential Services Commission.

Recommendation 3 - To Local Government Victoria:

Use of debt collectors

Work with councils, the Municipal Association of Victoria and Procurement Australasia to ensure that arrangements with debt collection agents:

1. are subject to clear and enforceable standards
2. require debt collection agents to comply with the Australian Competition and Consumer Commission and Australian Securities and Investment Commission guidelines for debt collection
3. require debt collection agents to be familiar with and comply with council rates hardship policies
4. require debt collection agents to inform ratepayers of all statutory options available for hardship relief
5. refer ratepayers who disclose financial hardship to the council for consideration.

Accepted | In progress

See response to Recommendation 1

Recommendation 4 - To Local Government Victoria:

Building collaboration

Work with the Essential Services Commission, councils and local government professional associations to build regular and ongoing consultation with financial counsellors, community legal groups and other sectors and organisations that work with people in financial hardship.

Accepted | In progress

See response to Recommendation 2

Protecting human rights

The Ombudsman has always played a vital role in assessing whether actions and decisions are compatible with human rights, and in making it easier for people to complain about possible breaches. Victoria's Charter of Rights Act sets out 20 protected rights and freedoms. It recognises all people are born free and equal in dignity and rights, subject to reasonable limitations.

My office actively prioritised COVID-19 related human rights complaints as the pandemic took hold. We did this to encourage a culture of human rights compliance across the public sector and to avoid any perception that in a state of emergency, human rights somehow matter less. COVID-19 concentrated the minds of many on human rights, as freedoms once taken for granted were limited to help keep the community safe.

Among the most high-profile of the matters we investigated involved the sudden lockdown of some inner-Melbourne public housing towers. Our review exposed a failure to properly consider the human rights of thousands of residents. Though the Victorian Government did not accept my recommendation to apologise to these people, many other changes have flowed from this report which I hope will promote and protect the rights of Victorians in future.

Another strong reminder that human rights considerations apply to everyone, regardless of where they live or their background, was our investigation into the assaults of five children in state care. The report showed a stretched system struggling to meet the rights of vulnerable children. The recommendations aimed to improve the resourcing and structure of the system.



Investigation into the detention and treatment of public housing residents arising from a COVID-19 'hard lockdown' in July 2020

Tabled 17 December 2020

Why I investigated

On 4 July 2020 about 3,000 residents of nine inner-Melbourne public housing towers were detained in their homes without warning to control a COVID-19 outbreak linked to the estates. The Premier of Victoria announced the lockdown, effective immediately, at 4.08pm. A rushed intervention saw armed police surround the towers, and some residents left without food and medicine. The lockdown was lifted after five days at eight of the nine towers. More than 400 residents at 33 Alfred Street, where infection rates were highest, were detained for two weeks. During this time my office received more than 85 complaints about the operation.

My 'own motion' investigation sought to understand whether human rights implications were properly considered as the crisis unfolded.

What I found

My investigation concluded the lockdown was not compatible with the residents' human rights, including their right to humane treatment when deprived of liberty. While a temporary lockdown was warranted and successfully contained the outbreak, the immediacy was not based on direct public health advice. Victoria's Deputy Chief Health Officer had about 15 minutes before the lockdown announcement to consider and sign the directions for it. Senior officials had agreed that morning that emergency intervention was needed, but anticipated that it would start the next day to allow for planning and logistics.

The sudden intervention caused chaos and confusion in the towers at first. Many residents came from diverse backgrounds but information in community languages was delayed, and there was an unacceptable absence of qualified interpreters during the critical first evening of lockdown. For many residents, the overwhelming police presence was traumatic. Some had no access to fresh air and outdoor exercise for more than a week.

Proper consideration of human rights would have allowed for time to communicate and, at least to some degree, better plan the public health response. This would have reduced or eliminated much of the distress that followed.

The Victorian Government did not agree that the urgent response of a temporary lockdown was not based on direct public health advice, that the detention may have been contrary to law, or that any human rights were breached.

What's happened since

The North Melbourne and Flemington public housing towers residents are still waiting for an apology from the Government. Given its unwillingness to accept my recommendation, it seems unlikely one will ever be offered. But even with the amount of time that has now passed, acknowledging the impact of the hard lockdown and expressing regret would be an important step toward rebuilding trust and helping affected residents heal.

Apology aside, it is evident immediate lessons were learnt from the public housing towers lockdowns, with authorities taking a far more measured – and health-centred – approach when subsequently quarantining other apartment residents as the pandemic continued. More broadly, amendments to the Public Health and Wellbeing Act flowing from my recommendations will improve information provided to people about their detention, and introduce review rights.

These are important gains for future pandemic management, though disappointingly the amended Act stopped short of legislating access to fresh air and outdoor exercise.

Two of my recommendations centred on increasing meaningful engagement with the diverse residents living in Victoria's public housing. The initiatives the Department of Families, Fairness and Housing has outlined in response will likely have a positive impact on residents' lives, extending beyond COVID-19 prevention and response activities.

Better co-ordination and collaboration between State Government agencies, local councils, service providers and community leaders are intended to deliver a broad array of benefits to all social housing residents.

Investments in improving communication and strengthening relationships with individual residents will reduce the risk of a repeat of the chaos seen in the early stages of the hard lockdown. Residents should also be more involved in improving the services they use, and in solving the broader systemic issues their communities face.

The success of initiatives and programs in response to both the pandemic and my recommendations will depend on the Government maintaining a long-term commitment, rather than short-term or one-off efforts. My office sought comment from Inner Melbourne Community Legal. Their insights from engaging with residents and partner organisations reinforce the need for ongoing dialogue with the community about their needs during the pandemic and beyond.

On an administrative note, from February 2021 the Department of Health and Human Services ('DHHS') split into the Department of Health and the Department of Families, Fairness and Housing ('DFFH'). The recommendations I made to DHHS were reallocated to the responsible departments.

Observations from Inner Melbourne Community Legal

Apology

Residents felt disheartened and let down by the lack of an apology. A resident of 33 Alfred Street said it was a barrier to rebuilding trust with the government and the department and that many people were angry. The impact lasted beyond the lockdown itself. For example, the loss of trust with the government meant parents hesitated to return their children to school.

...

High-risk settings

The High-Risk Accommodation Response ceased on 30 June 2022, replaced by the Community Connectors Program. Ongoing and sustainable funding will be integral to its success. While the program is on a significantly reduced scale (four engagement officers, down from 12), the commitment to flexible service design and delivery is welcome. It is hoped that the continuation of community engagement staff will enable the practical health support for residents, such as delivering medicine and food.

The Government improved cleaning and services in the public housing estates during the winter outbreak 2021, but this was off a low bar. Residents have reported continued problems, with only one cleaner per tower – 20 floors with 10 units on each floor.

We commend the Department's program to relocate residents experiencing medical conditions or severe overcrowding, though the narrow eligibility was disappointing. One of our clients, a single mother of seven children (some with disabilities) in a two-bedroom flat was ineligible for relocation.

We have concerns that not all sensitive high-risk accommodation settings received equal levels of support to prevent outbreaks and while most of Melbourne is operating under few health restrictions, many community spaces in public housing estates have remained closed. At times, safety measures have been at odds with the Ombudsman's recommendations.

Complaints

People in disadvantaged communities received more fines for COVID-19 offences than those in areas of higher socio-economic advantage. In addition to s.185(1) complaints, the Department of Health should set out clearly how a person can complain about a COVID-19 infringement notice. For fair use and oversight of the emergency powers, people must have effective review mechanisms for alleged breaches of public health orders.

Strengthen trust and engagement

The Government has invested in the Paving the Way program and community grants for the Flemington and North Melbourne public housing communities. We support the investment in community and co-design of service delivery and planning. We would welcome an independent evaluation of the program's outcomes to inform future initiatives.

Some residents have reported to us that the program felt like a 'tick box exercise'. Newsletters are provided but they often do not contain practical information about critical issues, such as cleaning, maintenance and security in the estates.

When residents contact Paving the Way Forward, the team often do not know what is going on, and take time getting back to them with no real information. There is an on-the-ground disconnect between the Paving the Way team and Homes Victoria.

Paving the Way Forward are building up community-led initiatives and development workers on the ground, but this work requires ongoing resources. Public housing residents are tired of services that come in, ask their opinions, are there for a year or so, and leave again. It takes time to build skills and trust.

Improve relationships

Community-led and coordinated agency support services in North Melbourne lag behind other estates, such as Richmond or Ascot Vale. The draft North Melbourne Local Area Action Plan provides a level of transparency that had been missing. The plan uses community consultation to inform practical actions to address areas of concern including maintenance, health, and community development. The plan clearly identifies and links agencies and services.

Resident advisory groups have also been established in the public housing estates. We have not received any resident feedback about the effectiveness of these groups and the action plans, however we have identified a desire among residents to establish their own governance structures.

Status of my recommendations				
Implemented	In progress	Not started	Not accepted	No longer relevant
				

Recommendation 1 - To the Victorian Government:

Apologise publicly to residents of the Flemington and North Melbourne public housing estates for harm or distress caused by imposition of the immediate lockdown on 4 July 2020.

Not accepted

DoH advised:

DoH in its response to the Ombudsman's investigation accepted that the lockdown was an incredibly difficult period for the residents of the public housing estates. Nevertheless, the lockdown and associated measures were aimed at stamping out the spread of a deadly virus and preventing the ill-health or death of residents.

DoH is of the view that, in the circumstances outlined, the isolation, detention and testing of the residents was an appropriate course of action that properly balanced the rights under the Charter, including the right to life and the public health risks involved in the localised public health emergency.

Recommendation 2 - To the Victorian Government:

Amend the *Public Health and Wellbeing Act 2008* (Vic) to:

- a) allow a person subject to detention under section 200(1)(a) to apply to both the Chief Health Officer and VCAT for review of the decision
- b) require that a person subject to detention under section 200(1)(a) be promptly provided with information concerning the following in a manner and form they are capable of understanding:
 - the purpose and terms of their detention
 - availability of, and processes for seeking, relevant exemptions
 - any right(s) of complaint or review
- c) require that a person subject to detention under section 200(1)(a) be provided with regular and meaningful access to fresh air and outdoor exercise, wherever practicable.

Partially accepted | Implemented

The Public Health and Wellbeing Act was amended to:

- a) allow a person subject to detention to make an application to the Detention Appeals Registrar for a review
- b) require a person be provided with the following information in a form that the person is capable of understanding -
 - the purpose of the detention and its terms
 - any exemptions that may be available to the person in respect of the detention
 - an explanation of the person's rights and entitlements in relation to making a complaint or seeking a review of the decision.

Recommendation 3 – To the Department of Health and Human Services:

Identify all sensitive and high-risk accommodation settings administered by the Victorian Government and invest in them to ensure appropriate COVID-19 outbreak prevention, preparation and response measures are in place.

Accepted | Implemented

DFFH advised:

The High-Risk Accommodation Response (HRAR) was DFFH's primary program supporting sensitive residential locations where the risk of COVID-19 transmission is considered higher. HRAR encompassed almost 30,000 properties and was delivered in partnership with 24 community health providers across 31 local area catchments state-wide. It sought to empower residents to make informed public health-related decisions based on clear, accessible, culturally, linguistically, and religiously appropriate and authoritative public health and support service information. The HRAR program demonstrated the critical role that residents and local communities play in health prevention outcomes, and the employment pathways that form part of these partnerships. HRAR funding ceased on 30 June 2022.

The Government is establishing a Community Connectors program for teams of local residents that will act as a 'connector' to link people at their doorstep to preventative and early intervention health and social services they need. The program is an \$8.5 million additional investment from the Victorian Government. Community health providers will be funded to deliver initiatives that respond to the needs and issues most relevant to local communities. Local residents will be employed from the communities which it seeks to serve, in many cases continuing employment that has been supported during the COVID-19 emergency.

The program will build on the lessons learnt and successes of the HRAR program funded by the Government to assist residents to access vaccinations, testing and actively linking people to health and social supports via community health services.

The Community Connectors initiative will continue these aspects and bring a stronger focus on health promotion and access to health services and broader social care services.

Recommendation 4 – To the Department of Health and Human Services:

Establish processes to regularly evaluate implementation and impact of these measures for the duration of the COVID-19 pandemic.

Accepted | Implemented

DFFH advised:

DFFH previously committed to publicly release key findings from a formal evaluation of the HRAR program.

Due to the rapidly evolving nature of the pandemic and diverting DFFH's full efforts to manage outbreaks for those at highest risk, a formal evaluation was not completed.

DFFH has been committed to an intentional 'test, respond and adapt' approach to regularly monitor the impacts of the prevention, preparedness and outbreak response activities delivered through HRAR.

A range of critical enablers were pivotal in supporting this adaptive approach, such as:

- ensuring the HRAR service model design was flexible and agile, fostering innovation and a local catchment response
- ensuring governance arrangements facilitated and responded to new and emerging risks in a timely manner
- facilitating a culture of continuous learning and reflection through internal and external program reviews, monthly agency community of practice meetings, advisory group meetings, and divisional stakeholder forums
- requirement for monthly agency reporting of activities against the HRAR service specifications to monitor program impacts and identify opportunities for improvement.

The Community Connector Initiative will be monitored and evaluated.

Recommendation 5 – To the Department of Health and Human Services:

Develop and implement local guidelines, procedures and training relating to exercise of the emergency detention power identified in section 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic) in response to an outbreak of an infectious disease, addressing, at a minimum:

1. the circumstances in which it may be appropriate to detain a person during a public health emergency
2. considerations informing use of the power, including the need to respect and protect the health and wellbeing of those being detained
3. legislative safeguards relating to the use of the power, specifying, where possible, measures to be adopted to ensure compliance with these safeguards
4. obligations arising under the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

Accepted | No longer relevant

Note: Changes to the Public Health and Wellbeing Act mean this specific recommendation is no longer relevant, though its intent is effectively covered by changes to other sections of the Act.

DoH advised:

DoH Authorised Officers undertake a mandatory training program prior to being placed in accommodation settings that includes detention powers under the *Public Health and Wellbeing Act 2008* (Vic) and the obligations under the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

This training is regularly reviewed to ensure alignment with current operational procedures. The Legal Services Branch has supported this work by preparing guidance materials for Authorised Officers to refer to in considering the obligations arising under the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

An updated Guidance Note has been developed by DoH to support Authorised Officers in making a decision to detain (under s 200(1)(a) of the *Public Health and Wellbeing Act 2008* (Vic)) and issuing Detention Notices, which includes legal, public health and Charter of Human Rights advice. The Guidance Note also provides advice on several other possible 'decisions' under the Detention Notice.

DoH is also responsible for administering the legislated detention review scheme for the review of Authorised Officers' decisions to detain. A Guidance Note has also been developed to support detention review officers in addition to training.

Recommendation 6 – To the Department of Health and Human Services:

Consider measures to improve DHHS’s capability to perform health emergency management functions, including by:

1. appointing or investing in staff with relevant emergency management expertise
2. clarifying and enhancing surge capacity arrangements for health emergencies
3. reinforcing partnerships with relevant service providers in support of emergency preparedness, response and discovery activities.

Accepted | Implemented

DFFH advised:

A comprehensive training program has been implemented for the upskilling of departmental and temporary staff. The program features foundational training in emergency management, advanced emergency leadership training, emergency exercise development principles and quality debriefing and learning processes.

Surge capacity for health emergencies has increased significantly by the introduction of Local Public Health Units (LPHUs). The LPHUs strengthen the public health response to COVID-19 by engaging directly with the community, enabling better integration of care provision and public health functions, and improving the ability to respond to future public health needs.

DFFH established Catchment Leadership Groups across the state to provide a local area approach for the delivery of services, with delineated roles and responsibilities between agencies and government bodies. Catchment Leadership Groups consist of a range of stakeholders, including:

- Lead Community Health Providers
- Victorian Government representatives
- LPHUs and associated health partnerships
- identified community leaders
- local government
- local health and community services
- disability providers and local Commonwealth Disability Liaison Officers
- culturally and linguistically diverse (CALD) representative organisations
- Aboriginal and Torres Strait Islander representative organisations.

Health Concierge teams established at most high-rise towers assist residents in accessing information in many languages, linking them to community-based health professionals and providing support services if needed. Residents and community members have been hired as part of Health Concierge and community engagement.

DFFH continues to engage with key peak bodies to assist with preparedness, engagement, sharing of critical information and compliance activities. These bodies include National Disability Services, Community Housing Industry Association, Consumer Affairs Victoria and Municipal Association of Victoria.

DFFH is also committed to developing a whole-of-Victorian-Government Shared Responsibility Framework for people most at risk in emergencies. The framework will guide emergency management planning for those identified to be most at risk before, during and after an emergency. It will apply to Victorian Government agencies, peak bodies, non-government organisations and communities, noting that we all have degrees of responsibility for planning for, and responding, to emergencies. The framework builds upon lessons learned during recent emergencies, including the 2019-20 Victorian Bushfires, the COVID-19 pandemic and the 2021 June and October storm and flood events.

Recommendation 7 – To the Department of Health and Human Services:

Develop and publish information clarifying the process for making complaints under section 185(1) of the *Public Health and Wellbeing Act 2008* (Vic), including specific information for people seeking to complain about the exercise of emergency powers during the COVID-19 pandemic.

Accepted | Implemented

DoH advised:

DoH's Feedback and Complaints website does not limit nor specifically refer to complaints about the exercise of a power by an authorised officer.

DoH's Feedback and Complaints website has been amended and the online complaint form now provides a drop-down option for a complaint to be identified as being made about the exercise of power by an authorised officer. DoH has placed on the complaint online form information as to what powers an authorised officer may exercise. Additionally, a link directing complaints about detention notices to the Detention Appeals portal has been placed on the Feedback and Complaints internet page.

DoH has procedures in place to identify complaints made via the online complaint form that are complaints made pursuant to section 185 of the Public Health and Wellbeing Act about the exercise of power by an authorised officer.

Recommendation 8 – To the Department of Health and Human Services:

In consultation with the Victorian Multicultural Commission, work with community leaders and public housing residents to strengthen trust and engagement, and develop and implement measures to:

1. establish avenues for improving the accuracy of public housing records maintained by the Housing Division, including primary/preferred language and country of origin data
2. improve understanding of the needs and preferences of culturally and linguistically diverse people living in public housing
3. establish and maintain partnerships with community leaders and residents to support timely communication with people living in public housing
4. increase participation of multicultural communities in policy, planning and project activities relating to public housing.

Accepted | Implemented

DFFH advised:

DFFH enhanced its Housing Victoria Online Services platform which allows residents to update their own personal details, including primary language, country of origin, preferred contact methods, interpreter needs and Aboriginal or Torres Strait Islander identification. This information is used by departmental staff to inform services and operations.

The Culturally and Linguistically Diverse Communities Taskforce progressed work to enhance engagement with CALD communities and partners with community organisations to provide direct support to community members. DFFH works in close partnership with the Victorian Multicultural Commission to create a two-way dialogue with community leaders.

The Victorian Government invested \$7.5 million in 2020-21 and a further \$6.5 million in 2021-22 to fund the Paving the Way Forward program which continues to focus on building trusting and robust relationships with individual residents, community groups, provider agencies and local government as a platform for joint work and forward focused planning. This has involved a spectrum of engagement approaches including community online forums, tower by tower conversations and pop-up discussion booths, regular email newsletters, responsive WhatsApp channels and individual conversations, all of which are focused on hearing issues and working together towards agreed outcomes, and enabling self-determination by residents in providing solutions.

DFFH has developed a Lessons Learnt best practice guide that has been incorporated into the way we work, with a focus on community designed and led initiatives with trusted organisations and community leaders. This includes training and building the leadership capacity of over 140 employed bicultural workers and over 50 community health champions.

Local Area Action Plans for both North Melbourne and Flemington have been developed with input from renters and other stakeholders. They have been shared with the Local Action Groups and will be launched in the third quarter of 2022. Each site has been allocated \$500,000 to fund the activities in the plan and advocacy work is also underway to seek additional funding or services that meet the goals of the plan.

Recommendation 9 – To the Department of Health and Human Services:

Consider other measures to improve relationships between DHHS and residents of the Flemington and North Melbourne public housing estates, including:

1. forming one or more tenant representative bodies
2. further opportunities for remunerated employment or workplace learning within the Victorian Government that could be made available to residents during and beyond the COVID-19 pandemic
3. identify opportunities to expand the community engagement model adopted during the lockdown to broader departmental activities.

Accepted | Implemented

DFFH advised:

The decision to place these estates into lockdown was a difficult one and DFFH recognises that it was a very challenging time for residents. DFFH was – and is – listening and acting on resident feedback on the ground.

The Paving the Way Forward program builds on DFFH’s intensive engagement with residents during the COVID-19 emergency at the North Melbourne and Flemington public housing estates in 2020 and expands this engagement across all estates to drive system-wide future reform. Residents’ voices and experiences, as identified through community engagement and formal governance mechanisms, are a central tenet of the program.

A significant amount of work has taken place to develop an action plan focusing on improving pathways to education, training, and employment outcomes for residents of North Melbourne and Flemington. This work has been undertaken in partnership with DJPR with a four-year funding commitment, plus 12 months funding for a new Step into Training and Employment to complement existing programs targeting employment opportunities for renters in North Melbourne.

As part of the Victorian Government’s investment in the program, \$2.4 million will be focused on supporting the residents of the North Melbourne and Flemington estates through enhanced engagement and partnerships to improve health, social and economic outcomes.

New representative bodies will be set up to support enhanced housing services that meet resident needs and improve outcomes.

Resident Action Groups work with the on-site Paving the Way Forward team and design and implement Local Action Plans for each estate focused on community capacity building activities and housing amenity. A new residents committee will provide input into decision making on the estate with representation for each tower.

A focus on improved training and local employment opportunities has already seen over 40 jobs created for public housing residents.

Work has commenced on the design of the Empowered Renter Decision-Making models project. The project seeks to develop a number of ways renters can participate in decisions that impact their homes and the places they live. The models will be trialled in North Melbourne and Flemington as well as other DFFH sites.

Recommendation 10 - To the Department of Health and Human Services:

Report publicly on steps taken to implement recommendations 3-9 above, on or before 30 June 2021.

Accepted | Implemented

DFFH published the progress towards implementing the Ombudsman's recommendations on DHHS's website on 30 June 2021.



Investigation into complaints about assaults of five children living in Child Protection residential care units

Tabled 29 October 2020

Why I investigated

Five complaints alleging children were assaulted while in residential care raised questions about the placement and supervision of children by DHHS (now DFFH), its Child Protection unit and contracted care organisations. The complaints claimed the five children had been sexually or physically assaulted, by other children in care or by people in the community. Given the complaints had some common themes, I decided to examine the experiences of these five children to identify systemic problems. This included looking at the organisations which operate residential care units, along with the actions and decisions of DFFH, which funds and regulates the system.

What I found

The investigation heard sad and shocking stories of young people who had lived difficult lives before going into care, and who were harmed further by their experiences in care. It found a system where placements are dictated by bed availability and not always based on the best interests of the child. The investigation found the current 'four-bed' model – where four unrelated children may be housed under one roof – does not suit the complex histories and needs of vulnerable children.

The five cases I considered also demonstrated ongoing challenges with incident reporting and response systems, with some staff not telling police about alleged assaults. We also found evidence suggesting children may have been medicated to manage their behaviour.

In the disability sector this is known as 'chemical restraint' and is carefully controlled, but no such controls exist in residential care.

What's happened since

The investigation recommended major reforms to the Child Protection residential care system to improve the welfare and safety of children. By their nature, such reforms will take time to implement and will hinge on funding decisions and extensive stakeholder negotiation and engagement.

I recommended the establishment of an independent advocate for children in care within the Commission for Children and Young People ('CCYP'), and pleasingly, work on this has begun. In June 2022, the Government introduced the *Children and Health Legislation Amendment (Statement of Recognition and Other Matters) Bill 2022* (Vic). This Bill introduces an advocacy function for CCYP. It is of the utmost importance that this new function be adequately funded once established.

It is heartening to see some progress on my recommendation to reduce the number of beds in each residential care unit. Nineteen new homes with either two or three beds and enhanced access for children to services are up and running. It's a good start and will make life better for the 41 children housed in those units. For the remaining children placed in four-bed homes, DFFH reports additional funding to strengthen operations throughout 2022 and 2023.

Investigation into complaints about assaults of five children living in Child Protection residential care units (continued)

However, to fully implement my recommendation to transition from four-bed homes, the Government needs to commit to significant further investment.

My office continues to receive complaints from young people and their family members concerned about young people experiencing abuse, feeling unsafe, or accessing drugs and alcohol. A report tabled by the CCYP in June 2021 highlighted the fact that such issues increase the risk of children leaving or going missing from their residential care.

While the relevant Ministers accepted the need for better oversight of the use of medication as a form of restraint, we are yet to see a practical change on this front. DFFH reports that the COVID-19 response has diverted energy from this issue; however, it has recently established a working group to develop guidance on the use of chemical restraints. I trust this will bring residential care in line with the disability and aged care sectors which have already taken steps towards better controlling chemical restraint.

We sought the Commissioner for Children and Young People's observations since the tabling of my report. The Commissioner expressed concerns about medication errors in residential care settings. In response, DFFH advised that 'training and resources to support Residential Care Workers will be finalised in 2022 for implementation in early 2023'.

At an individual level, DFFH has assured me that each of the five children whose cases were detailed in my report have been connected with all the relevant services needed to support their recovery.

Observations from Liana Buchanan, Commissioner for Children and Young People

Improvements to medication management

In 2021, the Commission identified additional issues with medication management in residential care, which may be considered relevant to the Ombudsman's second recommendation of this report:

'[t]hat the Minister for Child Protection Implement a state-wide medication management policy for children in residential care that includes minimum standards and regulation for the prescription, administration and notification of chemical restraints to children.

Our 2020-2021 Annual Report outlined that the Commission identified an increase in medication errors in residential care settings, including instances of children being given double the required medication, being provided medication at the incorrect times, or not being provided prescribed medication as required.

The Commission wrote to DFFH seeking improvements to systems and processes associated with medication administration in residential care and encouraging the development of systems to identify and track medication errors.

[DFFH] advised the Commission that a state-wide medication administration policy is being developed and expectations will be reflected in updates to the program requirements for residential care in Victoria. [DFFH] further advised that consideration will be given to additional assurance and monitoring mechanisms to support strengthened compliance with the updated requirements. The Commission continues to monitor the implementation of systemic improvements in this area.

Establishment of an independent children's advocacy function within CCYP

The Commission has particular interest in the implementation of Recommendation 3 [establishing an independent children's advocacy function within the CCYP].

The Principal Commissioner has continued to argue that this function is critically needed, noting the vulnerability of children in the out of home care system and the protracted and long-term nature of reforms to improve that system.

On 7 June 2022, the *Children and Health Legislation Amendment (Statement of Recognition and Other Matters) Bill 2022* was introduced into Parliament. If passed, provisions in this Bill will enable the Commission to assist, support and advocate on behalf of child protection clients, children and young people in out of home care and those making the transition to independent living.

The Commission welcomes this legislation.

Status of my recommendations			
Implemented	In progress	Not started	Not accepted
			

Recommendation 1 - To the Minister for Child Protection and the Minister for Mental Health:

Commence conversion of standard four-bed residential care units to therapeutic two-bed units with enhanced access for the children to services, particularly mental health and education, while maintaining some capacity in the system for larger groups (ie siblings).

Accepted In principle | In progress

DFFH advised:

Implementation of new two-and three-bed residential care homes has commenced with 19 houses delivering services now operational. Program guidelines for the two- and three-bed therapeutic residential care model have been developed and include the requirements for the therapeutic specialist and education/vocation support roles, including specifications in relation to direct service delivery with the young person to promote accessibility and engagement.

The new homes provide greater flexibility and capacity within the system to better meet the individual needs of children and young people and include access to therapeutic and educational/vocational specialist supports attached to each home.

The transition of existing four-bed homes to two-bed homes is subject to additional budget.

Sibling groups will be supported through existing capacity in the residential care system, as well as a new Care Hub approach being trialled in DFFH's North Division. This approach includes a multidisciplinary team providing early and intensive assessment and planning to children and young people new entrants to care, including sibling groups.

Recommendation 2 - To the Minister for Child Protection and the Minister for Mental Health:

Implement a state-wide medication management policy for children in residential care that includes minimum standards and regulation for the prescription, administration and notification of chemical restraints to children. This should be supported by:

- mandatory training for residential care workers
- updates to the Residential Care Program Requirements and Child Protection Manual
- guidance to medical practitioners.

Accepted In principle | In progress

DFFH advised:

Work has recommenced to address this recommendation through policy, practice advice and a review of training to improve the management and administration of medication in residential care, reduce staff related medication errors and improve oversight and monitoring of the issue of chemical restraint. A working group including the sector, relevant health professionals and young people is being established to support this work.

Recommendation 3 – To the Minister for Child Protection:

Consider establishing an independent children’s advocacy function within the CCYP to enable it to:

- participate in placement decision-making for residential care, to prevent unsafe decision making
- promote the rights of children to participate in decisions about placement, service-delivery and incident investigations that affect them
- support or represent children to make complaints about their care
- make representations on behalf of children identified as high risk
- refer serious concerns to independent complaint handling and investigative oversight bodies such as the Victorian Ombudsman
- regularly visit and inspect residential care settings
- publicly report on its activities and outcomes.

Accepted In principle | In progress

DFFH advised:

In June 2022, the *Children and Health Legislation (Statement of Recognition and Other Matters) Bill 2022* (Vic) was introduced into Parliament with the provision for an independent advocacy function for children within the CCYP.

The function will enable the CCYP to assist, support and advocate on behalf of child protection clients, children and young people in out of home care.

At the time of writing, the Bill had passed through the Legislative Assembly (on 23 June 2022).

DFFH will continue work to progress the policy proposal and engage with key sector stakeholders and children and young people with lived experience of the child protection and alternative care systems. DFFH anticipates commencing reform implementation by the end of 2022.

With the *Social Services Regulation Act 2021* (Vic), DFFH is strengthening protections for children and youth accessing social services. Throughout 2022, DFFH will work with a Taskforce to engage sector stakeholders and develop regulations to operationalise the legislative framework in the Social Services Regulation Act and fill known gaps in the safeguarding system framework.

Recommendation 4 – To the Department of Health and Human Services:

Within 90 days, undertake the following actions for each child to address the deficits in care identified in the report:

- for current clients, conduct a review by a Principal Practitioner of the existing placement to confirm that it is safe and appropriate to meet the child’s needs, and that the child’s views have been taken into consideration
- ensure reports are made to police for all allegations of assault
- with the child’s consent, engage specialist therapeutic services such as sexual assault counselling to support their recovery from trauma
- confirm the child’s eligibility, and make referrals for support, from Victims of Crime, the Redress Scheme and independent legal services for advice about their rights and care.

Accepted | Implemented

On 23 February 2021 the Secretary provided a report to the Ombudsman of a review completed on 13 January 2021.

Recommendation 5 – To the Department of Health and Human Services:

In consultation with Victoria Police and CSOs providing out-of-home care, review the Protocol between Department of [Health and] Human Services – Child Protection and Victoria Police (2012) and the Addendum: Preventing sexual exploitation of children and young people in out-of-home care (2014) to ensure all allegations of physical and sexual assaults of children in residential care are:

- reported to Victoria Police, regardless of whether the victim wants to make a statement
- recorded in the systems of Victoria Police and the reporting agency.

Accepted | In progress

DFFH advised:

Child Protection Policy, Aboriginal Children in Aboriginal Care Providers and Victoria Police have undertaken a comprehensive review and update of the 2012 Protecting Children Protocol incorporating the 2014 Addendum: Preventing Sexual Exploitation of children and young people in out-of-home care. The draft document is in final stages of review.

Follow-up on recommendations from earlier reports

Meaningful and effective change takes real commitment, and often, time. For this reason, this report revisits two older investigations that were previously detailed in my *Ombudsman's recommendations – third report* from June 2020.

One of these reports was about WorkSafe and the handling of complex workers compensation claims.

The other was about the solitary confinement of children and young people. Both reports made recommendations for significant reforms. It is important to keep sight of the progress being made toward implementing changes which can take many years.



WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims

Tabled 3 December 2019

Why I investigated

In 2016 I tabled an 'own motion' report into WorkSafe agents' handling of complex claims and made recommendations to improve decision making and increase oversight. Continued complaints to my office and anecdotal evidence of persistent failings in the management of disputed claims prompted me to launch a second investigation in May 2018.

What I found

The second investigation found changes made to the WorkCover scheme following my 2016 report were unsuccessful, and more fundamental reform was needed. It found some unfair practices were continuing and discovered new issues such as unjustified surveillance of workers and unreasonable return-to-work practices. While WorkSafe had improved its audits of the quality of decisions made by agents, we found concerning examples of it passing questionable decisions and failing to properly exercise its powers.

What's happened since

An independent review ordered in response to my first recommendation underscored my finding that systemic change was desperately needed. That review, finalised in April 2021 and made public in March 2022, concluded that the administration and management of complex claims under WorkSafe's outsourced agent model was 'unsuitable, inadequate and ineffective'. It said:

[...] it is not an overstatement to say that the Victorian workers' compensation system is, in some cases, destroying lives. This situation has been allowed to continue for too long and must change.

The review made 22 recommendations which the Government has largely accepted in principle. Together with the 15 recommendations I made, they represent substantial reforms which will significantly improve the experience of many injured workers as they navigate the system.

While such large-scale change can take time to flow through to workers, pleasingly some positive developments have already occurred.

WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims (continued)

WorkSafe has established a central complaints service which acts as a single point of contact for end-to-end complaint management. It has also formed a Claims and Recovery Support Team to better manage long-term claims. While data is being gathered about this team's impact, surveys of a small number of injured workers suggest encouraging results.

I also recommended that WorkSafe should intervene directly in appropriate cases, forming a dedicated unit to independently review disputed decisions where agreement cannot be reached at conciliation. The Workers Compensation Independent Review Service ('WCIRS') launched in April 2020. It has reviewed about 700 agent decisions, with slightly more than a third of these being overturned in the worker's favour. The proportion of sustainable decisions made by agents has improved steadily since early 2021.

Since the tabling of my report, complaints to my office about WorkSafe have decreased, with numbers down about 16 per cent in both 2020 and 2021 when compared to 2019 levels. This reduction is likely due to a combination of practice improvements by WorkSafe and its agents, and the establishment of WCIRS.

It is likely complaint numbers will reduce further now that one of my more substantial recommendations has been implemented – a new arbitration function for the independent Accident Conciliation Compensation Service. Legislated in 2021, and launched in September 2022, the renamed Workplace Injury Commission is intended to provide timely and inexpensive binding decisions on disputes. It complements existing dispute resolution processes and should make the system less challenging for injured workers to navigate.

While this represents encouraging progress on a major systemic issue, my office has received complaints from employees of self-insurers (employers that manage their own workers compensation claims). Decisions made by self-insurers are not subject to independent review by WCIRS. Indeed, how an injured worker is managed under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic) ('WIRC Act') depends on who their employer is. This difference, along with potential power imbalances for workers of self-insuring employers, is now the focus of a new investigation into the workers compensation scheme.



Case study: New service restores injured worker's faith

Injured worker Melissa* spent 16 years unsuccessfully challenging the calculation of her weekly payments.

Since 2005, Melissa had felt that her pre-injury weekly earnings had been miscalculated, resulting in payments that were lower than she expected.

She had tried over the years to resolve her dispute directly with WorkSafe Victoria and her agent and had also participated in multiple conciliation attempts.

At one stage she went as far as launching legal action in the County Court. With a hearing date approaching, she made a further attempt in 2020 to resolve the matter out of court.

She made a new application to WorkSafe Victoria and the agent asking for increased weekly payments, but they advised it would be inappropriate to consider the matter because she had started court proceedings.

When further attempts at conciliation failed, Melissa decided, in September 2021, to try the new WCIRS, established in response to an Ombudsman's recommendation.

Melissa feared 'more of the same' and was shocked to hear in April 2022 that WCIRS had directed the agent to overturn its 2020 decisions not to consider her new application.

'I just kept playing the message over and over and I was just staring at my phone in disbelief I just couldn't take it in' she said.

Soon after, Melissa received a back payment of \$246,600.

'It was just fabulous. I cannot speak highly enough of them ... the proof is in the pudding, bang, \$246,600 is in my bank account.'

'It's changed my life ... I keep logging into the bank to look at it and just making sure it's still there. And to sit there last night, paying off my credit card and paying back people that I owe money to so I didn't lose my house and just knowing I can possibly have a life ... it's opened a whole world that was just not there before.'

"It was just fabulous. I cannot speak highly enough of them ..."

- Injured worker Melissa

Melissa said the quick and free service meant she avoided the hassle and expense of having to go to court. She said there were still some unresolved elements of her case, but that the WCIRS process had helped narrow the issues in dispute.

'They are caring when they deal with you, they are open, they are honest, they are helpful, if they say they are going to do something they'll do it, they'll get back to you. It was just unbelievable, really refreshing and it started to restore my faith in human beings.'

* not her real name

Figure 6: Media announcement of reforms for injured workers

Media Release
Ingrid Stitt MP
Minister for Early Childhood and Pre-Prep
Minister for Workplace Safety



Wednesday, 13 July 2022

NEW ARBITRATION SERVICE TO ASSIST INJURED WORKERS

Workers compensation disputes will be resolved more quickly and efficiently thanks to the Andrews Labor Government's new arbitration service – helping workers get back on their feet as soon as possible.

The new arbitration service to be established within the Accident Compensation Conciliation Service, will be rebranded as the Workplace Injury Commission and begin operating from 1 September.

The service will give injured workers an additional dispute resolution option without the need to go through a long and costly court process.

The changes deliver the Victorian Ombudsman recommendation to introduce a new dispute resolution process which allows for inexpensive, timely and binding determinations on the merits of claims decisions.

Many injured workers are deterred by the cost, time and complexity of court proceedings, making this path to dispute resolution lengthy and stressful.

Under the new service, injured workers can choose to have their matter arbitrated by the Workplace Injury Commission if it is not resolved at conciliation.

A hearing must start within 30 days of the dispute being referred so the process can be timely and inexpensive.

The Workplace Injury Commission will have powers to make binding determinations on disputes, including compensation for weekly earnings, medical expenses, superannuation payments or interest payable.

Quotes attributable to Minister for Workplace Safety Ingrid Stitt

"The new arbitration service will save injured workers money, time and stress by resolving their compensation disputes in a simpler and cheaper manner – meaning fairer outcomes for all Victorian employers and workers."

"Victorians injured at work will be able to focus on their recovery and getting back on their feet and back to work faster, rather than dealing with the stress of spending time and money on complex court proceedings."

Source: Premier of Victoria Media centre

Status of my recommendations

Implemented

15

In progress

0

Not started

0

Not accepted

0

Recommendation 1 – To the Victorian Government:

Commission an independent review of the agent model to determine how and by whom complex claims should be managed, taking into account:

- a) the need to ensure appropriate compensation is provided to injured workers, as well as the financial viability of the scheme
- b) 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.

Accepted | Implemented

The Victorian Government commissioned an independent review of the agent model and the administration and management of complex claims. The review was conducted by Peter Rozen QC, finalised in April 2021 and the report made public in March 2022.

Recommendation 2 – To the Victorian Government:

Introduce a new dispute resolution process which:

- a) allows for binding determinations on the merits of claims decisions, including factual disputes; is inexpensive; and provides timely outcomes
- b) complements the existing dispute resolution processes of conciliation and legal review at court.

Accepted | Implemented

The *Workplace Injury Rehabilitation and Compensation Amendment (Arbitration) Act 2021* (Vic) introduces an arbitration function to the Accident Compensation Conciliation Service under the *Workplace Injury Rehabilitation and Compensation Act 2013* (Vic).

Recommendation 3 – To WorkSafe:

Establish a dedicated business unit to independently review disputed decisions when requested by workers following unsuccessful conciliation. Where necessary, WorkSafe should use its existing powers to direct agents to overturn decisions which do not have a reasonable prospect of success at court (ie would not be sustainable).

Accepted | Implemented

WorkSafe advised:

WorkSafe established WCIRS on 30 April 2020. The WCIRS independently reviews disputed decisions following conciliation. Independent review officers are empowered to make determinations on the sustainability of decisions.

The WCIRS reviews all decisions in line with a Sustainability of Decision-Making Framework (SDMF) which was developed for the function. The Framework requires agents to demonstrate that their decisions are fair, reasonable, based on the best available evidence and are reasonably likely to be upheld by a Court.

WorkSafe is monitoring decisions reviewed by the WCIRS to identify trends that will inform the development of agent training, policies and decision-making practices.

Recommendation 4 – To WorkSafe:

Amend its quality decision making audit procedure to ensure that:

- a) only sustainable decisions pass
- b) unsustainable decisions identified through the audit process are overturned.

Accepted | Implemented

WorkSafe advised:

The Sustainability of Decision-Making Framework principles were integrated into the Quality Decision Making ('QDM') audit criteria and processes on 31 May 2020. The principles aim to ensure that unsustainable decisions are effectively identified, assessed and overturned.

WorkSafe's Audit Protocol and Wrongfully Disentitled Procedure communicates WorkSafe's authority to issue directions to agents and outlines its procedure for doing so.

Recommendation 5 – To WorkSafe:

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 IMEs.

Accepted | Implemented

WorkSafe advised:

On 31 March 2020, WorkSafe established the Centralised Complaints Service for all workers compensation complaints received by WorkSafe. The centralised function triages and coordinates the end-to-end complaints management process.

WorkSafe has enhanced resources in the function to improve complaints response times and implemented a process to regularly communicate progress to the complainant.

A simplified Complaints Management Policy has also been published on the WorkSafe website to improve accessibility and provide a clear outline of the process.

WorkSafe has developed a *Centralised Complaints Management Maturity Roadmap* which articulates the strategy to continually improve and mature the function in line with leading practice.

Recommendation 6 – To WorkSafe:

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

- a) require that agents make sustainable decisions
- b) 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
- c) 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
- d) clarify the circumstances in which agents should refer a worker to a psychiatrist IME for assessment of a potential secondary mental injury
- e) provide guidance on the appropriate IME specialty to assess workers with chronic pain syndrome or a pain disorder
- f) 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
- g) 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
- h) 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.

Accepted | Implemented

WorkSafe advised:

Since April 2020, WorkSafe has delivered a range of training modules, agent engagement initiatives and Claims Manual updates.

An online learning module *Understanding surveillance for Independent Medical Examiners* ('IME') and agents launched in September 2020. In August 2020, online training module, *Assessing material change for IMEs*, was also released. This training complemented a new 'material change' question being added to IME letters.

WorkSafe has also delivered a range of Claims Manual updates as part of its response to this recommendation, including major updates about what constitutes adequate evidence, chronic pain and pain disorders, including when to use an IME, and mental injury claims rejected under s40 of the WIRC Act.

Recommendation 7 – To WorkSafe:

Increase WorkSafe’s oversight of the following claims management activities by agents, through targeted ‘health checks’ or audits:

- a) agents’ use of surveillance
- b) mental injury claims rejected under section 40(1) of the WIRC Act (reasonable management ground)
- c) return to work non-compliance notices
- d) terminations of ‘top up’ weekly payments provided under section 165 of the WIRC Act (or section 93CD of the *Accident Compensation Act 1985* (Vic)).

Accepted | Implemented

WorkSafe advised:

From March 2019, WorkSafe introduced quarterly ‘health checks’ of agents’ decisions to:

- undertake surveillance
- use return-to-work non-compliance warnings.

WorkSafe has also introduced specific audits of return-to-work non-compliance decisions, which result in termination or suspension of entitlements, into its monthly QDM audit program.

WorkSafe has expanded its oversight of mental injury claims rejected under s40(1) of the WIRC Act, incorporating an increased number of audits into its monthly QDM audit program.

WorkSafe has also included all decisions taken to terminate ‘top up’ weekly payments, under s165 of the WIRC Act (or section 93CD of the *Accident Compensation Act*), into the population of claims decisions that may be audited in its QDM program.

Recommendation 8 – To WorkSafe:

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.

Accepted | Implemented

WorkSafe advised:

On 1 July 2020, WorkSafe amended the 2020-21 Injured Worker Survey to increase the weighting on claims of 670 or more days from 13 per cent to 20 per cent.

The amended survey has a stronger focus on the experience of injured workers with complex claims, asking them about their experience and their trust in WorkSafe. Responses from the survey will help WorkSafe improve planning and services.

WorkSafe has also increased its reporting timeframes to monthly to review survey results of injured workers with complex needs.

Recommendation 9 – To WorkSafe:

Introduce a contractual requirement regarding the timeframe in which agents must respond to:

- a) requests for reinstatement of weekly payments
- b) requests for medical and like treatment.

Accepted | Implemented

WorkSafe advised:

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.

Where an agent does not meet the Minimum Compliance Standard for either measure, a remuneration reduction of 1 per cent of the agent's Annual Premium Fee Base may be applied.

WorkSafe is monitoring compliance.

Recommendation 10 – To WorkSafe:

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.

Accepted | Implemented

WorkSafe advised:

In late September 2020, WorkSafe launched a new review process for Medical Panel outcomes to identify potential trends in IME opinions, agent use of IMEs and agent decision-making.

By 2 March 2022, 1,673 Medical Panel reviews had been completed.

Information from trend reporting is included in quarterly audits of agents' decision-making quality and IME quality reviews to provide a feedback loop for improvement.

WorkSafe will continue developing the process through improved data analytics and systems design to capture relevant information.

Recommendation 11 - To WorkSafe:

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.

Accepted | Implemented

WorkSafe advised:

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.

Recommendation 12 - To WorkSafe:

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:

- a) 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
- b) providing training to IMEs on what constitutes 'suitable employment'.

Accepted | Implemented

WorkSafe advised:

WorkSafe has amended template questions that require IMEs to detail how each factor in the definition of suitable employment has been considered in providing their opinion.

A two-part Suitable Employment online training module launched in July 2020, which helps IMEs understand what constitutes 'suitable employment'.

All of WorkSafe IMEs have completed the training modules on Suitable Employment, part A and B. This was compulsory as part of the approval process for IMEs conducted in 2021. New IMEs recruited in early 2022 are required to undertake the training module within three months of their commencement.

Recommendation 13 - To WorkSafe:

Provide different time allocations for independent medical examinations of injured workers with 'complex claims' and remunerate IMEs for these accordingly.

Accepted | Implemented

WorkSafe advised:

From 1 July 2020, WorkSafe introduced longer appointments and an additional fee for IMEs when they conduct a work capacity examination of an injured worker with complex needs (workers who have been in receipt of entitlements for longer than 78 weeks).

WorkSafe has also updated its systems to ensure fees are appropriately defined and effectively processed.

Recommendation 14 - To WorkSafe:

Provide guidance and/or training to IMEs regarding:

- a) what constitutes 'material change' in a worker's condition since a previous Medical Panel examined them and provided an opinion
- b) how surveillance material should be considered when forming an opinion about a worker's work capacity.

Accepted | Implemented

WorkSafe advised:

In line with Recommendation 6 agent training, WorkSafe released an online learning module, *Understanding surveillance for IMEs and agents*, in September 2020.

The training provides IMEs with tools, legislation, guidelines and training to help them fulfil their role under workers compensation laws.

WorkSafe also released the online training module 2020, *Assessing material change for IMEs*. This training was in addition to a new 'material change' question added to IME letters.

Recommendation 15 - To WorkSafe:

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.

Accepted | Implemented

WorkSafe advised:

WorkSafe has continued to monitor IME Y to ensure they are acting in line with the WIRC Act and complying with IME Service Standards.

Four reports written by IME Y between September 2020 and March 2021 were peer reviewed. IME Y was provided with feedback and overall the reports met the required criteria.

Ongoing monitoring of IME Y continues. Nine reports were reviewed, between May 2021 and January 2022, and showed improvement made by IME Y has been sustained.



OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people

Tabled 5 September 2019

Why I investigated

Australia ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2017. I completed my second OPCAT-related investigation in 2019. The investigation was completed in two parts.

The first part examined different operating models for OPCAT and recommended an appropriate model for Victoria. The second part was a thematic inspection of 'solitary confinement', which is sometimes also referred to as 'seclusion', 'isolation' or 'separation', depending on the setting. The inspection considered the treatment of children and young people at an adult prison, a youth justice centre and two Secure Welfare Services (facilities overseen by DFFH that provide short-term secure care for young people deemed to be at substantial and immediate risk of harm).

Isolation of children and young people is inherently harmful given they are still developing physically, mentally, neurologically and socially. The investigation, assisted by an Advisory Group, aimed to strengthen protections for young people deprived of their liberty and vulnerable to mistreatment or abuse.

What I found

The first part of the report analysed different models for the regular visits to places of detention required under OPCAT by independent bodies known as National Preventive Mechanisms ('NPM'). I concluded Victoria would benefit from having a single NPM with the support of a legislated Advisory Group to ensure a single, clear and consistent voice.

The second part of the report found children and young people in Victorian prisons and youth justice systems were being damaged rather than rehabilitated through excessive use of isolation. We found the adult prison particularly ill-equipped to deal with the challenging behaviour of young people, who were disproportionately subject to isolation practices. Within the youth justice facility, the investigation found a genuine commitment at many levels to welfare and rehabilitation. But we noted a culture that prioritised security, as well as a chronic problem of lockdowns, often in response to staff shortages. The Secure Welfare Services offered the most therapeutic approach, though this was somewhat undermined by outdated facilities.

What's happened since

The report made 27 recommendations – one in relation to the preferred NPM model, the rest relating to solitary confinement.

Part 1 – Implementation of OPCAT

The Australian Government ratified OPCAT in December 2017, though postponed its implementation until January 2022. Earlier this year it sought a further 12-month extension, citing COVID-19 and 'considerations relating to the country's federal system of government and to resources'.

Western Australia, the Northern Territory, the Australian Capital Territory and Tasmania have nominated an NPM, but Victoria remains silent on the matter. While DJCS says it has done a significant amount of work to implement OPCAT, it is extremely disappointing that the specifics of designating and funding a Victorian NPM or NPMs are not yet known.

A Legislative Council Legal and Social Issues Committee report, tabled in Parliament in March 2022, *Inquiry into Victoria's Justice System*, recommended the Government provide a comprehensive update and timeframe for the full implementation of OPCAT in Victoria. The Government's response to the Inquiry is due by late September 2022.

During the inquiry, DJCS reaffirmed the Victorian Government's support for the principles of OPCAT. In its update to my office, it attributed the delay in nominating a Victorian NPM to a lack of federal funding:

Victoria is yet to nominate an NPM, but the Government advises it will do so once the Commonwealth commits ongoing funding to Victoria to deliver OPCAT. The absence of such a commitment has hampered Victoria's ability to progress work and consultation.

The delays have not stopped the important work of the OPCAT Subcommittee on the Prevention of Torture. It is understood to have advised Corrections Victoria that it intends to inspect places of detention here in October 2022.

With the United Nations Committee Against Torture expecting full adherence to the OPCAT treaty by early 2023, and with Australia standing on a world stage, I hope Australian and state governments can come to a consensus in order to realise our commitment to the protocol.

Meanwhile, concerns relating to the treatment of detained people in Victoria continue to arise. IBAC's 2021 *Special report on corrections* examined human rights violations and workplace conduct and culture. My recent *Report on investigations into the use of force at the Metropolitan Remand Centre and the Melbourne Assessment Prison* reviewed eight use of force incidents and found half involved officers using unreasonable force.

The investigation also explored issues of poor prison culture, the importance of encouraging staff and prisoners to report improper conduct, and the need for greater use of de-escalation techniques and body worn cameras. DJCS reports significant reform in corrections and integrity issues since 2019. However, prison cultural issues and addressing corruption vulnerabilities remain an ongoing task requiring vigilance.

At the time of writing, a coronial inquest into the death of Aboriginal woman Veronica Nelson at the Dame Phyllis Frost Centre in 2020 is underway. Her treatment by prison and medical staff has been called into question.

The need for greater action on implementing OPCAT is obvious to all, and I will continue to monitor and report on progress, or the lack of it.

Part 2 - Thematic Inspection

While the Government said it intends to prohibit solitary confinement, legislative change has been slow in the three years since I tabled my report, in part because these changes are tied to multiple larger reform packages.

The introduction of the *Children, Youth and Families Amendment (Child Protection) Bill 2021 (Vic)* to Parliament in October 2021 creates a path to end solitary confinement in Secure Welfare Services.

Meanwhile DJCS is developing standalone youth justice legislation which will include the prohibition of solitary confinement. Some steps have been taken on a practical front, though it is not known when these Bills will progress. Similarly, the time frame for considering amendments to the *Corrections Regulations* relating to solitary confinement in adult prisons is also unknown.

OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people (continued)

Other shortcomings identified in my report are also slow to be addressed, with departments responding that most of my recommendations are ‘in progress’.

Regrettably, the Government rejected one of the key recommendations, opting not to carry out a system-wide review of how young people in custody are managed. The Government stated it ‘would not be feasible’ to remove young people from mainstream prisons into a dedicated facility.

That said, the DJCS update on progress toward my other recommendations outlines a variety of projects, policies, procedures, training, building works and other changes. Taken together, these changes appear likely to improve practices in Victoria’s adult and youth facilities.

The development of new facilities – the Cherry Creek Youth Justice Centre and the Western Plains Correctional Centre – provides the Victorian Government with an opportunity to embrace a new model of offender management.

DJCS reports Cherry Creek is purpose-built to focus on rehabilitation with key design features including an intensive intervention unit and a dedicated mental health unit, due to open progressively in the first half of 2023. The Parkville Youth Justice Centre introduced a therapeutic intensive intervention unit in mid-2020.

DJCS has also reported that construction of therapeutic spaces as alternatives to management units is under way at Western Plains and several other adult prisons and that it is reviewing options for separation accommodation.

Given the significant proportion of people in these closed environments already experiencing mental illness or cognitive disabilities, the availability of therapeutic spaces cannot come soon enough.

“I didn’t want to harm myself so I asked for help and you put me in a cell like this? ... I regret even asking [for help].”

- A prisoner, on his experience in separation at Metropolitan Remand Centre

DJCS has launched a multi-pronged ‘Separation Reform Project’ which appears to hold medium-term promise for addressing many concerns raised in my report. DJCS says it involves a review of separation across the system to develop a new operating model ‘in line with international obligations’. Already several trial projects have been conducted, including a ‘separation as a last resort’ pilot which is reportedly expanding.

Corrections Victoria has followed my recommendation and requested a Victorian Equal Opportunity and Human Rights Commission (VEOHRC) review of the central governing policy around separation. Unfortunately, this, like some other promised changes, has been delayed by COVID-19.

While interested observers – myself included – will continue to closely monitor the ongoing system-wide reform and its future impacts, a designated OPCAT NPM would provide greater benefits through dedicated and ongoing monitoring and preventive visits to places of detention.

Status of my recommendations

Implemented

9

In progress

16

Not started

0

Not accepted

1

Recommendation 1 (Part 1) – To the Victorian Government:

The Ombudsman recommends the Victorian Government:

- a) designate an NPM in accordance with the principles set out in paragraphs 267 to 280; and
- b) resource that NPM adequately to allow it to demonstrate compliance with OPCAT standards.

Accepted in principle | In progress

DJCS advised:

The Government has indicated that it supports the principles of OPCAT, and there are robust oversight regimes in place to ensure that people in detention are protected against torture and other cruel, inhuman, or degrading treatment or punishment.

The Government has indicated that as the Commonwealth's ratification of OPCAT imposes additional and separate obligations on states and territories, a sufficient and ongoing funding commitment from the Commonwealth is essential to implement and deliver on these obligations.

On 18 October 2021, the Victorian and NSW Attorneys-General wrote jointly to the Commonwealth, explaining that Victoria and NSW would be unable to take steps to implement OPCAT, in the absence of a sufficient and ongoing funding commitment from the Commonwealth. At the 12 August 2022 Meeting of Attorneys-General it was agreed that participants would continue to work together on implementation of OPCAT in advance of the 20 January 2023 deadline for implementation.

DJCS will continue to support the Government's discussions with the Commonwealth to facilitate the implementation of OPCAT in Australia in a way that is effective and sustainable.

Recommendation 1 (Part 2) – 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.’

Accepted | In progress

DJCS advised:

The Government has accepted this recommendation and intends to consider a legislative prohibition on solitary confinement through the development of standalone youth justice legislation.

In practice, this is not permitted in youth justice custodial centres due to the requirement to observe young people and maintain contact (in line with relevant legislative and human rights requirements). Any young person subject to isolation is closely monitored and supported. All isolations are recorded in a register.

Daily entitlement checklists are completed for young people isolated for short periods in their bedrooms or overnight in isolation rooms. These are recorded and saved into the young person’s CRIS file.

Amendments to the *Corrections Regulations* are currently under consideration.

The Separation Reform Project has proposed that the definition of what constitutes separation be changed to ‘a prisoner being confined to their cell for a minimum 21 hours a day, with very limited to no meaningful contact with others’. This would increase the mandatory out of cell hours from one hour to a minimum of three hours. In addition to this, prisoners will also be required to have a minimum of two hours of meaningful engagement, which can include mixing with other prisoners, engaging in case management with custodial staff, accessing peer support or accessing work, programs or education.

DFFH advised:

DFFH has taken action to prohibit solitary confinement through legislative reform to modernise the *Children, Youth and Families Act 2005* (Vic). *The Children, Youth and Families Amendment (Child Protection) Bill 2021* (Vic) was introduced to Parliament on 5 October 2021.

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.

Not accepted

DJCS advised:

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* include some additional requirements for decisions involving children under 18 years.

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.

For young people sentenced by an adult court through the ‘dual track’ system, the suitability assessment process details the young person’s vulnerability and prospects for rehabilitation and informs their management in prison.

For young people transferred from a youth justice centre to prison, procedures provide for the exchange of case management and health information between Corrections Victoria and youth justice about the young person. This helps to inform placement decisions.

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.

Accepted | In progress

DJCS advised:

DJCS is exploring options to re-purpose existing infrastructure to create alternative spaces in adult custody that may be used in lieu of cells to house those in separation, according to international best practice.

In addition to this, new infrastructure is currently under construction at Western Plains Correctional Centre, Marngoneet Correctional Centre and the Dame Phyllis Frost Centre which create close support and supervision units. These units replace what has traditionally been referred to as a management unit. The design of these units contains a number of communal yards, lounges and programs areas designed to facilitate more areas for meaningful interaction between prisoners and staff. The operating models of these units will provide prisoners with increased support, interventions and opportunities to engage meaningfully in activities that support their rehabilitation. Intensive case management is central to these operating models, used as the primary conduit to engage prisoners in meaningful activity and link them to the services they need to transition into a less restrictive placement.

An intensive intervention unit at the Parkville Youth Justice Precinct – and servicing all youth justice centres – accommodates young people who present a significant or heightened risk of harm to themselves or others. Cultural supports are an important component of the model.

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.

Most isolation in youth justice is under two hours in duration, and in a young person's bedroom. This allows young people access to their personal belongings including culturally specific items.

Youth justice will continue to:

- use bedrooms as the preferred space for isolation wherever safe to do so, as a more supportive space with access to personal belongings including culturally specific items
- provide culturally relevant items to support young people in isolation including specific weighted animal toys and blankets, and cultural care packs
- develop specific responses and support targeted to young women.

DFFH advised:

Secure care services has developed therapeutic cultural spaces in both units including a healing garden, yarning space and gathering space to reduce the potential for more restrictive alternatives such as seclusion. These were developed in collaboration with local Aboriginal and Māori community artists.

Recommendation 4 – To the Victorian Government:

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

- a) Neither the *Corrections Act 1986* (Vic) nor the *Corrections Regulations 2019* (Vic) prohibit the use of separation as a punishment.
- b) Prison staff are not required to regularly observe children, young people and other prisoners who are subject to separation.
- c) Prisons are not required to maintain a register of separations made under the *Corrections Regulations 2019* (Vic).
- d) 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.

Accepted | In progress

DJCS advised:

Amendments to the Corrections regulations are currently under consideration. This has been delayed by COVID.

These amendments will include consideration of the removal of full loss of privileges as a punishment through the General Managers Disciplinary Hearing process (which includes separation). A trial has recently been approved to take place within the women’s system, the results of which will determine a policy position for the men’s system.

Isolation in youth justice is authorised in accordance with relevant legislative and human rights requirements.

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:

- a) 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.
- b) 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 for extended periods in other areas of a facility, such as Malmsbury's Intensive Supervision Annexe and other areas of the Secure Welfare Services.
- c) 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.
- d) Staff are not required to inform children and young people of the reasons for isolation or seclusion.
- e) 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.
- f) Isolations 'in the interests of the security of the centre' are not required to be recorded in the Isolation Register
- g) 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.

Accepted | In progress

DJCS advised:

DJCS will consider this recommendation as part of the development of standalone youth justice legislation.

The current operating policy determines that young people must be observed in isolation, and the frequency of observation. Isolations are recorded in an isolation register.

DFFH advised:

Implementation of parts a), b) and d) are being progressed through legislative reform to modernise the *Children, Youth and Families Act 2005* (Vic). *The Children, Youth and Families Amendment (Child Protection) Bill 2021* was introduced to Parliament on 5 October 2021.

Parts c) and g) will be addressed through updated policy and/or practice guidance that supports implementation of secure care services. The implementation of g) requires further consideration in the context of secure care services where seclusion is only used where necessary to respond to an immediate threat, and staff capability in their role as carers.

Recommendation 6 – To the Victorian Government:

Recognising that isolation section 488(7) of the *Children Youth and Families Act 2005* (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 *Corrections Act 1986* (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.

Accepted | In progress

DJCS advised:

The Government has indicated it will consider this recommendation as part of the development of standalone youth justice legislation.

In the meantime, DJCS will continue to explore ways to mitigate the effects of any disruption or deprivation due to security arrangements during any industrial dispute, emergency, or other circumstances.

For example, during the COVID-19 pandemic, youth justice continued to support young people with their education and development needs using technology and continued to attend to young people's health and mental health needs ... including onsite'.

Recommendation 7 – To the Department of Justice and Community Safety:

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.

Accepted | In progress

DJCS advised:

Youth justice has developed a Certificate IV in Youth Justice to strengthen the focus on learning and development for entry-level youth justice custodial staff during the first 12 months of employment.

As part of the Certificate IV, pre-service training is delivered to all youth justice custodial workers, including a revised trauma-informed practice package delivered to all new staff in pre-service since January 2022.

Restorative justice practices are also in place youth justice facilities, which provides a trauma-informed approach to recovering from incidents between staff and young people. Behaviour support specialists support custodial staff to address challenging behaviours among young people.

The Aboriginal Youth Justice Strategy (Wirkara Kulpa) recognises the need for therapeutic trauma-informed healing responses to address the many co-occurring issues that drive Aboriginal children and young people's contact with the youth justice system.

Corrections Victoria has developed and will deliver a training package to relevant staff across all prisons.

The Safer Skills training model was based on a comprehensive literature review regarding best practice training approaches for prison officers working with women. The Safer Skills training model is designed to enhance the capacity of custodial staff in the Victorian women's prison system to deliver gender-responsive, trauma-informed case management. The model seeks to frame all aspects of the prison officer role within a case management framework and emphasises the importance of prison officer interactions with women in implementing trauma-informed practice.

Some modules on trauma-informed behavioural management have been introduced into pre-service training for officers at Dame Phyllis Frost Centre and Tarrengower. This program also includes modules for ongoing professional development which are completed by staff post-graduation. It is part of wider reform in the women's prison system.

Discussions are underway about implementing a pilot trauma-informed gender-responsive training module for custodial staff, with a view of utilising this model in all Victorian men's prisons.

Funding is being sought to fully implement the Safer Skills training model at Dame Phyllis Frost Centre and Tarrengower. The Chisholm Road Planning and Prison Services Group are anticipating the development of a trauma-informed training model for male prisoners subject to funding.

The Separation Reform Project has commenced with a focus on reviewing the use of separation and other restrictive placements across the system to develop a new operating model for such placements. The project will ensure the new operating model is in line with international obligations and combines individualised therapeutic and trauma-informed approaches to prisoner management. The broader aim of the project is to ensure that separation is only utilised where absolutely necessary, and where it is utilised, it is for the shortest length of time required to manage the risk and all rationales for its use are clearly documented.

Another key focus of the project is to increase access to a range of meaningful activities and increased opportunities for meaningful interaction for those who are separated. The project will also aim to develop and embed further specific ongoing training for staff working within these environments in addition to the Safer Skills training model.

As an interim measure, the Separation Reform Project has developed an interactive engagement package for custodial staff at all levels which focuses on educating staff about the harmful impacts of restrictive placements and the long-term effects separation can have on an individual, so this is front of mind when making decisions around such placements.

Cultural awareness training has been embedded as a core part of the pre-service training program for custodial staff within the adult corrections system for many years.

Recommendation 8 – To the Department of Justice and Community Safety – 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 | In progress

DJCS advised:

It is current practice in youth justice that an Aboriginal Liaison Officer (‘ALO’) 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 ALO was contacted upon isolation. This has now also been included in CRIS.

The Aboriginal Youth Justice Strategy (Wirikara Kulpa) seeks to strengthen:

- cultural support planning in youth justice custody to deliver a single plan that can be shared by all agencies working with Aboriginal children and young people
- cultural competency of all youth justice staff to deliver a culturally safe and responsive youth justice custodial services.

Similarly, Aboriginal Wellbeing Officers (‘AWO’) are posted at all Victorian prisons. AWOs provide support in all specialist units, including management units, and are advised following any significant incidents or placement decisions. AWOs (or equivalent) are also involved in the development of risk management plans.

Amendments to Deputy Commissioner Instruction 1.17 were published in October 2020. These updates include the requirement for AWOs to be notified when Aboriginal prisoners are separated (which was already practice), and AWOs are to see separated Aboriginal prisoners twice per week (minimum) when a separation exceeds seven days. This requirement will also be listed in the Sentence Management Manual, amendments to which are currently awaiting endorsement by the Commissioner. This will ensure that the same requirements apply to private prisons.

Recommendation 9 – To the Department of Justice and Community Safety – Corrections Victoria:

The Secretary should delegate her power under Regulation 32(7) of the *Corrections Regulations 2019* (Vic) 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.

Accepted | Implemented

DJCS advised:

The Secretary has delegated her power under Reg 32(7) as per the recommendation where the same level of prison officer is authorised under section 32 of the *Corrections Regulations* to order and revoke a separation of a prisoner.

Recommendation 10 – To the Department of Justice and Community Safety – 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 | Implemented

DJCS advised:

A separation flag has been created in the Prisoner Information Management System. This will enable prompt and accurate state-wide data collection related to demographics of separated prisoners and a range of other issues specific to the use of separation within the prison system.

Following successful pilots in 2021, the Separation Reform Steering Committee endorsed state-wide operationalisation of the flagging process. The Deputy Commissioner Instructions and relevant Sentence Management Manual chapters have been updated to reflect this change in practice and staff have received training.

The Separation Reform Project is reviewing the daily running sheets utilised in high security and management units to identify improvements in how the frequency of staff supervision, observation, and interactions are recorded. This will include the addition of requirements to record all meaningful engagements and activities as well as out-of-cell activities.

Recommendation 11 – To the Department of Justice and Community Safety – 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 | Implemented

DJCS advised:

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.

The Local Operating Procedures reflect that out-of-cell time is limited to a maximum of six hours per day, an increase from three hours.

Recommendation 12 - To the Department of Justice and Community Safety - Corrections Victoria:

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 in mainstream units.

Accepted | Implemented

DJCS advised:

Refer to response to Recommendation 11.

Recommendation 13 - To the Department of Justice and Community Safety - Corrections Victoria:

Pursuant to section 41(c) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic), request the Victorian Equal Opportunity and Human Rights Commission 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.

Accepted | In progress

DJCS advised:

The Commissioner for Corrections Victoria has written to the VEOHRC requesting a review against the charter of management units at maximum-security prisons, and the central governing policy around separation regimes.

The Deputy Secretary of Corrections and Justice Services met with the former VEOHRC Commissioner to discuss this review.

Due to restrictions on physical attendance at prison locations and the number of policy amendments already implemented across the system and those yet to be considered following the various Royal Commissions, this action has been delayed.

Recommendation 14 - To the Department of Justice and Community Safety - Corrections Victoria:

Amend policy and practice and immediately cease the routine use of restraints without a contemporaneous risk assessment.

Accepted | In progress

DJCS advised:

DJCS remains committed to exploring opportunities to reduce the number of occasions that mechanical restraints are applied to prisoners and that where they are applied, it is based upon the risks presented by the prisoner.

A review has recommended a trial be conducted at a maximum-security prison whereby separated prisoners can be escorted within prison grounds without handcuffs if a risk assessment supports this action. A trial has commenced at the Metropolitan Remand Centre Chartwell management unit utilising a risk assessment developed in consultation with health and safety representatives at the prison. This trial will run until the end of 2022, the results of which will inform state-wide policy.

Recommendation 15 - To the Department of Justice and Community Safety - 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 | In progress

DJCS advised:

Distinguished Professor James R. P. Ogloff AM (assisted by the Justice Assurance and Review Office) reviewed 'at risk' practices in Victorian prisons. This review found that the system for preventing suicides in Victoria's prisons is largely effective, particularly for prisoners identified as being at risk of suicide.

Of the 10 recommendations made by the report and accepted by DJCS, three have been completed and seven remain in progress (five of these being dependent on favourable budget outcomes).

DJCS commits to providing VO with further advice in relation to the Ogloff Review.

Recommendation 16 - To the Department of Justice and Community Safety - 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 progress

DJCS advised:

Corrections Victoria is currently updating its separation policies to better articulate the considerations that need to be made, with a focus on human rights, young people, and Aboriginal and Torres Strait Islander prisoners.

The Separation Reform Project has developed an interactive engagement package for custodial staff at all levels which focuses on educating staff about the harmful impacts of restrictive placements and the long-term effects separation can have on an individual.

A pilot 'separation as last resort' project at Marngoneet Correctional Centre and Karreenga aimed to ensure that separation was only used where absolutely necessary, and to ensure that where it was used the rationale was clearly articulated and documented. The pilot intended to empower staff to consider alternative options to formal separation at the earliest point possible. A new Separation Assessment Form ensured that where formal separation was used it was clearly articulated and documented that it was the only available option to manage the risk and included consideration of medical or psychiatric conditions as well as consultation with key stakeholders (Prison Intelligence Unit, Forensic Intervention Services, Aboriginal Welfare Officer).

Following the successful pilot in 2021, the Separation Reform Steering Committee endorsed extending the 'separation as last resort' process to all prison locations to replace the current Authority to Separate form/process. The project team will initially focus on medium and minimum-security locations, then commence consultation, engagement and training of all maximum security locations with the aim to have these sites utilising this process before the end of 2022.

The project is also currently focused on the development of an operating model for the management of unacceptable behaviour that poses a risk to the good order and security of the prison or the safety of prisoners or staff within the women's prison system. Staff will be encouraged to consider the individual circumstances of the prisoner (including medical and psychiatric conditions).

The women's system operating model will be completed and operationalised to coincide with the opening of a new close support and supervision precinct at DPFC. The new model created for the women's system will then provide guidance for separation regime reform in the men's system.

Recommendation 17 - To the Department of Justice and Community Safety - Corrections Victoria:

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 his conduct, and that assessment is adequately recorded.

Accepted | In progress

DJCS advised:

Refer to response to Recommendation 16.

Recommendation 18 – To the Department of Justice and Community Safety – Youth Justice:

Ensure Isolation Registers record whether an Aboriginal support officer was contacted upon isolation.

Accepted | Implemented

DJCS advised:

A new field has been added to capture whether an ALO is contacted upon isolation. Youth Justice workers enter this information into the Client Relationship Information System ('CRIS').

Recommendation 19 – To the Department of Justice and Community Safety – Youth Justice:

Amend policy and practice and ensure that the routine use of restraints without a contemporaneous risk assessment cease immediately.

Accepted | In progress

DJCS advised:

Revised procedural guidance provides that the application of mechanical restraints only occurs where reasonable and necessary to prevent a young person from harming themselves or another person, and that the staff member applies handcuffs in accordance with Operational Safety Training guidelines.

These instruments are only used for the minimum time necessary where no other means of control are available to ensure the safety of all persons.

DJCS remains committed to exploring opportunities to reduce the number of occasions that mechanical restraints are applied to prisoners, and that where they are applied, it is based upon the risks presented by the prisoner.

A review has been conducted, which recommended that a trial be conducted at a maximum-security prison whereby separated prisoners can be escorted within prison grounds without handcuffs if a risk assessment supports this action.

A trial has commenced at the Metropolitan Remand Centre Chartwell management unit utilising a risk assessment developed in consultation with health and safety representatives at the prison. This trial will run until the end of 2022, the results of which will inform state-wide policy.

Recommendation 20 – To the Department of Justice and Community Safety – Youth Justice:

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.

Accepted | In progress

DJCS advised:

Communication with staff is ongoing and the isolation policy and procedure will be subject to regular review.

Daily monitoring and reporting of the use of behavioural isolation continues on an ongoing basis, with data provided to the Commission for Children and Young People.

DJCS publishes isolation data relating to Youth Justice on its website. The data shows a declining trend in the use of isolation when comparing 2021-22 to 2020-21.

Recommendation 21 – To the Department of Justice and Community Safety – Youth Justice:

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

Accepted | Implemented

DJCS advised:

DJCS is focussing on the recruitment and retention of staff. The Youth Justice Workforce Strategy was launched in January 2020 and focuses on attraction, retention, quality and skill development, and occupational health and safety of custodial staff.

DJCS continues to conduct frequent recruitment drives to build on staffing capacity, which includes several positions currently advertised for Cherry Creek Youth Justice Precinct. The State Budget has funded Cherry Creek to open progressively from the first half of 2023.

A suite of new policies and procedures have been implemented to support transparent decision-making in relation to lockdowns and rotations due to staff shortages. A dynamic risk assessment process has been introduced at both precincts to inform decision making on ending a lockdown.

The daily monitoring and reporting of rotations and lockdowns caused by staff shortages continues and is provided to the Commission for Children and Young People.

Recommendation 22 – To the Department of Health and Human Services:

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 | In progress

DFFH advised:

Property condition audits of the two secure care properties have been completed and DFFH is reviewing the recommendations of these.

Additional funding has been secured for the 2022-23 and 2023-24 financial years to undertake works to address critical recommendations.

Further consideration of a new purpose-built facility will occur as part of a broader project to review the model of care for secure care services being undertaken by DFFH’s operational division.

Recommendation 23 – To the Department of Health and Human Services – Secure Welfare Services:

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).

Accepted | Implemented

DHHS advised:

DHHS has updated the Secure Welfare Services manual to provide 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 Secure Welfare Services management meeting to monitor and oversight adherence and implementation.

Recommendation 24 - To the Department of Health and Human Services - Secure Welfare Services:

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.

Accepted | Implemented

DFFH advised:

DFFH has taken action to ensure the seclusion rooms are fitted, at minimum, with a washbasin and toilet. Actions have also been taken to improve the therapeutic nature of the space eg provision of mattresses, painting of the rooms, and the provision of therapeutic resources to assist young people with self-regulation, such as therapeutic pillows and stress balls. No further human rights assessments have been carried out.

Recommendation 25 - To the Department of Health and Human Services - Secure Welfare Services:

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.

Accepted | Implemented

DFFH advised:

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.

Recommendation 26 - To the Department of Health and Human Services - Secure Welfare Services:

The General Manager should ensure that outstanding maintenance repairs and necessary refurbishments are completed as soon as possible.

Accepted | Implemented

DFFH advised:

All planned maintenance and refurbishment work identified at the time of the investigation [has] been completed. 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. Daily facility compliance checks occur to ensure any urgent maintenance items are identified and addressed. Every three weeks and each quarter facility quality and maintenance meetings and site checks occur to identify and progress maintenance and refurbishment items.

Appendix 1: Procedural fairness

This report contains adverse comments about:

1. the former Chief Executive Officer, Ballarat City Council
2. the former Director of Infrastructure and Environment, Ballarat City Council
3. a former School Principal and a Business Manager of a Victorian Public School
4. a former City of Melton Officer
5. a former Manager and some senior managers at Warrnambool City Council.

These adverse comments were first made in the original investigation reports to which this report refers. Each individual was provided with the opportunity to respond to those comments before the original reports were finalised and tabled in parliament.

In accordance with section 25A(3) of the *Ombudsman Act 1973*, any other persons who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion. They are named or identified in the report as the Ombudsman is satisfied that:

- it is necessary or desirable to do so in the public interest
- identifying those persons will not cause unreasonable damage to those persons' reputation, safety or wellbeing.

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2022

Investigation into a former youth worker's unauthorised access to private information about children

September 2022

Investigation of a matter referred from the Legislative Council on 9 February 2022 Part 1

July 2022

Joint investigation with IBAC Operation Watts, a joint investigation into allegations of serious corrupt conduct involving Victorian public officers, including Members of Parliament

July 2022

Investigation into complaint handling in the Victorian social housing sector

July 2022

Report on investigations into the use of force at the Metropolitan Remand Centre and the Melbourne Assessment Prison

June 2022

Investigation into Environment Protection Authority decisions on West Gate Tunnel Project spoil disposal

May 2022

2021

Investigation into decision-making under the Victorian Border Crossing Permit Directions

December 2021

Investigation into allegations of collusion with property developers at Kingston City Council

October 2021

The Ombudsman for Human Rights: A Casebook

August 2021

Councils and complaints - A good practice guide 2nd edition

July 2021

Investigation into good practice when conducting prison disciplinary hearing

July 2021

Investigation into Melton City Council's engagement of IT company, MK Datanet Pty Ltd

June 2021

Investigation into how local councils respond to ratepayers in financial hardship

May 2021

Investigation into the Department of Jobs, Precincts and Regions' administration of the Business Support Fund

April 2021

Outsourcing of parking fine internal reviews - a follow-up report

March 2021

Investigation of protected disclosure complaints regarding the former Principal of a Victorian public school

February 2021

2020

Investigation into the detention and treatment of public housing residents arising from a COVID-19 'hard lockdown' in July 2020

December 2020

Investigation into complaints about assaults of five children living in Child Protection residential care units.

October 2020

Investigation into corporate credit card misuse at Warrnambool City Council

October 2020

Investigation into review of parking fines by the City of Melbourne.

September 2020

Investigation into the planning and delivery of the Western Highway duplication project

July 2020

Ombudsman's recommendations - third report

June 2020

Investigations into allegations of nepotism in government schools

May 2020

Investigation of alleged improper conduct by Executive Officers at Ballarat City Council

May 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

WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims

December 2019

Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust

November 2019

Revisiting councils and complaints

October 2019

OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people

September 2019

Investigation into Wellington Shire Council's handling of Ninety Mile Beach subdivisions

August 2019

Investigation into State Trustees

June 2019

Investigation of a complaint about Ambulance Victoria

May 2019

Fines Victoria complaints

April 2019

VicRoads complaints

February 2019

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2018

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

June 2018

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

2017

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

2016

Investigation into the transparency of local government decision making

December 2016

Ombudsman enquiries: Resolving complaints informally

October 2016

Investigation into the management of complex workers compensation claims and WorkSafe oversight

September 2016

Report on recommendations

June 2016

Investigation into Casey City Council's Special Charge Scheme for Market Lane

June 2016

Investigation into the misuse of council resources

June 2016

Investigation into public transport fare evasion enforcement

May 2016

2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 2 – incident reporting

December 2015

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

November 2015

Investigation into the rehabilitation and reintegration of prisoners in Victoria

September 2015

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

September 2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight

June 2015

Investigation into allegations of improper conduct by officers of VicRoads

June 2015

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

April 2015

Councils and complaints – A report on current practice and issues

February 2015

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

February 2015

2014

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

Victorian Ombudsman
Level 2, 570 Bourke Street
Melbourne VIC 3000

Phone 1800 806 314
Email complaints@ombudsman.vic.gov.au
www.ombudsman.vic.gov.au