

Ombudsman's recommendations – second report
July 2018

**Ordered to be published
Victorian government printer
Session 2014-18
P.P. No. 413**

Accessibility

If you would like to receive this publication in an alternative format, please call 9613 6222, using the National Relay Service on 133 677 if required, or email vocomms@ombudsman.vic.gov.au.

The Victorian Ombudsman respectfully acknowledges the Traditional Owners of the lands throughout Victoria and pays respect to them, their culture and their Elders past, present and future.

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 *Second report on recommendations*.

A handwritten signature in black ink, reading "Deborah Glass". The signature is written in a cursive, flowing style.

Deborah Glass OBE
Ombudsman

4 July 2018

Contents

| | | | |
|---|-----------|--|-----------|
| Foreword | 4 | Protecting Human Rights | 65 |
| Introduction | 6 | Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre | 66 |
| Highlighting systemic failures | 11 | Additional report | 73 |
| Investigation into Casey City Council's special charge scheme for Market Lane | 12 | Investigation of a matter referred from the Legislative Council on 25 November 2015 | 73 |
| Investigation into the transparency of local government decision making | 14 | | |
| Investigation into public transport fare evasion enforcement | 19 | | |
| Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint | 24 | | |
| Apologies | 27 | | |
| Exposing poor behaviour in the public service | 29 | | |
| Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board | 30 | | |
| Report into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board | 36 | | |
| Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus | 38 | | |
| Supporting vulnerable people | 41 | | |
| Investigation into the management of complex workers compensation claims and WorkSafe oversight | 42 | | |
| Investigation into Victorian government school expulsions | 48 | | |
| Investigation into the management of maintenance claims against public housing tenants | 54 | | |
| Investigation into the financial support provided to kinship carers | 61 | | |

Foreword

Integrity agencies are well known for making recommendations. We make them because we believe they are necessary to improve public administration, to address the issues identified in our investigations. But what happens after the report and its recommendations have landed on Parliament's heavy wooden tables? Do they simply gather dust? Do agencies pay lip service in agreeing to accept them, but nothing really changes, while the Ombudsman moves on to the next topic? Or do things, actually, change for the better?

I do not make recommendations lightly, and I do not believe more is better. I have tabled two reports on important subjects that made no recommendations – as work was already in progress to achieve change, which I intend to monitor. But when I make recommendations I will follow up – and if necessary, reinvestigate the issue to see whether they have been effective.

This is happening following my 2016 investigation into Worksafe's oversight of complex workers compensation claims. My report made 17 recommendations nearly two years ago, all accepted. Yet we continue to get large numbers of complaints about these issues. Given the impact of the workers compensation system on the lives of some particularly vulnerable people, I believe it is incumbent on me to have another look at it.

On the other hand, following my report into the Registry of Births Deaths and Marriages in January 2017, complaints have dropped by about a third. Complaints can be a powerful indicator of whether recommendations are working.

While my reports in the two years to April cover a wide range of issues and agencies, from public housing maintenance debts to nepotism in the Metropolitan Fire Brigade, keen readers of Ombudsman reports will have noticed some distinct themes.

Some reports expose poor behaviour, with wider lessons for the public sector. A single complaint, such as one about a council decision taken behind closed doors affecting a lane in Narre Warren, may result in a major investigation into the transparency of local councils and impending changes to the Local Government Act.

But the strongest theme emerging should be one of social justice for the most marginalised in our society, and the impact on all of us when it is not realised. For the most part, these are not popular causes. I have investigated oversight of abuse in the disability sector, which I continue to monitor as the National Disability Insurance Scheme rolls out. In my first year I also began looking into rehabilitation in prisons, and since then I have investigated some of the many aspects of social disadvantage that all too often contribute to our burgeoning prison population.

We investigated the unfairness of a system that discriminates against kinship carers, many of them grandparents on low incomes struggling to look after children when the child's own parents cannot cope. They not only take on some very damaged children to provide a supportive family environment, a key factor missing in many children who end up in trouble, they save us a fortune when children might otherwise be in state care.

We investigated expulsions in schools – formal and informal – one of the common factors that can start a child on a life of crime. Following the disturbances in Parkville and Malmsbury in 2016 we looked at youth justice centres – where some 60 per cent of children have previously been expelled or suspended from school. We enquired into the provision of alcohol and other drug services following release from prison. Most recently, we inspected the State's main women's prison, and considered what Victoria needs to do to comply with the United Nations protocol against torture, recently ratified by the Commonwealth Government.

Many recommendations arose from those reports – almost all of them accepted, and many implemented. I accept that it will take time to see the benefits of many of them, and it is too soon to determine whether I need to reinvestigate any of them.

It is good to see the investment in mental health and drug and alcohol rehabilitation – although not enough for many – as well as the expansion of some therapeutic forms of justice such as Drug Courts. It is good to see that Aboriginal prisoners can retain the proceeds of their artwork in prison to support their rehabilitation. I wait to see if the new youth justice facility will have the focus on rehabilitation needed to address the dangerous behaviour of some young offenders, rather than punitive measures that do not work.

But some of the indicators are troubling. Prison numbers continue to grow, and we are spending more than ever on prisons. Since my 2015 report the prison population has grown a further 20 per cent. A recent Auditor-General report tells us each prisoner now costs the State an average of \$127,000 a year. When I reported in 2015, 24 per cent of prisoners were on remand – ie had not been convicted of a crime – now it is over a third. Why are the numbers of women prisoners growing so rapidly – when so many are the victims of crime or abuse themselves? Considering how few are charged with violent offences, why are so many on remand?

And why has the government not accepted my recommendation to stop the abusive practice of routinely strip searching women prisoners – in fact, the only recommendation out of 125 not accepted?

But what should really trouble us is the recidivism rate, which remains around 44 per cent, from a low of 33.7 per cent in 2010.¹ I said in 2015 that building more prisons was not making us safer – over 99 per cent of prisoners will be released one day. We need to do more to ensure they do not come out only to reoffend and return, at the cost both to public safety and the public purse.

But we have not yet seen a greater focus on a whole-of-government approach to reducing offending – the first recommendation I made in my 2015 report. Until we start focusing more on the causes of crime – many of which have their origins in early childhood, education, health, housing and employment – we will not solve this problem.

If the hard-line US state of Texas can reduce both crime and spending on prisons by diverting resources to rehabilitation, surely, so can Victoria.

I cannot enforce my recommendations – rightly so, as many involve policies and resources, and I am not responsible for government policy or the state budget. But I do monitor them, and as an independent officer of Parliament I can express views that may not be popular. To fully implement some of my recommendations will take long-term investment – beyond an electoral term – and sustained political will. The benefits should be to us all.

Deborah Glass

Ombudsman

¹ 2014-15 rate: 44.1 per cent; 2016-17 rate: 43.6 per cent Source: Corrections Victoria.

Introduction

1. The power of the Ombudsman ranges far beyond the decision to investigate public sector bodies and make formal recommendations for change: it extends to monitoring the acceptance and implementation of those recommendations.
2. This biennial recommendation report reflects the impact of Ombudsman investigations and the Ombudsman's driving influence on administrative improvement, as a result of monitoring the implementation of recommendations.
3. The report is a statement of record, and summarises and updates the work of my office. It underscores my commitment to improving administration in the public sector to enhance beneficial social outcomes. It is also part of my accountability mandate.
4. The *Ombudsman Act 1973* (Vic) sets out my powers to investigate and report on decisions and actions of the Victorian public sector. Where I find error or poor conduct, I can hold the sector to account and recommend steps be taken to remedy, mitigate or otherwise deal with the cause or effect of the decision or action. While my recommendations are not legally binding, I am pleased to report they are almost always accepted. However, where my recommendations are not implemented within a reasonable time, the Ombudsman Act allows me to report to the Governor in Council and the Parliament.
5. Finding out what happens to recommendations means effectively communicating with jurisdictional agencies to ensure practical change that benefits the Victorian public sector and the community actually occurs.
6. Following up on our recommendations is also a practice which demonstrates the Ombudsman's commitment to continuous learning – if we fully understand which recommendations are most effective in bringing about a desired result, we have optimal opportunity to formulate future recommendations with the most potential for success.
7. This report has four sections; each highlighting a theme that represents an area of focus for my office, with the relevant reports set out below:
 - Highlighting systemic failures
 - i. Investigation into Casey City Council's special charge scheme for Market Lane
 - ii. Investigation into the transparency of local government decision making
 - iii. Investigation into public transport fare evasion enforcement
 - iv. Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint
 - v. Apologies
 - Exposing poor behaviour in the public service
 - i. Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board
 - ii. Report into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board
 - iii. Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus

- Supporting vulnerable people
 - i. Investigation into the management of complex workers compensation claims and WorkSafe oversight
 - ii. Investigation into Victorian government school expulsions
 - iii. Investigation into the management of maintenance claims against public housing tenants
 - iv. Investigation into the financial support provided to kinship carers
- Protecting human rights
 - i. Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre

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

9. I have also tabled a report concerning the conduct of Members of Parliament, in response to a matter referred from the Legislative Council on 25 November 2015. While for completeness, I have included the recommendations and the response to them, it should be noted that this investigation was carried out in addition to the core work of my office in dealing with public complaints, protected disclosures and systemic issues.

10. I made 125 recommendations in my 14 public reports between 1 April 2016 and 31 March 2018, of which 123 (98.4 per cent) were accepted or partially accepted. I did not seek a response to one recommendation, because it was made to all 79 local councils. Only one recommendation was not accepted.

Figure 1: Acceptance of public recommendations made 1 April 2016 – 31 March 2018

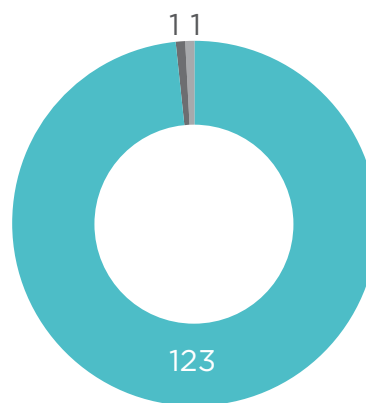
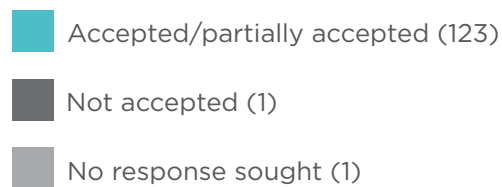
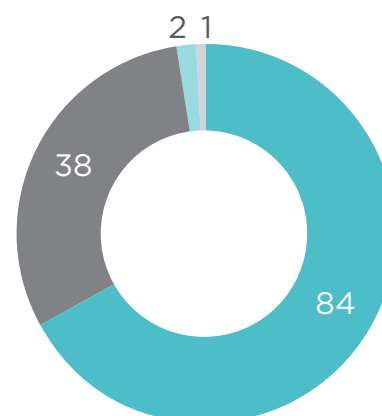
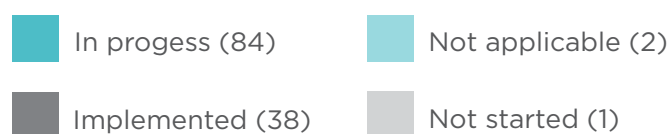


Figure 2: Implementation of all public recommendations made 1 April 2016 – 31 March 2018



Follow-up on my 2016 Report on recommendations

Every two years, I provide a snapshot of how the implementation of my recommendations is progressing. In my 2016 *Report on recommendations*, I reported on authorities' progress to implement 61 recommendations made between April 2014 and March 2016. At the time, 19 (31 per cent) recommendations had been implemented and work to implement a further 38 recommendations had started. Now, 49 (80 per cent) of the 61 recommendations have been implemented.

Further to monitoring the implementation of my recommendations, I evaluate whether the desired improvements have been realised. In some instances, the benefit gained is clear and tangible. However, occasionally it becomes evident that underlying issues remain unresolved. The following are examples of what can happen several years after my reports are tabled.

Councils and complaints – A report on current practice and issues

In February 2015 I tabled *Councils and complaints – A report on current practice and issues*. The report highlighted the value of complaints, set out seven principles of effective complaint handling and made three recommendations aimed at ensuring councils met high standards when dealing with complaints. This report was accompanied by a guide that provided practical advice to assist councils in developing and implementing effective, efficient and fair complaint handling systems.

When I tabled this report and published the Guide, the Government was in the early stages of reviewing the *Local Government Act 1989* (Vic).

After three years of consultation, on 23 May 2018, the Local Government Bill 2018 was introduced into Parliament. If the Bill passes, my recommendations that a 'complaint' be defined and that all councils should have a complaint policy will become law.

Investigation into the rehabilitation and reintegration of prisoners in Victoria

In September 2015 I tabled a report on my *Investigation into the rehabilitation and reintegration of prisoners in Victoria*. The investigation was prompted by the growth in prisoner numbers, rates of reoffending and increasing cost to the Victorian community. This investigation resulted in 25 recommendations. The recommendations centred on a whole of government approach to reducing reoffending, in addition to increasing investment in, enhancing and improving the availability of programs aimed at preventing and reducing recidivism rates.

At the time of my 2016 report, only four recommendations had been implemented. Since then, the Department of Justice and Regulation (DJR) has implemented a further 16 recommendations, with five still in progress. Despite this progress, the same concerns that prompted me to investigate persist. Prison numbers and the cost to the public are at all-time highs, and close to half of all prisoners released reoffend and return to prison within two years. As the Government tightens sentencing and bail conditions, and builds more prisons, there is no indication that these trends are likely to change.

The steps taken by DJR to respond to my recommendations are significant. I have seen tangible benefits, such as the introduction of a new Drug Court in Melbourne, a new Koori Court in Mildura and increased funding to non-government organisations that provide transitional support to prisoners.

However, we are still yet to see a whole of government approach where education, health, housing and employment all play their role in reducing offending.

I will continue to monitor and report on the need for a whole of government approach, but it is clear that the community must also act as advocates for change to achieve long-term and sustainable reductions in offending and its cost to the community.

Reporting and investigation of allegations of abuse in the disability sector

In June and December 2015, I tabled the two phases of my report on *Reporting and investigation of allegations of abuse in the disability sector*. Together the reports contained 13 recommendations to the Government and Department of Health and Human Services (DHHS).

At the time of my 2016 *Report on recommendations*, work to implement the recommendations had started, however none were completed. It was difficult to see what changes would be made to ensure that DHHS's oversight of the disability sector and the processes for incident reporting improved.

Since then, DHHS has kept my office informed of its approach and progress. It has responded to my recommendations by developing an entirely new Client Incident Management System (CIMS). DHHS says that CIMS, and its supporting policies and procedures, is client-focused, has clear reporting lines, and is easy for disability providers and DHHS staff to use. It gives DHHS clear oversight of incident reporting and investigations, and fulfils the intent of a number of my recommendations to DHHS.

DHHS has expanded its use to other areas of DHHS, including:

- child protection
- family violence and support services, and
- public and some health services.

By doing so, DHHS says it is now able to easily track client access to multiple services, supporting better coordination across its operational divisions.

Figure 3: Client Incident Management System

The screenshot shows the 'Client Incident Management System' interface. At the top, there is a dark blue header with the system name and a 'Need help with this application? Call' link. Below the header, a navigation bar includes '1. Incident' and a menu with 'Service', 'Reporting officer', 'Dates', 'Description', 'Clients', and 'Others involved'. The 'Service' tab is active. The main content area is titled 'Service details' and contains a descriptive paragraph, a note about mandatory fields, and several input fields: 'Organisation name*', 'Address of service delivery*' (with a 'No address match for my organisation' checkbox), 'Area*', and 'Program*'. Each field has a 'What is this?' link. A 'Next >' button is located at the bottom right of the form area.

Client Incident Management System

Need help with this application?
Call

1. Incident

Service Reporting officer Dates Description Clients Others involved

Service details

This section contains information about the organisation delivering the service to the client at the time of the incident.

Mandatory fields are marked with an asterisk (*)

Organisation name*

[What is this?](#)

Address of service delivery*

[What is this?](#)

No address match for my organisation

Area*

[What is this?](#)

Program*

[What is this?](#)

Next >

Highlighting systemic failures

11. Every year my office receives tens of thousands of complaints. In most cases, complainants raise concerns specific to their circumstances. However, sometimes I come across similar concerns that suggest the existence of systemic failures due to ingrained deficiencies in a process.
12. Often, these systemic failures are relevant to large parts of the community. The issues concern agencies and services that we interact with regularly, sometimes daily – councils, public transport and the Registry of Births, Deaths and Marriages. For most of the public, most of the time, these services and the agencies that provide services are reliable and form an integral part of life. However, as illustrated in this section of my report, when they go wrong, it can have significant consequences.
13. Since April 2016, I have tabled five investigation reports about systemic failures in public administration. Two of these investigations were prompted by specific complaints:
 - Investigation into Casey City Council's special charge scheme for Market Lane
 - Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint.
14. The other three investigations resulted from my office observing a pattern of similar issues across multiple complaints:
 - Investigation into transparency of local government decision making
 - Investigation into public transport fare evasion enforcement
 - Enquiry into apologies.
15. The source of systemic failures varied across these investigations. Some, for example, stemmed from out-of-date laws, overstretched resources or archaic case management systems. Often, a combination of factors contributed to the failures. The one factor common to these investigations was authorities' inflexible application of their policies, procedures or business rules – where an unwavering focus was placed on process, rather than purpose.



Investigation into Casey City Council's special charge scheme for Market Lane

Why I investigated

Between June and September 2014, I received a series of complaints about Casey City Council's special charge scheme in Market Lane, Narre Warren South. Special charge schemes are set out under the *Local Government Act 1989* (Vic). This scheme required residents to pay a levy that would cover the cost of sealing and installing drainage and lighting in Market Lane.

Residents raised concerns about the council's:

- consultation process, which appeared to discount submissions or concerns where they were not in favour of the scheme
- provision of information, including about owners' right to object and the interest rate that would be applied
- decision to increase the interest rate during a closed council meeting, in which residents could not participate.

Initial enquiries with the council made by my office confirmed that there was a lack of transparency in this case, which led to my decision to investigate the council's decision making relating to the special charge scheme.

What I found

Casey City Council initially estimated that each affected property owner would be liable for between \$15,000 and \$20,000 depending on the benefit they would receive. Council proposed that owners could pay the amount as a lump sum or could opt to make 60 quarterly repayments subject to an interest charge of 4.25 per cent. Notably, although councils are legally permitted to charge interest, in this instance the council intended to fund the scheme from its own cash reserves and would not actually incur external borrowing costs.

I found that during the council's consultation on the proposed scheme, the council largely discounted residents' objections and concerns, and proceeded with the scheme without any modifications.

My investigation identified numerous issues with the council's development and declaration of the special charge scheme. It failed to act on owners' concerns about and opposition to the scheme, did not provide important information to owners about their rights, and made a decision to substantially increase the interest rate without reasonable justification, and behind closed doors.

What has happened since

Since my report, the council rectified the issues I highlighted. It not only returned the originally agreed interest rate to the special charge scheme, but also agreed to refund the residents the difference already charged.

On a larger scale, Local Government Victoria has clarified the provisions relating to special charge schemes through the Local Government Act review. The future Local Government Act will specify the circumstances under which such a scheme can be levied, and limits variation on the amount of the charge.

| Status of my recommendations to Local Government Victoria and Casey City Council | |
|---|---|
| <p>Recommendation 1 - to Local Government Victoria</p> <p>Consideration should be given in the current review of the <i>Local Government Act 1989</i> (Vic) to amending the special rate and charge provisions to remove any ambiguity relating to interest charged and borrowings.</p> | Accepted and implemented in the draft Local Government Bill. |
| <p>Recommendation 2 - to Local Government Victoria</p> <p>Further guidance should be provided to councils on declaring special rates and charges to ensure consistent application by all councils.</p> | Accepted and implemented in the draft Local Government Bill. |
| <p>Recommendation 3 - to Casey City Council</p> <p>Council should develop a special rate and charge scheme section on its website to ensure all relevant information about schemes are available to the community.</p> | Accepted and implemented. |
| <p>Recommendation 4 - to Casey City Council</p> <p>Council should consider refunding residents for the interest charged over and above 4.25 per cent per annum - the rate as at February 2014 that was notified to residents - until 1 September 2015.</p> | Accepted and implemented. A total amount of \$2,204.50 was refunded to residents. |
| <p>Recommendation 5 - to Casey City Council</p> <p>In light of its view that it erroneously decided to enter a closed meeting on 17 June 2014, Council should consider releasing on its website all minutes and documentation associated with this closed session regarding the Market Lane Special Charge Scheme interest rate.</p> | Accepted and implemented. |
| <p>Recommendation 6 - to Casey City Council</p> <p>Council should institute a process of revising its special charge scheme interest rate annually as part of its budget process.</p> | Accepted and implemented. The council now sets the interest rate of special charge schemes as part of its annual budget development process. |
| <p>Recommendation 7 - to Casey City Council</p> <p>Council should review the provisions of section 89(2)-(3) of the Local Government Act and, in future, ensure it fulfils its obligations to record the reason(s) for a decision to close a council meeting.</p> | Accepted and implemented. |



Investigation into the transparency of local government decision making

Why I investigated

About a quarter of the complaints received by my office are about local councils. The varied nature of the issues identified in these complaints reflects the breadth of important services councils provide to their communities. In these complaints, individuals occasionally mention council decisions that were made 'in secret' or 'behind closed doors' as contributing to their suspicions about, or dissatisfaction with, the council.

The *Local Government Act 1989* (Vic) contains provisions that encourage public participation in councils decision making processes. My investigation into Casey City Council's special charge scheme for Market Lane highlighted the opportunity councils have to make decisions in meetings that are closed to the public without justification, contrary to the Local Government Act.

In March 2016, I started investigating the transparency of council decision making. My investigation considered councils closure of meetings; handling of confidential matters; use of delegations in decision making; and the nature and quality of its records and public availability of those records. While my investigation examined information about all 79 councils, I decided to undertake a more detailed examination of 12 councils which were geographically and demographically representative of councils across Victoria.

In September 2015, the government announced its intention to review the Local Government Act. I intended the evidence obtained during my investigation, as well as the resultant findings and recommendations, to inform the government's review.

What I found

My investigation found that Victorians are subject to a 'postcode lottery' when it comes to local government transparency. Some councils modelled best practice in transparency, utilising new technologies to live-stream their council meetings to the public. In contrast, others prioritised making decisions at closed council meetings, at the cost of input from and accountability to those they were elected to represent.

The Local Government Act allows for this level of disparity. While it supports the flexibility required of councils to accommodate the specific needs of its constituents, it is outdated and does not reflect current community expectations. It allows council meetings to be closed for a very broad range of reasons that too easily permit secretive decision making. This can breed suspicion amongst those not able to access the decision making process. It also lends itself to being misused and makes decisions made in closed meetings almost impossible to question.

Beyond the decisions and processes that take place in council meetings – closed or open – are the discussions and agreements that occur in other fora, such as pre-meetings, briefing sessions and council dinners. These settings are not subject to the same levels of public scrutiny, nor do they attract the record keeping requirements, that apply to council meetings. The deals and arrangements made between councillors outside council meetings, hidden from the public, can improperly influence decisions made within meetings.

What has happened since

Since my report was tabled, the government's review of the Local Government Act has been completed. On 12 December 2017, the government published an exposure draft of the new Local Government Bill for consultation. On 23 May 2018, the Local Government Bill 2018 was introduced into Parliament.

In keeping with my recommendations, the replacement Local Government Act narrows the grounds on which meetings can be closed; mandates that councils develop a public transparency policy; and strengthens the conflict of interest provisions. Local Government Victoria, which has been responsible for the review, has been open and willing to engage with my office in relation to the recommendations it had partially accepted.

Further to the proposed amendments to the Act, I have noticed many councils have made a concerted effort to increase the transparency of their decision making. Research by my office shows that the number of councils live streaming meetings has almost trebled since my report was tabled, with 30 councils now live streaming meetings and a further two councils due to commence live streaming in July 2018.

Live streaming boosts transparency at Council meetings

In a boost to transparency and community engagement, [City of Port Phillip] Council meetings held at St Kilda Town Hall will be live streamed, starting 6.30 pm on Wednesday 17 May [2017].

...

Mayor Bernadene Voss said a Victorian Ombudsman report in 2016 identified live streaming of Council meetings as an excellent way to facilitate community engagement with local governments.

'It's exciting because live streaming means more people will have easier access to watch democracy in action...'

Source: www.portphillip.vic.gov.au/may-2017-media_6980.htm

Status of my recommendations to the Government / Local Government Victoria

Recommendation 1 - to the Government / Local Government Victoria

In its review of the Local Government Act, ensure that the following are reflected in primary legislation or regulations:

- requirements for the closure of meetings, including:
 - a public interest test similar to that in section 10B of the *Local Government Act 1993* (NSW)
 - the removal of any 'catchall' provision for meeting closures from section 89(2)
 - a requirement for more detailed reasons in relation to the closure of meetings to be specified in the minutes, similar to the requirements in section 90 of the *Local Government Act 1999* (SA)
 - a requirement for councils to include a 'sunset' provision in relation to all items discussed in closed meetings, which specifies a date or event after which the information will no longer be confidential without a further resolution of council
 - that embarrassment to, or potential adverse criticism of, council are irrelevant considerations in deciding whether to close a meeting to the public, similar to that in section 10B of the *Local Government Act 1993* (NSW) or section 90 of the *Local Government Act 1999* (SA).
- appropriate conflict of interest requirements to extend to members of advisory committees
- a requirement for councils to maintain an up to date list of advisory committees, special committees and members of those committees on their website.

Partially accepted and in progress.

The Local Government Bill removes the 'catch-all' reason for closing council meetings. It also strengthens the conflict of interest requirements on councillors, and extends the requirements to council staff and members of committees.

| | |
|--|---|
| <p>Recommendation 2 – to the Government / Local Government Victoria</p> <p>Ensure that the following areas are covered, as a minimum, in guidance for all councils:</p> <ul style="list-style-type: none"> • agendas being made available to the public at least five days before a council meeting • reporting on the exercise of delegations • use of notices of motion • recording of public questions and answers at council meetings in minutes, or through audio or audio-visual recording and publication • councillor briefing sessions • <i>en bloc</i> voting [dealing with several decisions through a single vote] should only occur in clearly defined circumstances including: <ul style="list-style-type: none"> • <i>en bloc</i> voting should not be used to decide planning matters or other matters where the interests of third parties are involved • every resolution made at a council meeting, including a resolution to pass a number of matters <i>en bloc</i> should be clearly recorded in the minutes of the meeting. • audio recording wherever practicable of both open and closed council meetings, and posting of audio recordings of open meetings on council websites. | <p>Partially accepted and in progress.</p> <p>Local Government Victoria is preparing guidance materials for councils which coincide with the commencement of the new legislation. These guidelines will address council agendas, reporting on the use of delegations, uses of motion, record keeping at open council meetings and requirements for <i>en bloc</i> voting.</p> |
| <p>Recommendation 3 – to the Government / Local Government Victoria</p> <p>Amend the <i>Freedom of Information Act 1982</i> to ensure documents relating to closed meetings are not classified as ‘exempt documents’, in order to encourage consideration of the contents of individual documents on a case by case basis.</p> | <p>Accepted.</p> |

| | |
|---|---|
| <p>Recommendation 4 – to the Government / Local Government Victoria</p> <p>Develop and implement:</p> <ul style="list-style-type: none"> • a uniform Code of Councillor Conduct for all Victorian councils setting out the minimum requirements • a mandatory training program based on the Code of Councillor Conduct for all Victorian councillors. | <p>Partially accepted.</p> <p>A uniform Code of Councillor Conduct was not agreed to. Instead, it is proposed that the new Local Government Act will set out governance principles, as minimum standards, that councils must include in their individual councillor codes of conduct. Guidance will also be provided to councils.</p> |
| <p>Recommendation 5 – to the Government / Local Government Victoria</p> <p>Review the LGPRF (Local Government Performance Reporting Framework data) transparency measure in light of the information contained in this report.</p> | <p>Accepted and in progress.</p> |
| <p>Recommendation 6 – to councils</p> <ul style="list-style-type: none"> • Any council which has not done so in the last three years: <ul style="list-style-type: none"> • review their governance and meeting procedure local laws to ensure consistency with the requirements of the Local Government Act • review their special committees to determine their level of compliance with the requirements of the Local Government Act and whether the special committee structure is fit for the committee’s purpose. • maintain an up to date special committee page on their website listing all special committees, with links to their delegations, meeting notices, minutes of meetings and any other relevant materials. | <p>No response sought.</p> |



Investigation into public transport fare evasion enforcement

Why I investigated

Since the introduction of Authorised Officers (AOs) to check tickets on public transport, my office has received complaints about their behaviour and excessive penalties associated with fare evasion.

Most complaints about public transport fares and fines are dealt with through the Department of Economic Development, Jobs, Transport and Resources' (DEDJTR) internal review process or the Public Transport Ombudsman, or they end-up in court. Prior to my investigation, the Public Transport Ombudsman had raised concerns with me about an increase in complaints about infringements and on-the-spot penalty fares received by her office.

Between 10 August 2014 and 1 December 2015, my office received almost 400 complaints about public transport infringement-related issues. The complaints included people's accounts of being fined despite their circumstances clearly indicating they were unaware of their obligations (visitors from rural areas or overseas); entitled to travel on a concession fare; were suffering a significant impairment; or were homeless and would be unable to pay the fine. People also reported that they felt AOs had pressured them into paying the on-the-spot penalty fare, thereby forfeiting any right to appeal or review without being informed of these consequences.

I decided to focus my investigation on whether the approach to preventing fare evasions was fair and equitable to public transport users, and whether the use of infringements and on-the-spot penalty fares operated as an effective deterrent to fare evasion.

What I found

In 2014-15, 564 million trips were made using Victoria's public transport on trains, trams, buses and coaches. In 2015-16, the number of trips made on public transport increased to 594 million. Fare evasion costs the state tens of millions of dollars each year. Fare enforcement is both a deterrent and sanction, acting to mitigate these losses.

The aspects of the infringement system that I found particularly concerning included the:

- 'on-the-spot' penalty fare option created a two-tier system that was not properly integrated and did not target recidivist offenders
- lack of discretion exercised by AOs in issuing Report of Non-Compliance (RONCs), reinforced by a lack of guidance and training to AOs, including to individuals who:
 - evidently had made a genuine mistake that could have been easily rectified had the opportunity been provided
 - clearly had a concession entitlement, regardless of whether they were carrying a concession card
 - met the criteria for 'special circumstances' that would likely result in any penalty being waived or withdrawn.
- inadequacy of resources dedicated to DEDJTR's internal review process which involved little consideration of the merits of the decision and was accompanied by poor administrative practices
- DEDJTR's tendency to prosecute infringements at significant cost, given only two in ten resulted in any financial penalty.

My investigation found that the fare enforcement scheme took a heavy-handed approach to dealing with non-compliance, and had poor review and appeal processes, which contributed to a costly and ineffective system.

What has happened since

While my investigation was underway, DEDJTR undertook its own review of public transport fare enforcement.

Since my investigation and DEDJTR's review, the Victorian Government has implemented significant changes to the fare enforcement system. Notably, on 11 October 2016, the Victorian Government announced legislative changes that resulted in on-the-spot penalty fares being abolished from 1 January 2017.

Since my investigation, the number of complaints to my office about public transport infringement-related matters has decreased dramatically.

Status of my recommendations to the Department of Economic Development, Jobs, Transport and Resources'

| | |
|--|--|
| <p>Recommendation 1</p> <p>The system should provide for a single penalty with the ability to seek a review.</p> | <p>Accepted and implemented.</p> <p>From 1 January 2017 the two-tier enforcement approach:</p> <ul style="list-style-type: none"> • on-the-spot penalty fares were abolished • the use of official warning letters was embedded in the approach for non-compliance under specific conditions • the well-established transport infringement notice (TIN) system was retained, with improved access to and processing of internal reviews. |
| <p>Recommendation 2</p> <p>How to seek a review or make a complaint should be made clear during a passenger's interaction with an AO.</p> | <p>Accepted and implemented.</p> <p>When recording a report of non-compliance, AOs also provide the recipient a pamphlet containing information about how to seek a review and contact details for the DEDJTR.</p> |
| <p>Recommendation 3</p> <p>The system should provide for clear options if payment is not made, or if the penalty is challenged.</p> | <p>Accepted and implemented.</p> <p>All public information (printed and digital) has been reviewed and updated. It includes information about how people should apply for a review, what supporting evidence is required, the statutory timelines for each stage of the infringements process, and when matters may be escalated to court.</p> |
| <p>Recommendation 4</p> <p>A review should be on the merits against objective, published criteria which include 'special circumstances', whether proof of concession has been provided and whether the person was an interstate, overseas or regional visitor who was unaware of how to comply.</p> | <p>Accepted and implemented.</p> <p>The City of Melbourne's <i>Special Circumstances Infringement Review: A Model Operating Policy for Enforcement Agencies</i> (February 2014) has been adopted for public transport infringements.</p> <p>A <i>Public Statement on the Government's Strategy for Compliance and Enforcement of Public Transport Ticketing</i> has been published. The statement includes criteria that may be taken into account as part of a review, together with forms of evidence that people can provide to support a review request.</p> |

| | |
|---|---|
| <p>Recommendation 5</p> <p>The department should enable the lodgement of a review via an online form with predefined fields to assist the passenger to understand if their reasons are likely to fit the criteria for a successful appeal and to allow for faster internal processing.</p> | <p>Accepted and implemented.</p> <p>A new internal review application form has been developed and is available on DEDJTR's website. The form can be completed electronically and submitted via email.</p> |
| <p>Recommendation 6</p> <p>The department should review its prosecutorial guidelines to ensure that in considering whether it is in the public interest to prosecute a matter, that court outcomes are considered, particularly where special circumstances or concession matters are involved.</p> | <p>Accepted and implemented.</p> <p>The updated prosecution policy framework requires that the public interest is always taken into consideration when deciding whether to take matters to Court, including matters involving concessions.</p> <p>Work with the Department of Justice and Regulation has commenced on implementing the Work and Development Permit Scheme. Some public transport offenders have already been able to 'work off' transport fines through participating in community service. The process appears to be functioning well to date.</p> <p>DEDJTR prosecutions of public transport infringement fines have reduced by 39 per cent for the period January to August 2017 compared to January to August 2016.</p> |
| <p>Recommendation 7</p> <p>The department should review the template letters it uses when providing responses to requests for review so they are in plain English and address the specific concerns raised by the passenger.</p> | <p>Accepted and in progress.</p> <p>Letters and correspondence templates have been updated to be in plain English and to clearly explain the rationale for decisions.</p> |
| <p>Recommendation 8</p> <p>The guidelines that apply to AOs and their use of discretion should be amended to specify that, in the following circumstances, AOs should not issue Reports of Non-Compliance:</p> <ul style="list-style-type: none"> • where there is clear evidence that 'special circumstances' apply to a passenger • where there is clear evidence that the passenger is visiting Melbourne from interstate, overseas or regional areas and was genuinely unaware of how to comply. | <p>Accepted and implemented.</p> <p>The guidelines for AOs in accordance with the recommendation.</p> <p>Information sessions, reinforcing the changes to the guidelines, have been provided to AOs.</p> |

| | |
|---|--|
| <p>Recommendation 8 (continued)</p> <ul style="list-style-type: none"> where there is clear evidence of concession entitlement, for example, where a school uniform is being worn or another card is available (Health Care Card or similar), even though the fare evader does not hold the required proof of concession entitlement. | |
| <p>Recommendation 9</p> <p>The department should consider how a record of fare evasion can assist with targeting recidivist offenders, by for example, retaining a record of any warnings issued to passengers.</p> | <p>Accepted and implemented.</p> <p>All reports of non-compliance and official warnings are recorded. A person's history is considered when DEDJTR officers decide what action to take in relation to an infringement.</p> |
| <p>Recommendation 10</p> <p>Penalties for concession offences should be withdrawn at the review stage if a concession entitlement existed at the time of the offence and can be proven.</p> | <p>Accepted and implemented.</p> <p>The new official warning system, which allows one warning every three years, for inadvertent non-compliance, applies to concession-related offences.</p> |
| <p>Recommendation 11</p> <p>The department should develop a protocol similar to that which exists in New South Wales, including that AOs are authorised to not issue Reports of Non-Compliance to homeless people.</p> | <p>Accepted and in progress.</p> <p>The updated guidelines for AOs specify that a report of non-compliance should not be completed where there is clear evidence that 'special circumstances' apply to a passenger, including those passengers who are experiencing homelessness.</p> <p>The government is in the process of developing a state-wide protocol for government officers on how to best engage and interact with homeless persons in public places.</p> |
| <p>Recommendation 12</p> <p>The department and AOs should accept Victorian primary and secondary school issued identification cards, or the wearing of school uniforms, as proof of concession entitlement for primary and secondary school students.</p> | <p>Accepted and implemented.</p> <p>AOs have been instructed to exercise discretion and accept the wearing of school uniforms as proof of concession entitlement for primary and secondary school students.</p> |



Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint

Why I investigated

In May 2016, I received a complaint from a mother, Ms X, who had experienced the devastating loss of her young child. Ms X contacted my office after she had tried to resolve issues concerning her application for documents from the Registry of Births, Deaths and Marriages (BDM). She had requested copies of her son's birth certificate without a 'deceased' annotation; a copy of his surviving twin brother's birth certificate; and a copy of the death certificate containing correct details. BDM advertised a 10 - 20 day turnaround timeframe, but Ms X had waited months to receive the documents.

Attempts by my office to resolve Ms X's complaint informally were not successful. Instead, the responses received from BDM to my office's initial enquiries suggested potentially systemic issues. We also observed that in the 12 months prior to Ms X's complaint, we had been receiving an increasing number of complaints about BDM, the majority relating to delays and poor communication.

Therefore, as part of my ensuing investigation I not only examined BDM's handling of the specific complaint, but also looked more broadly at its management of applications; the way in which it communicated its decisions; and whether it took into consideration the personal circumstances of the people and the families which rely on its documents.

What I found

My investigation found BDM had no documented policy, or clear rationale, for including the 'deceased' annotation as a matter of course. BDM's processes were not consistent with the *Births, Deaths and Marriages Registration Act 1996* (Vic) which provided BDM the option not to use the annotation.

The fact the legislative discretion exists indicated that law makers anticipated exceptional circumstances where it would not be appropriate to include the annotation.

In relation to BDM's processing of Ms X's application, I found a series of deficiencies. BDM was unable to confirm receipt of Ms X's application and had failed to inform her that it had deemed the application documents incomplete, meaning that the applications would not be processed. This all occurred despite Ms X submitting complete applications and paying processing fees totalling \$99.65, which had been held by BDM. It was after my investigation had commenced that BDM provided Ms X two birth certificates and one death certificate.

More broadly, I found that processing delays and poor record keeping were not isolated to Ms X's case. BDM lacked policies, procedures and proper processes for managing and responding to applications. Its database was outdated and could not perform simple tasks, such as linking an email to a record of a person's life events, with staff resorting to managing applications in spreadsheets. BDM officers' advice to members of the public was inconsistent and, at times, unhelpful and incorrect. Collectively, these conditions did not support BDM officers to operate effectively and efficiently, and resulted in poor interactions with members of the public.

What has happened since

Since my investigation, BDM has taken steps to remedy the issues I identified. This has included providing Ms X an apology for mishandling her application, and refunding the processing fees for her three applications.

BDM has established a written policy to always include a 'deceased' annotation on a birth certificate for a person who is deceased, acknowledging that greater discretion is allowed for by the Births, Deaths and Marriages Registration Act. The policy includes the rationale for this approach. Given this position, BDM has still not provided Ms X with a second copy of a birth certificate that does not contain the 'deceased' annotation. Ms X remains dissatisfied with this outcome.

To address the broader processing and record keeping issues, BDM appointed an external auditor to review its business practices. BDM has also completed work to improve communications with the public, which has included a refresh of its templates and updated processes that cover when and how it should follow-up with applicants, including using more helpful language.

My investigation started during a marked increase in complaints about BDM with 197 complaints received in 2016, or almost double the number received in 2015. However, since my report was tabled this trend has turned around. During 2017, we received 90 complaints about BDM and observed a steady decrease month-to-month as the year progressed.

| Status of my recommendations to the Department of Justice and Regulation and the Registry of Births, Deaths and Marriages | |
|--|---|
| <p>Recommendation 1</p> <p>Review the Registry's business practices and performance through an external audit agency in 18 months' time.</p> | <p>Accepted and implemented.</p> <p>In April 2018 an external agency completed a review of BDM's business practices and performance.</p> |
| <p>Recommendation 2</p> <p>Develop a written policy regarding the Registrar's discretion to use a 'deceased' notation on birth certificates for deceased persons under the Births, Deaths and Marriages Act; giving consideration to the wording of the policy to allow the Registrar not to record a deceased status on birth certificates in exceptional circumstances.</p> | <p>Accepted and implemented.</p> <p>The policy now states that the 'deceased' annotation will be used in all cases as a security requirement, acknowledging that legislative discretion exists.</p> |
| <p>Recommendation 3</p> <p>Ensure that applicants who have paid a fee, for which their application has been assessed as non-compliant, have been notified of this.</p> | <p>Accepted and implemented.</p> |



Apologies

Why I investigated

Sometimes I see an issue that affects all areas of government because it strikes at the heart of how people see the authorities that are meant to provide for, and support, them. Most of the time, the community expects and receives a reliable, responsive and quality service. However, when it does fall below reasonable expectations, the one constant thing many people want is an acknowledgement of the failure – recognition that some disappointment or, in more serious situations, harm has occurred at least in the form of an apology.

I have seen the positive effect of apologies. Relationships between an authority and a member of the public that may have seemed irreparably damaged have been rebuilt on the basis of an apology. I have also seen agencies refuse to say sorry, even where there is no doubt that their actions have been wrong, prolonging the sense of injustice and leaving that matter unresolved.

Given the very different approaches authorities take to providing apologies, I wanted to look at why some apologise and why some do not, the role apologies play in resolving disputes and to share any lessons from this work with the rest of the Victorian public sector.

What I found

I examined the use of apologies using my power to conduct enquiries under section 13A of the *Ombudsman Act 1973* (Vic). This power enables me to look at an administrative action – in this case, a decision to apologise – for the purpose of determining if an issue may be informally resolved or investigated.

As part of my enquiries, I asked 80 authorities from different areas of government (including departments, local councils, hospitals, universities, TAFEs, prisons, workers compensation insurers, regulators and complaint handling bodies) to tell me how they deal with apologies. The responses to my survey showed authorities have very different positions on making apologies. While almost all were willing to apologise at least some of the time, many were reluctant to acknowledge fault or responsibility and a small proportion stated they would never apologise. For the more cautious authorities, a common concern was that an apology constituted an admission of liability, leaving the authority open to being sued for costs and damages. This prospect was considered to be a substantial barrier to providing an apology.

After comparing the results of these surveys, my office conducted research into the legislative supports and obstacles to authorities providing apologies, and examined complaints my office had received. I then identified examples of best practice.

While apologies are not always appropriate or accepted, they are powerful when they are sincere and timely. Effective apologies will often consist of the following elements:

- Recognition – recognition of the mistake and the harm it caused
- Responsibility – an admission of responsibility or fault
- Regret – an expression of regret or sympathy

- Reasons – an explanation of what happened, or what will be done to investigate
- Redress – an explanation of what is being done to fix the mistake or prevent it happening again
- Release – if it is appropriate, a request for forgiveness.

As part of my report, I published a factsheet for authorities which summarises the value and elements of a good apology. I also recommended that the Government amend the *Wrongs Act 1958* (Vic) to separate an apology from being an admission of fault or civil liability. This recommendation was consistent with a previous recommendation made by the 2016 Access to Justice Review regarding amendments to the *Wrongs Act*.

What has happened since

The Government informed my office that it is currently considering the scope of possible amendments to the *Wrongs Act*. The Department of Justice and Regulation in conjunction with the Department of Health and Human Services is considering introducing a statutory duty of candour for the health sector, which would similarly require amendments to Victoria's apology laws.

Status of my recommendations to the Victorian Government

I recommend that the Victorian Government consider amending Part IIC of the *Wrongs Act 1958* (Vic) to:

- prevent apologies being used as an admission of liability or evidence in all types of civil proceedings
- expand the definition of apology to include apologies that involve an acknowledgement of responsibility or fault.

Accepted and in progress.

The Government is considering possible amendments to the *Wrongs Act*, however no decisions have yet been made to progress any legislative reform for apologies in the *Wrongs Act*.

Exposing poor behaviour in the public service

16. The *Protected Disclosure Act 2012* (Vic) encourages whistleblowers to report improper conduct involving public bodies or public officials by offering them legal protection against any detrimental action taken in reprisal for a disclosure of such conduct. A core function of my office is to receive disclosures about improper conduct and detrimental action, and to investigate protected disclosure complaints referred to my office from the Independent Broad-based Anti-Corruption Commission (IBAC).
17. I rarely report my findings of protected disclosure investigations. Many allegations are not substantiated, and when a person is alleged to have been involved in improper conduct, it can have a significant impact on their employment, personal wellbeing and more broadly impact those around them. I do not take a decision to publicly report on allegations of improper conduct lightly.
18. There are, however, circumstances in which the conduct is so at odds with the values of the public service and raises systemic issues which may serve as a warning to others, that it is in the public interest to report on my findings.
19. The reports about my protected disclosure investigations that I table in Parliament serve to remind those of us who perform a public function of our obligations to act in the public interest and the expectation by the public that we do so. These reports often identify gaps in the supports or controls that are intended to assist public officers and those receiving and expending public funding, to act with the highest levels of integrity.
20. Since my 2016 *Report on recommendations*, I have tabled three investigation reports concerning protected disclosure complaints:
 - Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board
 - Investigation into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board
 - Investigation into management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus.



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

Why I investigated

In March 2016, IBAC referred to me two matters that had been determined to be a protected disclosure complaint. I commenced an investigation into the conduct of the Chief Executive Officer (CEO), Property Manager and Chief Financial Manager of the Mount Buller and Mount Stirling Alpine Resort, and the Board Chair of the resort's board. After my investigation started, IBAC referred two more related matters to my office and a number of further allegations arose in the course of my investigation, all of which were investigated.

The allegations related to the subjects' use of public money and property for their own private benefit, including that they:

- purchased airfares for family members and paid for overseas travel costs for what were essentially personal holidays
- purchased personal goods and services on government credit cards
- provided free accommodation, and resort passes, to family and friends in contravention of the resort's policies
- awarded monetary and material benefits to senior staff outside the standards and requirements set for government sector executives.

What I found

I found that more than \$80,000 of public money was spent on international travel for the CEO's and Property Manager's families; entertainment for the CEO's friends; and giving extravagant prizes to resort staff and staff bonuses without adequate justification or transparency.

During the investigation, the subjects repeatedly claimed ignorance of the policies they had breached.

They maintained a view that their spending and use of public resources was justified – for example, suggesting that the level of spending and travel was necessary to operate a world-class resort, and that providing free accommodation to friends and family was appropriate given the isolation of their work.

The subjects' spending of public money on family and personal items, and the private use of public assets provided no public benefit and was entirely inconsistent with the values of the public sector, and the public policies, directives and legislation that support these values.

What has happened since

Following the tabling of my investigation report, the CEO and Board Chair resigned. The CEO also reimbursed the resort for the cost of his family's travel and meals for friends.

The resort's lack of policy on the proper use of its resources has also been addressed through the development and implementation of a suite of new policies that align with government policy and guidelines, including on:

- Travel and Work Related Expenses
- Purchasing Cards, which covers the management and authorisation of purchasing cards and requires that cardholders sign a Cardholder Agreement
- Accommodation policy, which specifies conditions and limits on use, and establishes approval requirements.

In November 2017, the Minister for Energy, Environment and Climate Change announced changes to the governance structure for Victoria's three northern alpine resorts, including the Mount Buller and Mount Stirling Alpine Resort Board. Additionally, the composition of the three boards was refreshed following an expression of interest process, with the new appointees announced in late March 2018.

Status of my recommendations to the Minister, Department of Premier and Cabinet, Department of Environment, Land, Water and Planning and the Board

| | |
|--|---|
| <p>Recommendation 1 - to the Minister</p> <p>Review the current governance arrangements of Alpine Resort Management Boards regarding the issues and findings raised in this report</p> | <p>Accepted and implemented.</p> <p>In January 2017, prior to this recommendation being made, the Government released the <i>Alpine Resorts Governance Reform Discussion Paper</i>. The issues raised in the discussion paper and the Ombudsman’s report led to the implementation of a new governance structure for the three northern alpine resorts.</p> <p>Each board now has three members specific to that board, with four members shared by each board. In March 2018, the Government announced the new board appointees.</p> |
| <p>Recommendation 2 - to the Secretary, Department of Premier and Cabinet</p> <p>Revise the Travel Principles to make it clear that public sector organisations are not permitted to enter into employment contracts that provide travel entitlements inconsistent with the Principles.</p> | <p>Accepted and implemented.</p> <p>A new Travel Policy has been agreed and distributed to all Victorian Public Sector departments.</p> <p>The new Travel Policy provides more detailed and practical guidance to public officers to manage travel in a way that represents value for money and meets community expectations.</p> |
| <p>Recommendation 3 - to the Department of Environment, Land, Water and Planning</p> <p>The department, in partnership with an external provider, consider developing and delivering an education and training program for people who are appointed to board or chief executive officer positions in public sector entities under the department’s portfolio to:</p> <ul style="list-style-type: none"> a. build their awareness and skills regarding public sector policies, obligations and accountabilities, particularly regarding the expenditure of public money b. target relevant parts of the program at office holders who have little or no experience in the public sector. | <p>Accepted.</p> |

| | |
|--|--|
| <p>Recommendation 4 - to the Board</p> <p>Develop a travel policy consistent with the Travel Principles, which:</p> <ol style="list-style-type: none"> conforms with the requirement that any partner's travel at public expense requires approval from the Premier requires that prior to approving travel, the Board or the CEO review documents detailing the purpose of the travel to satisfy itself that the travel is in the public interest; that the expense and duration of the travel are justified; and that the travel will not create the impression that official travel is being used to subsidise private travel. This assessment should be documented. | <p>Accepted and implemented.</p> <p>On 25 August 2017, the Mount Buller Alpine Resort Board implemented a new Travel and Work Related Expenses policy. The policy requires prior approval before incurring any travel & work related expenses, that all such expenses must be in accordance with the Victorian Public Sector Travel Principles, and that claims should be within the guidelines published by the Australian Taxation Office.</p> |
| <p>Recommendation 5 - to the Board</p> <p>Ensure that travel associated with research and development is justified on a case-by-case basis in accordance with organisational need and the Travel Principles, rather than as a personal contractual entitlement.</p> | <p>Accepted and implemented.</p> <p>There are currently no employment contracts that include an entitlement to travel.</p> <p>Any travel by the CEO must be approved by the Board. The CEO must approve any interstate travel for staff. All international travel by staff must be approved by the Board.</p> |
| <p>Recommendation 6 - to the Board</p> <p>The Board Chair provide an attestation in the Board's Annual Report annually for a period of three years that the Resort's travel expenditure and reasons for the travel comply with the Travel Principles.</p> | <p>Accepted and implemented.</p> <p>The Board's 2017 annual report includes the attestation, and it will also be included for the 2018 and 2019 reporting periods.</p> |
| <p>Recommendation 7 - to the Board</p> <p>Require that the CEO pay back the cost of his family's flights to the United States in May 2015, and the cost of meals for his family paid for on his corporate credit card in the United States in 2014 and 2015.</p> | <p>Accepted and implemented.</p> <p>The Board has been reimbursed by the CEO.</p> |
| <p>Recommendation 8 - to the Board</p> <p>Require that the CEO pay back the cost of meals he purchased at restaurants for Mr Y and Mr B while they were visiting Mount Buller.</p> | <p>Accepted and implemented.</p> <p>The Board has been reimbursed by the CEO.</p> |

| | |
|--|--|
| <p>Recommendation 9 – to the Board</p> <p>Require that the Property Manager pay back the costs of flights and accommodation for his family in France in 2015.</p> | <p>Accepted and in progress.</p> <p>The Board has issued a letter of demand and is involved in continuing legal proceedings.</p> |
| <p>Recommendation 10 – to the Board</p> <p>Engage an independent auditor to audit the use of all corporate credit cards from January 2014 to the present.</p> <ol style="list-style-type: none"> a. Action any identified breaches of the Purchasing Card Rules and Standing Directions of the Minister for Finance under the <i>Financial Management Act 1994</i> (Vic). b. Report to the Minister, within three months of the receipt of the final audit report, on the findings of the audit and recommendations and actions that will be implemented to prevent future instances of inappropriate use. c. Require any unjustified personal expenditure to be paid back by the parties responsible for the expenditure. | <p>Accepted and implemented.</p> <p>An independent auditor investigated all credit card usage from January 2014, and found no additional breaches of the Purchasing Card Rules and Standing Directions of the Minister for Finance under the Financial Management Act. A report was submitted to the Minister on 30 April 2017.</p> <p>The Board has implemented a new Purchasing Card policy on the management and authorisation of purchasing cards, which includes personal liability for any purchases made on the card, the need to transact in accordance with the Purchasing Policy and Instrument of Delegation, and to submit reimbursement claims within one month of receiving their statement. As per the policy, corporate cards are also to be kept to a minimum with only 3 currently on issue. Each cardholder signs a Cardholder Agreement before the issuance of the card.</p> |
| <p>Recommendation 11 – to the Board</p> <p>Regularly audit the use of corporate credit cards.</p> | <p>Accepted and implemented.</p> |

| | |
|--|---|
| <p>Recommendation 12 - to the Board</p> <p>Revise the Resort’s Accommodation Policy to ensure that it is consistent with the Alpine Resorts (Management) Regulations 2009 and the codes of conduct, including by:</p> <ol style="list-style-type: none"> a. requiring that all uses of the accommodation be documented and approved b. requiring that use of the accommodation by persons nominated by the CEO be pre-approved by the Board c. prohibiting the provision of complimentary accommodation to family, friends or personal associates where the purpose for visiting the Resort is primarily personal d. stipulating that accommodation can only be provided when it is in the public interest e. clarifying the meaning of ‘VIP’ for the purposes of the policy f. requiring that personal use by Board members be invoiced, as it is for personal use by Resort staff eg incorporating the requirement, currently found in the Board Charter, that Board members are entitled to use the Board/ VIP accommodation ‘on nights either side of a board meeting or official function’ only. | <p>Accepted and implemented.</p> <p>On 25 August 2017 the Board approved the new Accommodation Policy which only allows use by:</p> <ul style="list-style-type: none"> • Media, partners and sponsors when part of a contractual commitment or visiting for business purposes • Board members and Government officials either the night before or the night after attending the mountains on official business, including their partner and dependent children if travelling together • Staff when required to work outside normal hours and travelling would be a safety risk • Board members and staff and their immediate family for non-work purposes, subject to paying the charges established by the Board, with the booking able to be withdrawn up to 24 hours before arrival if the accommodation is required for business purposes. <p>The new policy has had the references to suppliers and VIP’s removed. Also removed is the CEO discretion to offer accommodation to anyone of his/her choosing.</p> <p>Accommodation usage must be approved in accordance with the Instrument of Delegations, with usage and the purpose reported to each Board meeting.</p> |
|--|---|

| | |
|--|--|
| <p>Recommendation 13 - to the Board</p> <p>Develop a policy within three months about the awarding of bonuses requiring that:</p> <ul style="list-style-type: none"> a. The CEO document the rationale for all decisions to award bonuses, and any reasons documented in individual staff members' files, and submit them to the Board for approval prior to awarding a bonus b. The Board Chair provide an attestation in the Annual Report annually for three years that the bonuses awarded in the past financial year comply with the Board's policy relating to the awarding of bonuses c. Bonuses be a separate line item in the Resort's salaries budget. | <p>Accepted and implemented.</p> <p>All employees other than the CEO are employed under the EBA [Enterprise Bargaining Agreement], which has no provision for bonuses. The CEO is employed under a government approved GSERP [Government Sector Executive Remuneration Panel] contract with no provision for a bonus.</p> <p>No bonuses have been paid since the Ombudsman's report.</p> |
| <p>Recommendation 14 - to the Board</p> <p>Consider and document how the Board will manage the CEO's perceived conflict of interest about any future engagement of the catering company by the Resort.</p> | <p>Accepted and implemented.</p> <p>Any engagement of contracted services must be in line with the Board's Purchasing Policy which was reviewed and approved in December 2017. In addition to this as per our Instrument of Delegations, the Delegate or a related party to the delegate can never be a beneficiary of the item they are approving.</p> |



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

Why I investigated

In July 2016, IBAC referred to me a 'protected disclosure complaint' about the Chief Information Officer (CIO) of the Metropolitan Fire and Emergency Services Board (MFB). I subsequently received a related disclosure. The allegations included that the CIO had:

- employed two of her children at the MFB and awarded them pay rises, without declaring the relationship
- manipulated recruitment processes to ensure one of her sons was successful in a recruitment process.

What I found

My investigation found that the CIO used her position to orchestrate the recruitment of her two sons to the MFB. All three also took steps designed to conceal their relationship and avoid scrutiny, which included:

- the CIO's sons changing their surnames, to remove any resemblance to their mother's surname, shortly before commencing employment at the MFB
- the CIO and her sons failing to declare their relationship or the associated conflict of interest
- the CIO manipulating recruitment agencies' processes to ensure her sons were offered as candidates.

While the CIO and her two sons were all involved in this scheme, it was the CIO whose behaviour was the most calculated. In addition to concealing her relationship with her two sons, she:

- in two instances claimed to have conducted interviews, despite evidence indicating no legitimate interviews took place

- claimed to have undertaken pre-employment checks, despite evidence indicating no such checks were made and the investigation uncovering she had fabricated reference-check documents
- falsified both sons' CVs to include experience or qualifications that they did not have
- arranged for one son's contract to be extended and for him to receive a pay rise without adequate transparency or justification
- coached and colluded with her sons to prepare them for roles she intended to appoint them to.

In total, the public purse paid more than \$400,000 to the CIO's two sons, despite neither being employed through a merit-based recruitment process.

What has happened since

The CIO tendered her resignation from the MFB on the same day as her interview with my office. While my investigation was underway, the MFB commenced a 'show-cause' process for the son engaged in an ongoing role. Both sons' contracts were terminated before the conclusion of my investigation.

In response to my recommendations, the MFB has strengthened the conflict of interest requirements in its recruitment policy and is looking to have the policy approved.

The MFB commissioned an audit of the subjects' financial transactions during their employment with MFB to identify any concerns and also commissioned a review of its systems that identified a number of risks in its financial and Human Resources processes. It is in the process of implementing a range of controls to manage and mitigate these risks.

| Status of my recommendations to the Metropolitan Fire and Emergency Services Board | |
|--|--|
| <p>Recommendation 1</p> <p>Review its Confidentiality / Conflict of Interest / Ethics policy to ensure that it is consistent with the standards set by the Victorian Public Sector Commission.</p> | <p>Accepted and in progress.</p> <p>The MFB has strengthened its internal policies with regard to conflict of interest. It is in the process of seeking approval for the revised policies prior to finalising them.</p> |
| <p>Recommendation 2</p> <p>Review its recruitment policies and procedures, particularly in relation to the engagement of temporary staff via recruitment agencies, pre-employment checks, and the identification and management of conflicts of interest.</p> | <p>Accepted and implemented.</p> <p>Revised recruitment policies and procedures were introduced by the MFB in December 2017. These changes are being reinforced by ongoing training for recruitment managers, review of recruitment documentation and spot compliance check.</p> |
| <p>Recommendation 3</p> <p>Audit Mrs Powderly-Hughes' [CIO] involvement in procurement processes with a view to identifying any irregularities or impropriety.</p> | <p>Accepted in progress.</p> <p>The MFB engaged an external consultancy to audit transactions involving Mrs Powderly-Hughes.</p> <p>In addition, it is putting in place financial controls to manage risks identified through the audit, which includes regular compliance checks and reporting.</p> |



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

Why I investigated

In June 2015, IBAC referred a protected disclosure complaint which detailed failures by disability service provider Autism Plus to manage the behaviour of a disability resident, Edward.² It was alleged that these failures led to Edward sexually assaulting another disability resident, Robert, on multiple occasions as well as making threats of physical violence against Robert and his family.

In this case, both the perpetrator and the person allegedly assaulted had multiple disabilities. Both were resident in a group home operated by Autism Plus.

What I found

Autism Plus was a for-profit provider of disability accommodation and day programs. It provided services to clients of the Department of Health and Human Services (DHHS) on a 'fee for service basis', under a service agreement with DHHS. In 2014-15, Autism Plus received over \$5 million in funding from DHHS, including \$266,923.58 allocated for Edward's care. DHHS was responsible for both funding and regulating the services provided by Autism Plus.

My investigation found that Autism Plus and DHHS failed to respond to a series of incidents involving Edward, including several alleged sexual assaults against Robert. Both Autism Plus and DHHS were aware of, and had discussed concerns about, the incidents but neither contributed to any significant changes to improve the support and accommodation arrangements for Edward or Robert.

The deficiencies in DHHS's oversight of Edward's care and support suggested a systemic problem. Edward was a dual client of DHHS's Child Protection and Disability Services, however there was a lack of coordination between these areas and confusion about who had primary responsibility for Edward's case.

DHHS did not adequately assess Edward's treatment or placement requirements, did not ensure Autism Plus completed necessary tasks and did not properly consider alternative placement options. DHHS's record keeping was poor, with documents incomplete, inaccurate or missing. In terms of its role as a regulator, DHHS did not adequately monitor Autism Plus and failed to intervene when issues with Autism Plus were known.

My investigation showed that Autism Plus and DHHS repeatedly made decisions that were not in the best interests of those they were charged with protecting, thereby exposing Edward, other clients and Autism Plus staff to unacceptable risks.

The investigation raised questions about the inherent conflict that arises from a private provider operating for profit, receiving government funding to perform a public function.

What has happened since

On 10 April 2018, following a review by DHHS and an order by the Minister for Disability, Autism Plus was placed under administration.

² The names of individuals referred to in this report were changed to protect their privacy.

| Status of my recommendations to Department of Health and Human Services | |
|---|---|
| <p>Recommendation 1 Dual Disability Services and Child Protection clients</p> <p>DHHS review its management of dual Disability Services and Child Protection clients to identify:</p> <ul style="list-style-type: none"> • ways to improve practitioners' knowledge of the Operating Framework • barriers to compliance with the Operating Framework • ways to ensure collaborative statutory case and stability planning for children and young people transitioning into adulthood • systems to monitor regular contact with clients by both services • systems to document and monitor practitioners' key decisions, including the legislative basis and authority • ways to create more placements for children with disabilities and effectively monitor these. | <p>Accepted and in progress.</p> <p>DHHS is reviewing its Operating Framework to identify improvements to the Child Protection workforce's knowledge of roles and responsibilities.</p> |
| <p>Recommendation 2 Risk assessments</p> <p>DHHS improve current training and supervision of Child Protection and Disability Services practitioners on:</p> <ul style="list-style-type: none"> • conducting and recording practitioner risk assessments that are dynamic and evidence-based • identifying high-risk and/or complex clients for whom external, specialist risk assessments are required • resources available for staff to make timely and high quality referrals for specialist risk assessments. | <p>Accepted and in progress.</p> <p>Child protection training is under review and will be updated.</p> |

| | |
|--|--|
| <p>Recommendation 3 DHHS internal coordination to reduce risk to clients</p> <p>DHHS examine ways to achieve better coordination between operational divisions and areas of DHHS and between business areas which fund service providers, monitor service providers (including Local Connections and the Office of the Senior Practitioner), make placement decisions and manage individual clients (case managers).</p> | <p>Accepted and in progress.</p> <p>DHHS Operations Division's oversight of service providers, including Local Connections, is under review. Improvements will be made to the monitoring of service providers and coordination of placement decisions across the department.</p> |
| <p>Recommendation 4 Suitability of Autism Plus as a service provider</p> <p>DHHS assess Autism Plus's suitability to provide programs and care for DHHS clients.</p> | <p>Accepted and implemented.</p> <p>Following a review of Autism Plus, a Governor in Council order was signed and Autism Plus was placed in administration on Tuesday, 10 April 2018.</p> <p>The department has informed the Disability Services Commissioner and Acting Commissioner, as well as the Chair of the Parents' Committee.</p> |
| <p>Recommendation 5 Oversight and audits of funded service providers</p> <p>DHHS improve its oversight and audits of funded service providers' compliance with their Service Agreements and Human Services Standards including training staff and auditors to identify:</p> <ul style="list-style-type: none"> • the use of unapproved restrictive interventions and other human rights issues at services • non-compliance with DHHS incident reporting requirements • absent, out-dated or unapproved Looking After Children, Residential Statements, Behavioural Support Plans and other key placement and support documents in client records • services that are not being staffed in accordance with individual client's planning, especially for clients funded for one-to-one care • non-compliance with safety screening policies including currency of police checks and WWCC [Working With Children Check] status checks. | <p>Accepted and in progress.</p> <p>The department released the Restrictive Interventions Self-Evaluation Tool in September 2017 to improve disability service provider's understanding of restrictive practices.</p> <p>In September 2017, the Capital Funded Organisations Performance Monitoring Framework was released to improve oversight of funded service providers.</p> <p>Further improvement options for the department's oversight of funded service providers will be undertaken in 2018.</p> |

Supporting vulnerable people

21. Many of the complaints my office receives are from people who rely on the State Government for essential support and services. Often, they are vulnerable, disadvantaged or experiencing significant disruption to their lives – for example, those who have a disability, have suffered a workplace injury, are in need of housing, are involved with child protection or are in the prison system.
22. The government is responsible for helping, giving protection, stability or funding, to the many who could not otherwise get by. Demand is high for these services and, of course, we rarely hear of the presumed majority of cases when the government gets delivery of the services right.
23. Sometimes, however, systems fail. The effect of failed service delivery for those dependent on government assistance to meet basic needs can be significant and lasting. The messages I receive from affected people who contact my office about system failure reveal frustration at being excluded from decision making processes, rigid requirements, even where it causes serious detriment, and feeling ignored and marginalised by the system.
24. Four of my investigation reports since March 2016 highlighted the struggle people can face when trying to access critical supports and services:
 - Investigation into the management of complex workers compensation claims
 - Investigation into the use of informal expulsions by state schools
 - Investigation into the recovery of maintenance costs from public housing tenants
 - Investigation into kinship carer access to funding.
25. These investigations are discussed in this section. They share many characteristics, including the complex and challenging nature of the personal circumstances of those involved; the demands on services; issues with the architecture of the system itself; and the occasional systemic failure by public services to treat individuals with humanity.



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

Why I investigated

The workers compensation scheme is an important safety net that provides medical and financial support to those who are injured at work. The scheme is administered by private insurance agents (WorkCover agents) and overseen by the Victorian statutory authority, WorkSafe.

Although I have jurisdiction to investigate complaints about workers compensation, my office had in the past generally advised WorkCover claimants to dispute decisions about their claim at conciliation. The Accident Compensation Conciliation Service (ACCS) was established for the specific purpose of dealing with such disputes.

Despite this option, my office continued to receive a significant number of complaints about the claims process, individual claim decisions and issues with payments. On closer examination of the complaints, I found multiple accounts of injured workers being put through unreasonable and unnecessary processes in order to continue receiving payments and other entitlements, and having claims terminated despite still being unable to work.

In September 2015, I decided to investigate the management of the small proportion of complex claims which represent approximately 20 per cent of new claims, but 90 per cent of the scheme's liabilities.

What I found

Part of my investigation examined decisions of the five WorkCover agents responsible for administering the workers compensation scheme at the time of the investigation, as well as WorkSafe's oversight of WorkCover agents' decisions.

I found many instances of good administrative decision making by some staff. However, my investigation also revealed poor behaviour by all five WorkCover agents when it came to complex claims.

I found numerous examples of WorkCover agents failing to adhere to requirements, including:

- selectively using evidence to support a decision to reject or terminate a claim, while disregarding evidence that did not support the decision
- preferentially engaging Independent Medical Examiners (IMEs) that were known to more likely hold an opinion adverse to the worker, as well as WorkCover agents 'shopping' for IMEs that would return a desirable assessment
- maintaining unreasonable decisions at conciliation, only to have the decision change or overturned at conciliation or court
- making decisions that were contrary to binding Medical Panel decisions.

The prevalence of unreasonable decision making when it came to complex claims strongly suggested that a culture of claim rejection and termination was being driven by financial incentives and penalties. This was further evidenced by an emphasis in WorkCover agents' internal documents on terminating claims and the timing of termination decisions that aligned with financial reward measures.

It was clear that the scheme's incentives needed to be recalibrated. It was also evident that WorkSafe's oversight of the scheme needed to directly target the management of complex, disputed claims and put in place the necessary systems to support its oversight of complex claims.

What has happened since

I received overwhelming support for my report and recommendations from claimants, treating medical professionals, members of the public and the State Government.

Since my report, WorkSafe has implemented all of my 15 recommendations directed to it. This has included adjusting the way in which WorkCover agents are rewarded; improving the prominence of information about making complaints; and reforming the way in which Independent Medical Examiners are selected and oversighted. Complaints about WorkCover agents and WorkSafe have, however, continued since my report was tabled.

Given the magnitude of the changes being made by WorkSafe, I recognise that it will take time for the effect of the changes made to the system to be fully felt. However, as I continue to receive complaints about the same issues highlighted in my report, on 7 June 2018, I announced that I had commenced a follow-up investigation.

| Status of my recommendations to the Government and WorkSafe | |
|--|--|
| <p>Recommendation 1 - to the Government</p> <p>Review the current dispute resolution model for workers compensation, in particular the process following unsuccessful conciliation, to ensure the model is fair and timely.</p> | <p>Accepted and in progress.</p> <p>WorkSafe has engaged RMIT's Centre for Innovative Justice to identify opportunities to use restorative justice conferencing within WorkCover dispute and enforcement. The Government will consider the outcome of this review.</p> |
| <p>Recommendation 2 - to the Government</p> <p>Amend the WIRC Act [<i>Workplace Injury Rehabilitation and Compensation Act 2013</i> (Vic)] to empower the ACCS [Accident Compensation Conciliation Service] to issue a direction to an agent where a decision has no reasonable prospect of success were it to proceed to court i.e. it is not sustainable.</p> | <p>Accepted and in progress.</p> <p>ACCS has undergone significant changes, including becoming a statutory authority and undertaking significant recruitment to fill conciliator roles. The Government is giving ACCS an opportunity to establish its new structure before making any changes to the legislation or operational framework.</p> |
| <p>Recommendation 3 - to WorkSafe</p> <p>Consider how the overall operation of the scheme can better target its resources and oversight to ensure quality decision making in the cohort of complex cases where disputes frequently arise.</p> | <p>Accepted and implemented.</p> <p>WorkSafe has undertaken a range of activities to support improvement to the WorkCover scheme. These have included improving communications with claimants, increasing early intervention for pending claims, providing better information to claimants and engaging agents to commit to actions, including training, that address the issues identified in the report.</p> |
| <p>Recommendation 4 - to WorkSafe</p> <p>Implement a system to record, collate and track complaints, feedback, discussions with agents and outcomes, and use this data to:</p> <ol style="list-style-type: none"> identify and remedy complaint patterns and systemic issues assist identifying trends in agent decision making practices and potential systemic issues in the scheme conduct ongoing audits of samples of claims disputed at conciliation, Medical Panels and court where the decision was changed. | <p>Accepted and implemented.</p> <p>A revised Complaints Management Framework has been implemented. The framework seeks to make it easy for people to complain, encourages agents to respond with a view to resolving and embeds oversight and continuous improvement as part of the process.</p> |
| <p>Recommendation 5 - to WorkSafe</p> <p>Provide conciliation officers access on request to the relevant agent claim files to enable better informed conciliation outcomes.</p> | <p>Accepted and implemented.</p> <p>Digitisation of claims files is completed. This gives agents faster access to documents and streamlines the provision of documents to ACCS when requested.</p> |

| | |
|--|--|
| <p>Recommendation 6 – to WorkSafe</p> <p>Review all claims subject to a direction at conciliation to identify opportunities to improve agent practices.</p> | <p>Accepted and implemented.</p> <p>Improvements have been made to the reporting and tracking of directions given at conciliation. This provides WorkSafe with greater oversight and the opportunity to identify and fix systemic issues.</p> |
| <p>Recommendation 7 – to WorkSafe</p> <p>Use its power to issue a written direction to an agent where it identifies that an agent’s decision is unreasonable and/or unsustainable, and the agent refuses to withdraw it.</p> | <p>Accepted and implemented.</p> <p>The WorkSafe audit protocol has been updated to reflect the steps WorkSafe will take to direct an agent where a worker is wrongly disentitled.</p> <p>In 2016-17 WorkSafe identified 28 claims where it considered a worker may have been wrongly disentitled. In each case, the agent reviewed the decision resulting in the workers receiving their correct entitlement, without the need for a written direction.</p> |
| <p>Recommendation 8 – to WorkSafe</p> <p>Update the Claims Manual to outline WorkSafe’s expectations in relation to the 130 week test and use of the ‘indefinite ground’, including:</p> <ul style="list-style-type: none"> a. That a medical opinion that is not definitive (i.e. states ‘possibly’, ‘may’ or ‘should have a capacity’ and/or provides no clear reason or justification) is not sufficient to meet the test. b. WorkSafe’s expectations around timeframes. | <p>Accepted and implemented.</p> <p>The meaning of ‘indefinite ground’ has been clarified, in line with the recommendation, in the Claims Manual.</p> |
| <p>Recommendation 9 – to WorkSafe</p> <p>Review the weightings given to the financial reward and penalty measures for 2017-18 to ensure that there is sufficient focus on good quality and sustainable decision making.</p> | <p>Accepted and implemented.</p> <p>WorkSafe has finalised the 2017-18 agent Annual Performance Adjustment which increases weighting on quality decisions and sustainable outcomes for workers.</p> |
| <p>Recommendation 10 – to WorkSafe</p> <p>Amend its quality decision making audit procedure so that agents cannot be rewarded for a decision upon which a review or appeal panel cannot reach a unanimous view.</p> | <p>Accepted and implemented.</p> <p>Where a review or appeal panel cannot reach a unanimous view, the decision is excluded from the audit sample.</p> |

| | |
|---|--|
| <p>Recommendation 11 - to WorkSafe</p> <p>Amend the scope of the Return to Work Index audits to ensure that it rewards agents for genuine and sustainable return to work outcomes.</p> | <p>Accepted and implemented.</p> <p>The Return to Work measure is now call 'Back @ Work 26 week' and is linked to workers that can successfully return to work for at least three weeks. A further RTW measure at 104 weeks has also been introduced.</p> |
| <p>Recommendation 12 - to WorkSafe</p> <p>In consultation with the agents, provide training to agent staff on the financial reward and penalty measures, including their purpose and their relationship to good administrative decision making (referred to in the Claims Manual) on claims and offers at conciliation.</p> | <p>Accepted and implemented.</p> <p>WorkSafe has developed and delivered training packages that cover the foundations of quality decision making.</p> |
| <p>Recommendation 13 - to WorkSafe</p> <p>Publish information on each of the financial reward and penalty measures at the start of each financial year.</p> | <p>Accepted and implemented.</p> <p>The WorkSafe annual reports include information about agents' key performance indicators and the incentive program for the coming year.</p> |
| <p>Recommendation 14 - to WorkSafe</p> <p>Implement changes to the current IME [Independent Medical Examiner] system to:</p> <ol style="list-style-type: none"> a. prevent agents from selectively using 'preferred IMEs', or b. provide injured workers a choice of the IME with the appropriate speciality, by whom they are examined. | <p>Accepted and implemented.</p> <p>WorkSafe has trialled a centralised system for booking some IMEs, which removes the ability for agents to select the IME. While workers cannot choose an IME, a worker's choice model may be considered as part of broader reforms to the IME model.</p> <p>Reporting and oversight of agents' selection of IMEs has also been improved.</p> |
| <p>Recommendation 15 - to WorkSafe</p> <p>Amend its IME complaint handling policy to provide scope for examination of complaints where a worker does not provide consent for the complaint to be provided to the IME, which may include the referral of the matters raised to the IME quality assurance division for intelligence gathering purposes.</p> | <p>Accepted and implemented.</p> <p>The process for managing complaints about IMEs now captures all complaints, regardless of whether the worker has provided consent for the IME to be contacted, ensuring that trends in complaints about specific IMEs can be identified.</p> |

| | |
|---|---|
| <p>Recommendation 16 - to WorkSafe</p> <p>Amend the IME quality assurance process to:</p> <ul style="list-style-type: none"> a. ensure IMEs subject to a high number of complaints are peer reviewed b. document the process by which WorkSafe will review an individual claim file where significant deficiencies are identified in relation to an IME's report, to ensure a worker's entitlements have not been unreasonably rejected or terminated based on the report. | <p>Accepted and implemented.</p> <p>The selection of IMEs subject to the quality assurance processes is now informed by the frequency and nature of complaint made about IMEs. The new processes ensure claims are reviewed where an IME's decision is found to be significantly deficient.</p> |
| <p>Recommendation 17 - to WorkSafe</p> <p>Review the injured worker's case detailed in case study 1 to ensure the worker has not been incorrectly disentitled to compensation.</p> | <p>Accepted and implemented.</p> |



Investigation into Victorian government school expulsions

Why I investigated

On 1 September 2016, I announced my decision to investigate Victorian state government school expulsions. This was the result of:

- a number of complaints from parents and guardians about expulsions being a disproportionate disciplinary response, there not being the opportunity to be heard, and a lack of support for students to find another school
- a 2016 report released by the Youth Affairs Council Victoria which concluded expulsions led to students disengaging from education and found a correlation with the longer-term disadvantage
- complaints data from the Department of Education and Training (DET) which indicated a 25 per cent increase in expulsions between 2014 and 2015
- public concern about youth crime in Victoria, and the known correlation with disengagement from education.

What I found

While comparatively few students are formally expelled from Victorian government schools, the consequences for those students can be significant and profound. Despite this, DET's collection of expulsion data was inadequate, with information collected haphazardly and records being incomplete and insufficient.

The inadequacy of DET's data collection limited its ability to effectively have oversight of expulsions and to make informed policy decisions, which contributed to DET's failure to:

- ensure schools complied with the Ministerial order that seeks to protect students from being unfairly expelled
- identify and address the prevalence of expulsions among vulnerable groups of students.

From the limited information available, I found that a disproportionate number of expelled students were from vulnerable groups – children in out-of-home care, who have disability or are Aboriginal or Torres Strait Islander – and often had experienced childhood trauma.

There is no doubt that dedicated principals and teachers can find themselves in a difficult position, balancing the high needs of students with challenging behaviours against the needs of their less disruptive peers, and that expulsions can be necessary as a last resort. But in many of the cases we reviewed, had the school been better supported to deal with the behaviour, the expulsion may not have been necessary.

While 'informal expulsions' are not permitted, they were clearly occurring and DET was not taking sufficient action to prevent or monitor these instances.

What has happened since

Since my investigation report was tabled, the Minister for Education and DET have reformed the expulsion process. In January 2018, a new ministerial order was gazetted, which contains additional safeguards against the use of expulsion for very young or vulnerable students.

The reforms also include:

- investing \$5.9 million in programs aimed at preventing the behaviours that lead to expulsion

-
- introducing better supports and additional departmental staff to assist all who are involved in an expulsion through the process – principals, parents, guardians, students and department officers – with a focus on ensuring that students remain engaged in education
 - enhancing the expulsion appeals process by appointing a new independent member to the expulsion review panel and introducing a new independent panel that can reconsider overturned expulsion decisions
 - improving data collection processes, monitoring and reporting
 - supporting school leaders to increase their capability in dealing with complex cases involving students and parents, including providing better access to alternative dispute resolution processes.

Status of my recommendations to the Minister and the Department of Education and Training

| | |
|---|--|
| <p>Recommendation 1 - to the Minister</p> <p>Amend Ministerial Order 625 to ensure that a principal cannot expel a student aged 8 years old or less from any government school without the approval of the Secretary or her delegate and consider any additional changes to the Order necessary to give effect to the recommendations that follow.</p> | <p>Accepted and implemented.</p> <p>In May 2018, the Minister for Education approved new Ministerial Order 1125 - <i>Procedures for Suspension and Expulsion of Students in Government Schools</i> (Ministerial Order 1125). Ministerial Order 1125 will commence from the start of Term 3, 2018.</p> <p>This Order increases support for vulnerable students and oversight by regional and local area-based DET staff of all expulsion processes. It also requires the Secretary to approve expulsion of students aged eight years old or less.</p> |
| <p>Recommendation 2 - to the Department</p> <p>Embed the principle and expectation in policy or guidance that no student of compulsory school age will be excluded from the government school system (even if expelled from an individual government school).</p> | <p>Accepted and implemented.</p> <p>Reforms to the expulsion system increase supports for students, parents, carers and school principals before, during and after an expulsion to ensure students remain engaged in the education system.</p> <p>Ministerial Order 1125 sets the expectation that no child of compulsory school age will be excluded from the Victorian government school system.</p> <p>Accompanying policy, guidance and resources, reinforce that expulsions are a last resort to be explored only when all other disciplinary measures, supports and interventions for a student have been implemented.</p> <p>Four Regional Engagement Coordinators, for each school region, have been appointed as a single point of contact on expulsions.</p> |
| <p>Recommendation 3 - to the Department</p> <p>Introduce an assurance system to monitor compliance with the Ministerial Order for expulsions, to be undertaken at least once annually. Noting that the legislative obligation under section 2.1.1 of the <i>Education and Training Reform Act 2006</i> (Vic) is on the parent to enrol a student of compulsory school age and ensure they attend a school (or are registered for home schooling), this should include consideration of the following</p> | <p>Accepted and implemented.</p> <p>DET has redesigned its data capture system to provide a single system for recording expulsions, ensuring that compliance with Ministerial Order 1125 can be monitored and followed-up.</p> <p>Local area and regional staff, working with principals, will support the transition arrangements and supports for expelled students, in partnership with their family, the current school and the receiving setting.</p> |

| | |
|---|--|
| <ul style="list-style-type: none"> a. all students of compulsory school age who are expelled are supported to be enrolled in another government school, or are appropriately supported to engage in other educational options, within one month of expulsion; and b. all students who are expelled and not of compulsory school age, are provided with advice and support to engage in other educational, employment or training opportunities. | <p>DET (through Regional Engagement Coordinators) will follow up with receiving schools, one month and six months following enrolment to ensure students are supported to engage with other educational options in all expulsion cases</p> |
| <p>Recommendation 4 - to the Department</p> <p>To inform policies and programs aimed at preventing disengagement and expulsions, collect and report publicly, to the extent possible considering privacy laws, each year on the following data:</p> <ul style="list-style-type: none"> a. the total number of expulsions each year b. the outcomes for students expelled each year (eg whether they were re-engaged in education, employment or training following expulsion) c. students with a disability or mental illness who receive supplementary funding d. Aboriginal or Torres Strait Islander students e. students in Out of Home Care f. newly arrived migrants, refugees and asylum seekers g. primary school students. | <p>Accepted and in progress.</p> <p>DET has redesigned its expulsion record-keeping and data collection process, and will publish statistical information about expulsions. Commencing from Term 3 2018, DET will publish government school expulsion data on its website annually.</p> |
| <p>Recommendation 5 - to the Department</p> <p>To enable more robust data collection, amend the Expulsion Report templates so that they reflect the requirements set out in the Ministerial Order, as well as reference to responsibilities under the <i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>.</p> | <p>Accepted and implemented.</p> <p>DET's policies, guidance and reporting templates have been revised to align with the new Ministerial Order 1125 and the <i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>. These resources include new templates and checklists for principals and regional staff.</p> <p>The new Expulsion Policy for Victorian Government Schools directs principals to consider human rights and anti-discrimination legislation.</p> <p>In addition, new and updated factsheets for students, parent/carers and other support people that have been developed in consultation with relevant key stakeholders. These are available on the DET website.</p> |

| | |
|---|---|
| <p>Recommendation 6 - to the Department</p> <p>Amend department policy and guidelines to ensure that:</p> <ul style="list-style-type: none"> a. principals ‘thoroughly investigate’ the incident or incidents that leads to an expulsion, and fully document this process to strengthen procedural fairness for students b. senior regional office staff are directly involved when expulsion is being considered for: <ul style="list-style-type: none"> i. students with a disability (including mental illness) who receive supplementary funding ii. Aboriginal or Torres Strait Islander students iii. students in Out of Home Care iv. newly arrived migrants, refugees and asylum seekers v. primary school students c. specific staff in regional offices and, where appropriate, other agencies, are nominated to provide support services and advocacy to assist students and their families during the expulsion process, including if an expulsion is appealed. | <p>Accepted and implemented.</p> <p>Ministerial Order 1125 and the new DET policy require principals to have thoroughly investigated the relevant incident before making an expulsion decision.</p> <p>The principal is required to inform the relevant Regional Director when an expulsion is being considered for Aboriginal and Torres Strait Islander students, and students with a disability, in addition to the protections already provided for students in out-of-home care and international students.</p> <p>DET local area and regional staff will connect schools with the appropriate supports and interventions for vulnerable students. The Expulsion Policy for Victorian Government Schools also provides information about relevant regional and community supports for vulnerable cohorts that principals can access.</p> <p>Senior staff appointed as Regional Approved Support Person (RASP) commenced training in Term 1. RASPs will provide advice and support to the principal throughout the expulsion process. Regional Engagement Coordinators will act as a dedicated point of contact on expulsions in each DET region. They will work in collaboration with local area and other regional staff to connect schools with available interventions and supports for students.</p> |
|---|---|

| | |
|---|--|
| <p>Recommendation 7 – to the Department</p> <p>In light of the apparent success of the Education Justice Initiative, Navigator and Lookout pilots, the Department develop and pilot a model to support schools to develop challenging behaviour prevention and early intervention strategies for all students with high needs and complex behaviours (including students with disabilities) that have an impact on the safety and wellbeing of themselves and others. This should involve a multi-disciplinary approach with expertise, support and advice from appropriate allied health, clinical, safety, human rights and regional staff provided to the school to support the student, and a support service for principals to access when considering expulsion.</p> | <p>Accepted and in progress.</p> <p>\$5.9 million has been committed to improve inclusion for students with behavioural challenges and complex needs. This funding is for schools to implement the School-Wide Positive Behaviour Support framework. Vulnerable students with complex behaviours at risk of disengagement will be supported by positive behavioural coaches. Schools will also have access to expert advice from a designated board certified behavioural analyst within each region.</p> <p>In addition, where appropriate, alternative dispute resolution processes will be encouraged to assist schools, students and families to resolve issues at the local level, before it reaches the expulsion stage.</p> <p>In addition, DET is piloting a restorative justice program in a small number of secondary schools over 12 months (2018-19). The project aims to deliver timely, safe and effective restorative intervention that is aligned with the daily operations of the school and designed to reduce rates of suspension and/or potential expulsion.</p> |
| <p>Recommendation 8 – to the Department</p> <p>In order to prevent informal expulsions:</p> <ol style="list-style-type: none"> a. implement mandatory and timely reporting to the relevant regional office by the principal when a student leaves a school via means outside a formal expulsion where this is preceded by behaviour or discipline issues involving that student. b. require that the parents or guardians complete a form regarding the student exit including whether they agree to the exit and report on the next educational, employment or training opportunity for that student. | <p>Accepted and in progress.</p> <p>The department is continuing to work with stakeholders to identify appropriate reporting mechanisms for school exits where they are preceded by behavioural issues</p> <p>DET has an existing exit process in place where parents, students and school staff are involved.</p> <p>In addition, DET has a complaints policy for parents and carers. Parents and carers can escalate a complaint about an informal expulsion to their principal and, if the complaint is not satisfactorily resolved by the principal, to their local regional office.</p> |



Investigation into the management of maintenance claims against public housing tenants

Why I investigated

In February 2016, the Tenants Union of Victoria contacted my office on behalf of one of its clients. It alleged that Housing Victoria, part of the Department of Health and Human Services (DHHS), unreasonably raised and pursued a maintenance debt in excess of \$20,000 against the client after she had vacated the property.

The client, a victim of family violence, had hastily left the property due to serious concerns for her safety. Despite DHHS being informed of her circumstances, there was no evidence of it having tried to contact her. Instead, DHHS escalated the disputed debt to the Victorian Civil Administrative Tribunal (VCAT). VCAT decided the client was liable for approximately 5 per cent of the original amount sought by DHHS.

As this complaint appeared to raise systemic issues, I decided to investigate DHHS's management of maintenance claims against its tenants. My investigation focussed on:

- the actions of DHHS at the end of tenancies
- whether DHHS was meeting its obligations as a model litigant when escalating disputed debts to VCAT.

What I found

My investigation found that while DHHS, in the context of high demand for limited tenancies, appeared to be sensitive to the vulnerabilities of its tenants when allocating housing, these critical factors were largely disregarded at the time the tenancy ended.

During the investigation, I found that DHHS routinely:

- raised and pursued repair and damage costs for unreasonable amounts, not taking steps to determine the cause of damage or deterioration nor considering the effect of reasonable wear and tear
- failed to send debt recovery notices to former tenants, instead unreasonably sending notices to the address that the tenant was known to have vacated
- breached its obligations as a model litigant by habitually escalating dispute debts to VCAT rather than determining liability for maintenance costs itself
- unreasonably prevented those with a debt from being able to access further housing, despite former tenants being unaware of the debt and in being in circumstances that would mean they cannot afford to repay it without suffering further hardship
- relied on inexperienced staff to assess maintenance requirements and represent DHHS at VCAT, without providing them with adequate time, training or support.

I also found that VCAT consistently awarded DHHS less than half of its original claim where the tenant attended to defend the claims, indicating that the amounts DHHS tried to claim from tenants were often exaggerated.

Overall, DHHS's end of tenancy practices showed that it was failing to be a fair social landlord. Its propensity to pursue significant amounts of money from people who were only eligible for public housing due to their circumstances, without checking whether they were truly liable, was unjust. DHHS needed to make comprehensive changes to the way it handled end of tenancy assessments and the recovery of maintenance debts.

What has happened since

My recommendations targeted specific areas requiring attention – broad policy and operational changes, improving internal guidance for department staff and embedding this guidance as part of the culture within the department.

At the time my report was tabled, the department had already started taking steps to improve its practices. Work to implement the recommendations has continued, and DHHS has informed me that it expects to complete implementation of all recommendations in 2019.

| Status of my recommendations to the Department of Health and Human Services | |
|---|--|
| <p>Recommendation 1</p> <p>To embed within policies, guidance and training the principle that the Department is a social landlord.</p> | <p>Accepted and in progress.</p> <p>The department commissioned the Australian Housing Urban Research Institute to establish principles and a definition for being a social landlord. This research is currently being considered.</p> <p>In the interim, the department has introduced staff to topics connected to behaving as a social landlord, such as assisting in the management of complex clients and victims of family violence.</p> |
| <p>Recommendation 2</p> <p>Policy and procedures be amended to ensure compliance with the <i>Charter of Human Rights and Responsibilities Act 2006</i> (Vic) including removing the requirement for applicants to make and maintain a debt repayment plan prior to an offer of public housing where that debt remains in dispute.</p> | <p>Accepted and in progress.</p> <p>The department is completing its current review of its guidelines for compliance with the <i>Charter of Human Rights and Responsibilities Act 2006</i> (Vic).</p> |
| <p>Recommendation 3</p> <p>Consistent with the spirit of the <i>Limitation of Actions Act 1958</i>, policy be amended to cease pursuing vacated maintenance debts older than 15 years from when the department obtained an order from the Victorian Civil and Administrative Tribunal and was unable to contact the former tenant.</p> | <p>Accepted and in progress.</p> <p>The department will not pursue maintenance debts older than 15 years from the time the order was obtained from VCAT where the former tenant was unable to be contacted.</p> <p>The department is redrafting its guidelines to reflect this change.</p> |
| <p>Recommendation 4</p> <p>Establish a high-level user group for public housing services to monitor the implementation of new and improved guidance.</p> | <p>Accepted and implemented.</p> <p>A high-level user group has been established to monitor the implementation of new and improved practice. The 'Public Housing User Advisory Group' includes external members from Justice Connect, TUV and the Victorian Public Tenants Association.</p> |

| | |
|--|--|
| <p>Recommendation 5</p> <p>Amend guidance to facilitate involvement of the tenant in end of tenancy property inspections including:</p> <ul style="list-style-type: none"> • Involvement in the completion of Tenancy Condition Reports • Development and promotion of processes that increase the likelihood that tenants will provide notice before they end their tenancy. | <p>Accepted and in progress.</p> <p>The department is establishing processes, including incentives to increase the likelihood of tenants providing notice before they end their tenancy, to promote the importance of front-line housing staff completing end of tenancy property inspections with tenants.</p> |
| <p>Recommendation 6</p> <p>Amend guidance to ensure compliance with the department's obligations under the Model Litigant Guidelines including full disclosure of all documents and information the department intends relying upon at VCAT.</p> | <p>Accepted and in progress.</p> <p>Support materials are being developed to guide front-line housing staff to practices consistent with the model litigant guidelines. The model litigant guidelines will also be embedded in future training programs.</p> |
| <p>Recommendation 7</p> <p>Amend the Business Practice Manual, Housing Appeals of July 2015 to allow current and former tenants to seek and have reviewed, an appeal of any maintenance claim decisions made by the department.</p> | <p>Accepted and in progress.</p> <p>The Business Practice Manual will be amended to allow an appeal of any decision to raise a maintenance claim against a tenant by the department, and staff informed that these decisions can be locally reviewed.</p> |
| <p>Recommendation 8</p> <p>Develop processes to ensure all reasonable efforts are made to obtain correct contact details for former tenants to facilitate end of tenancy communication. These may include:</p> <ul style="list-style-type: none"> • the use of data washing services • the implementation of information sharing protocols with other divisions within the department and/or external entities including other government departments, advocates and support services • the use of other modes of communication such as email and SMS • the use of 'person to person' registered post when sending letters. | <p>Accepted and in progress.</p> <p>The department is updating its practice note to raise front-line housing staff awareness of what it means to make reasonable efforts to obtain the correct details of former tenants, which will include using email and SMS communication.</p> <p>The department's Privacy Unit is testing information sharing protocols. The services provided by Australia Post relating to mail redirection and data washing services are also being investigated.</p> |

| | |
|--|--|
| <p>Recommendation 9</p> <p>Remove the ‘Vacated Tenants’ section of policy and guidelines to eliminate any distinction in treatment between current and former tenants.</p> | <p>Accepted and in progress.</p> <p>A review of the 2015 Tenant property damage operational guidelines has commenced. A draft of the revised guidelines was due to be released for stakeholder consultation before May 2018.</p> |
| <p>Recommendation 10</p> <p>Implement a robust change management package, including ongoing training programs, aimed at HSOs [Housing Service Officers], team leaders and managers, that properly equips these staff with the necessary knowledge, skills and resources to effect changes consistent with the expectations of the 2015 Guidelines.</p> <ul style="list-style-type: none"> • Devise and implement metrics that measure the effectiveness of this change management package, including the relevant training programs. | <p>Accepted and in progress.</p> <p>The department has commenced delivery of cultural change program to support front-line staff. Initiatives of the program include:</p> <ul style="list-style-type: none"> • information sessions on behaving as a model litigant and negotiating outcomes with tenants • a Housing Forum • a capability framework supported by a refreshed learning and development policy • operational reporting tools that will make it possible to determine how staff are completing tasks for tenant property damage. |
| <p>Recommendation 11</p> <p>Develop practical guidance for staff in the process of applying policy to the assessment of end of tenancy maintenance and repair and the raising and pursuit of maintenance claims.</p> | <p>Accepted and in progress.</p> <p>Practical guidance for staff is being developed and due to be completed by June 2018. The department is also considering future training on the practical assessment of fair wear and tear, damage, reasonably clean and how to account for the special circumstances of tenants.</p> |
| <p>Recommendation 12</p> <p>Improve file management/information sharing to ensure seamless and efficient access to information relevant to a property’s condition history and the relevant tenant’s history and special needs.</p> | <p>Accepted and in progress.</p> <p>The department will promote the existing tools that assist assessment of a property’s condition history and the relevant circumstances of tenants, together with a practice note on determining the age of repaired items.</p> |

| | |
|--|---|
| <p>Recommendation 13</p> <p>Ensure maintenance claim correspondence informs tenants and former tenants of:</p> <ul style="list-style-type: none"> • the basis for the department’s claim • the relevant guidelines • their right to seek a review of the department’s decision • their right to formalise an appeal • contact details for tenant advocacy services. | <p>Accepted and in progress.</p> <p>A review of correspondence for maintenance claims has commenced. This includes a ‘notice’ (letter) to former tenants providing them an early warning that the department is considering making a maintenance claim against them, and inviting contact to reach an early resolution.</p> |
| <p>Recommendation 14</p> <p>Change end of tenancy maintenance claim KPIs [key performance indicators] from timeframe-dependent to qualitative, based around requirements under the 2015 Guidelines.</p> | <p>Accepted and in progress.</p> <p>Alternative KPIs, that measure important requirements, such as the local negotiation of property damage and repayment plans, are being considered.</p> |
| <p>Recommendation 15</p> <p>Explore process improvements and/or resourcing to reduce current workloads for HSOs such that these workloads no longer provide an incentive for HSOs to ignore responsibilities under the 2015 Guidelines.</p> | <p>Accepted and in progress.</p> <p>A review of the department’s operating model for public housing has commenced. This review will consider the responsibilities and workloads of front line housing staff.</p> |
| <p>Recommendation 16</p> <p>Ensure managers and team leaders provide greater oversight to the activities of HSOs at specific junctures throughout the end of tenancy maintenance and repair process and implement mechanisms by which to measure this oversight, to include:</p> <ul style="list-style-type: none"> • When a HSO intends on raising a maintenance claim • When a maintenance claim is to be the subject of a VCAT application • Before the results of a review or appeal are communicated to a former tenant • Where a former tenant disputes a VCAT order made in their absence. | <p>Accepted and in progress.</p> <p>The department is developing a supervisory framework to involve managers at key decision points made by front-line housing staff. The department is currently working to update its IT system to include these checks. This is expected to be completed by June 2019.</p> |

| | |
|--|---|
| <p>Recommendation 17</p> <p>Ensure greater oversight of VCAT litigation. This may include:</p> <ul style="list-style-type: none"> • practical applications that guide the process for escalating a maintenance claim to a VCAT application and which acknowledges relevant legislative and policy requirements • the implementation of an accreditation process for staff representing the department at VCAT that covers the legislative and policy requirements of that role and which is subject to regular review and refresher training. | <p>Accepted and in progress.</p> <p>The department is developing tools that will guide front-line housing staff to follow key steps before escalating a maintenance claim to VCAT.</p> <p>The department will also review its training for staff representing the department at VCAT.</p> |
| <p>Recommendation 18</p> <p>Reconsider contract arrangements with debt collection agencies to:</p> <ul style="list-style-type: none"> • remove the disincentive for debt collectors to refer disputed claims back to the department for review • require compliance with public service values and codes of conduct. | <p>Accepted and in progress.</p> <p>The department will review its current contract arrangements with debt collection agencies and is updating its operational guidelines to include specifications for a new contract with the debt collector.</p> |



Investigation into the financial support provided to kinship carers

Why I investigated

Kinship care is an increasingly important and relied upon form of out-of-home care for children who cannot live with their parents or immediate families. Although kinship carers are the backbone of out-of-home care, they are not afforded the same level of funding or support compared with foster carers.

My office had steadily received complaints from kinship carers about delays and errors in processing kinship care payments and requests for increased allowances.

Previous research had already revealed that kinship carers were often disadvantaged themselves. They are more likely to be older, female, single and experiencing their own challenges, such as poor health and financial hardship. The research also showed kinship care was critical to ensuring Aboriginal and Torres Strait Islander children in out-of-home care maintained a connection with their kin and culture. These children are significantly overrepresented in out-of-home care placements when compared to their non-Aboriginal and Torres Strait Islander counterparts.

Within this context, I investigated the Department of Health and Human Service's (DHHS) oversight of the kinship care system, focussing on the financial support provided to kinship carers.

What I found

I found serious deficiencies in DHHS's administration of financial supports provided to kinship carers. These deficiencies repeatedly placed kinship carers under financial stress and were not in the interests of the children.

Kinship carers were automatically allocated the lowest level of allowance. This could be increased, however DHHS routinely failed to complete the assessments required to determine the needs and interests of the children, and failed to initiate the application for a higher allowance, leaving children inadequately supported.

Additionally, kinship carers were burdened with having to repeatedly prove their entitlement to financial support. These issues were further compounded by DHHS's lengthy delays in processing applications and payments, and a general lack of information being available to kinship carers about the application process and their eligibility for a higher care allowance.

The unnecessarily complicated processes involved in the administration of financial support for kinship carers not only caused financial hardship to kinship carers, but also potentially resulted in a poor outcome for the child where they were unable to stay in kinship care, and removed to foster or residential care. Overwhelmingly, I found the way in which kinship carers were treated in terms of their access to adequate financial support to be inequitable, unjust and wrong.

What has happened since

The findings of my investigation showed there was a clear case for DHHS to improve the financial support available to kinship carers. My recommendations addressed the inequity in the system; the need to complete assessments to ensure that children in out-of-home care kinship placements have their needs and interests met; and the need to increase information and awareness of the financial support that is available to kinship carers, to both carers and the Child Protection Practitioners who are responsible for ensuring that a child placement is adequately resourced.

In addition to the cases examined during the investigation, my office has continued to receive complaints from kinship carers. As a result of enquiries and investigations undertaken by my office since my report, a further \$201,224 of entitlements, including back payments, have been made to kinship carers. Also, \$4,108 in debt claimed by DHHS has been waived.

Status of my recommendations to the Department of Health and Human Services

| | |
|--|---|
| <p>Recommendation 1</p> <p>Review the administration of financial support to kinship carers. In particular, to:</p> <ul style="list-style-type: none"> • improve the transparency of decisions relating to higher care allowance levels by developing and publishing criteria for each level • reduce the number of decision-makers in the higher care allowance process for kinship carers • allow back-payments to kinship carers from the date an application for a higher care allowance begins • provide discretion to allow higher care allowances for kinship carers to be approved for more than 12 months • allow kinship carers to access Placement Support Brokerage. | <p>Accepted and in progress.</p> <p>DHHS has updated the care allowance policy to incorporate all components of Recommendation 1.</p> <p>A new model of kinship care commenced on 1 March 2018. It includes a new 'First Supports' package, delivered by Community Service Organisations and Aboriginal Community Controlled Organisations to new kinship placements expected to last three months or longer. The package includes a comprehensive assessment, of carer suitability, identification of needs, access to family services, and access to flexible brokerage (ad-hoc funding) of up to \$1,000 to help establish and support placements.</p> <p>For existing kinship placements that commenced prior to 1 March 2018, a one-off \$5 million State-wide allocation for flexible brokerage is available to provide necessary supports and stabilise placements, reduce the risk of placement break down and where appropriate, support the move to permanent care.</p> |
| <p>Recommendation 2</p> <p>Improve the kinship assessment process to ensure it adequately identifies the needs of each carer, as well as those of the child.</p> | <p>Accepted and in progress.</p> <p>A new model of kinship care was introduced on 1 March 2018. The Part B assessment form, which will focus on assessing suitability and determining placement needs for each unique child and carer, is under review.</p> |
| <p>Recommendation 3</p> <p>Ensure kinship assessments inform the application process for a higher care allowance.</p> | <p>Accepted and in progress.</p> <p>The Part A, B and C assessment forms are currently being updated. The Part B assessment includes a process for determining if access to a higher care allowance level is required.</p> <p>Training sessions will be provided to CSOs and ACCOs delivering 'First Supports'. Thirty-six new dedicated departmental kinship practitioners have been deployed to support implementation of the new model.</p> |

| | |
|---|---|
| <p>Recommendation 4</p> <p>Create a quality assurance system that checks for the completion of kinship carer assessments.</p> | <p>Accepted and in progress.</p> <p>Work has commenced to scope system changes to track completion of Part B assessments to enable monitoring of compliance.</p> |
| <p>Recommendation 5</p> <p>Update the department's <i>Care allowance policy and procedures (2017)</i> to include specific advice to Child Protection Practitioners about the continuance of the care allowance when a carer moves interstate and there is no court order in place.</p> | <p>Accepted and under consideration.</p> |
| <p>Recommendation 6</p> <p>Enhance the capacity of the kinship sector to participate in policy development and promote awareness of the department's processes for financial support.</p> | <p>Accepted and in progress.</p> <p>The manual for kinship carers was launched on 24 November 2017. It includes information about the financial support and additional services available to carers. The manual was developed in consultation with key kinship care advocacy groups and carers.</p> <p>Kinship Carers Victoria received additional funding in 2017-18 to support their role in providing advocacy, consultation and advice regarding the needs of kinship carers.</p> |
| <p>Recommendation 7</p> <p>Update the materials provided by the department, including the Child Protection Manual, to ensure they include information about how kinship carers can apply for increased financial support, and are in accessible formats.</p> | <p>Accepted and in progress.</p> <p>As part of the care allowance policy review and reform, factsheets, the manual for kinship carers and Child Protection Manual will be updated.</p> |

Protecting Human Rights

26. Victoria is the only state in Australia to have human rights legislation in force. The *Charter of Human Rights and Responsibilities Act 2006* (Vic) sets out 20 basic rights and freedoms which serve as minimum standards, protected by law, that citizens can expect of their government and its entities
27. Victoria public sector bodies, including my office, are required to act in a way that is compatible with the Charter. This means that anyone who exercises a public power or performs a public function must have regard to the rights of those who may be impacted as a consequence, and must take steps to ensure those rights are not unreasonably limited or breached.
28. My office has a responsibility to examine whether any administrative action I investigate or enquire into is compatible with Victoria's Charter of Human Rights and Responsibilities Act.
29. Of the investigations I concluded between 1 April 2016 and 31 March 2018, my investigation into *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* was unique with the primary focus of this investigation on human rights and compliance with the Charter.



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

Why I investigated

Given my office's role and experience in dealing with human rights, I have long held an interest in the United Nation's Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT aims to open environments of detention up to monitoring bodies, known as a 'National Preventative Mechanism' (NPM). The role of NPMs is to ensure that those held in detention are not subject to torture and other cruel, inhuman or degrading treatment. The settings that can be subject to monitoring include well recognised places of detention, such as police cells, immigration centres, psychiatric hospitals and prisons, but may also extend to other settings where liberty is in some way limited, such as aged care facilities.

In February 2017, the Commonwealth Government announced its intention to ratify OPCAT.

To test Victoria's readiness for implementing OPCAT, I conducted a two-pronged investigation. This first part looked at the current oversight agencies, laws and processes in place for monitoring places of detention in Victoria. It also considered the feasibility and challenges involved in implementing OPCAT.

The second part involved a pilot OPCAT inspection using my existing investigation powers under the *Ombudsman Act 1993* (Vic). The inspection took place over seven days monitoring activity at the Dame Phyllis Frost Centre (DPFC) – Victoria's largest women's prison – looking for risks that increased the potential for torture, and other cruel, inhuman or degrading treatment or punishment at the prison, and the safeguards that reduce these risks.

There were six focus areas during the inspection, as recommended by the Association for the Prevention of Torture in its *Monitoring placed of detention: a practical guide* (2004).

What I found

The inspection team identified several risks during the inspection, which I addressed through my recommendations:

- the use of controls (force and restraint) and solitary confinement (separation)
- the use of strip searches
- providing better information to prisoners about their rights
- improving health planning and services
- improving facilities for families
- the condition of older units
- better identifying and supporting prisoners with a cognitive disability, and; increasing the number of women prison officers.

DPFC officers routinely observed women undressing and changing into overalls for prison visits. While DPFC said that this was not a strip search, I considered that the observed practice was consistent with the definition of a strip search according to the *Corrections Regulations 2009* (Vic) and recommended that this practice cease.

This was the only recommendation not accepted, of the 125 public recommendations I made between 1 April 2016 and 31 March 2018.

What has happened since

On 15 December 2017, the Australian Government ratified OPCAT and appointed the Commonwealth Ombudsman as the Coordinator for NPM bodies in Australia.

While the Victorian Government has not yet announced any decisions in relation to NPMs in Victoria, my office is well placed to contribute to and participate in the establishment of the network of NPMs as necessary.

Status of my recommendations to the Department of Justice and Regulation and the Dame Phyllis Frost Centre

| | |
|--|--|
| <p>Recommendation 1 Use of force and restraint</p> <p>The Department of Justice and Regulation, with reference to the findings of this inspection report and the findings and recommendations of JARO’s recent review into the application and management of force:</p> <ul style="list-style-type: none"> a) propose how it will implement strategies to minimise the use of force at DPFC b) in accordance with section 41(c) of the Charter, request that its proposal be reviewed by VEOHRC [Victorian Equal Opportunities and Human Rights Commission] to assess compatibility with human rights. | <p>Accepted and in progress.</p> <p>From 1 February 2018, the department has commenced audit of 10 ‘uses of force’ a month across all prisons. The audits assess the appropriateness of the use of force and whether options could have been employed.</p> <p>Consultation with the VEOHRC will occur after the review process has been trialled.</p> <p>The DPFC is currently reviewing its Violence Prevention Committee.</p> |
| <p>Recommendation 2 Restraint of pregnant women</p> <p>The General Manager at DPFC ensure that officers comply with the Deputy Commissioner’s Instructions and Local Operating Procedures regarding restraint of pregnant women, including seeking her authority before applying restraints.</p> | <p>Accepted and implemented.</p> <p>Local Operating Procedure requirements were communicated to DPFC’s Operations Managers, Middle Managers, Supervisors, Senior Prison Officers, Prison Intelligence Unit and the Emergency Response Group.</p> |
| <p>Recommendation 3 Separation</p> <p>The Department of Justice and Regulation:</p> <ul style="list-style-type: none"> a) consider options for replacing the Swan 2 management unit b) engage clinical and human rights expertise to consider DPFC’s compliance with international standards and best practice regarding: <ul style="list-style-type: none"> • the long-term use of management for some women • the level of interaction between officers and women • access to purposeful activity. | <p>Accepted and in progress.</p> <p>A funding submission has been developed for a 40 bed Management Unit to replace Swan 1 & Swan 2 as well as a 100-bed reception/orientation unit.</p> <p>Part of the Women’s System Reform Project (WSRP) will involve the development of strategies to effectively manage the changing profile and growth in the women’s prison population. This includes future planning around appropriate infrastructure, women’s programs and services as well as an operating model configured to meet the complex needs of the Victorian women’s prison system. A working group has been established and meetings commenced in March 2018.</p> |

| | |
|---|--|
| <p>Recommendation 4 Conditions for separated women</p> <p>Pending the review in Recommendation 3(b), the General Manager at DPFC:</p> <ul style="list-style-type: none"> • ensure that women on separation regimes are offered at least one hour out of their cells each day • take steps to restrict viewing of CCTV monitors in Swan 2 to protect the privacy of women • ensure women are given written information outlining the goals they need to meet to return to mainstream units. | <p>Accepted and implemented.</p> <p>Women are offered at least one hour every day out of cell, except where it is necessary to lock down Swan 2.</p> <p>Privacy screens have been purchased to restrict viewing on CCTV monitors and ensure the privacy of women.</p> <p>A document outlining the expectations of women in management has been endorsed by the Sentence Management Division and General Manager of DPFC on 30 May 2018.</p> |
| <p>Recommendation 5 Strip searching</p> <p>The General Manager at DPFC:</p> <ul style="list-style-type: none"> • immediately cease the practice (by whatever name) of strip searching all women before and after contact visits and following external appointments • replace it with a Charter-compliant practice of strip searching based on intelligence and risk assessment. | <p>Not accepted.</p> <p><i>‘Despite not accepting this recommendation, the department recognises that strip searching is an intrusive practice and is committed to implementing gender specific procedures.</i></p> <p><i>A project is currently underway which is examining a range of policies, practices and technology that can be utilised as an alternative to strip searching or to reduce reliance on it in the women’s prison system. A workshop was undertaken on 13 February 2018 where a range of actions were identified that seek to implement change to women’s strip searching procedures and to reduce the amount of strip searching undertaken on women prisoners.</i></p> <p><i>The proposed recommendations for change were presented to the Women’s System Reform Project Steering Committee in April 2018, and the independent Women’s Correctional and Advisory Committee in May 2018. The department is currently considering an implementation plan for these changes’.</i></p> |
| <p>Recommendation 6 Detecting contraband</p> <p>The Department of Justice and Regulation strengthen alternative ways to detect contraband, including reviewing the resources of the Prison Intelligence Unit.</p> | <p>Accepted and implemented.</p> <p>Between May and July 2017, the department trialled two machines that detect metallic and organic items on the body.</p> <p>A further 2-3 weeks trial of a millimetre wave scanner was undertaken at DPFC in the contact visit centre. The scanner is due to be permanently installed by July 2018. It is also exploring alternatives to urine testing.</p> |

| | |
|--|--|
| <p>Recommendation 7 Rights of women on remand</p> <p>The General Manager at DPFC ensure that all unsentenced women are offered the option of wearing their own clothes.</p> | <p>Accepted and implemented.</p> <p>This matter has been discussed with the Prisoner Liaison Group which advised that prisoners do not want to wear their own clothes as they will stand out and may be stood over for their items.</p> <p>Unsentenced women have the option to wear their own clothes where it does not impact the safety or security of the prison.</p> |
| <p>Recommendation 8 Better information</p> <p>The General Manager at DPFC increase information for women about prison procedures and prisoner rights including:</p> <ul style="list-style-type: none"> • arranging for the orientation book for new prisoners to be provided in community languages, easy English and audio-visual versions • working with Justice Health and Correct Care Australasia to improve information for women about health services, including what constitutes emergency dental services • ensuring prison libraries have up to date copies of the Commissioner's Requirements and Deputy Commissioner's Instructions and appropriate legal resources. | <p>Accepted and in progress.</p> <p>DPFC has translated the booklet into Vietnamese and is continuing to consider options for additional languages.</p> <p>Justice Health has commenced a review and update of health orientation information for women, including accessible and culturally aware formats.</p> <p>The Legal Resource Library recently relocated and legal resources were reviewed at this time. All Commissioner's Requirements, Deputy Commissioner's Instructions and Local Operating Procedures (with the exception of restricted procedures) have been refreshed.</p> |
| <p>Recommendation 9 Health planning</p> <p>The Department of Justice and Regulation give proper consideration to the evidence in this report about the health services at DPFC to ensure that they are adequate to meet the women's needs now and into the future.</p> | <p>Accepted and in progress.</p> <p>The department conducted an audit of the current health services, which will be considered by the Women's System Reform Project.</p> |

| | |
|---|---|
| <p>Recommendation 10 Improving health services and privacy</p> <p>The General Manager at DPFC work with Justice Health and Correct Care Australasia to:</p> <ul style="list-style-type: none"> • devise an effective system for notifying women of the date and time of doctors' appointments • conduct a trial under which women can possess and self-administer appropriate over-the-counter medication • implement a consistent process for ensuring that doctors regularly review expiring prescriptions before they expire • ensure that medical information is not discussed in the presence of officers or other prisoners, except where permitted under international standards. | <p>Accepted and in progress.</p> <p>Work is being undertaken to devise an effective system for notifying women of medical appointments.</p> <p>A further trial of self-medication will commence in 2018.</p> <p>Correct Care Australia has implemented local systems and processes to manage expiring prescriptions on a regular basis.</p> <p>Justice Health is working with the prison health services provider and the prison staff to ensure that prisoner privacy is maintained.</p> |
| <p>Recommendation 11 Maintenance of older units</p> <p>The General Manager at DPFC ensure that outstanding maintenance repairs at the Hunter units are completed as soon as possible.</p> | <p>Accepted and in progress.</p> <p>Certain short-term maintenance repairs have been completed on bathrooms.</p> <p>Funding is currently being sought to undertake further costs, given the substantial costs associated with prison infrastructure upgrades.</p> <p>Longer-term infrastructure planning is being considered by the Women's System Reform Project.</p> |
| <p>Recommendation 12 Improving contact with children</p> <p>The General Manager at DPFC expand the Skype program at the prison to all women whose children cannot physically attend the prison, for distance or other reasons.</p> | <p>Accepted and in progress.</p> <p>Corrections Victoria is examining the possibility of DPFC being included in the Video Conferencing pilot currently being introduced at Tarrengower Prison.</p> |
| <p>Recommendation 13 Protecting contact with family</p> <p>The Department of Justice and Regulation amend its Commissioner's Requirements and Deputy Commissioner's Instructions to comply with section 17 of the Charter, by ensuring that telephone contact with children and family cannot be withdrawn as a punishment for disciplinary offences, except where demonstrably justified.</p> | <p>Accepted and implemented.</p> <p>The Commissioner's Requirement – <i>Disciplinary Process and Prisoner Privileges and Deputy Commissioner's Instruction 1.16 – Disciplinary Process</i> was updated to include a reference that telephone contact with children and family cannot be withdrawn as a punishment for disciplinary offences, except where demonstrably justified.</p> |

| | |
|---|---|
| <p>Recommendation 14 Aboriginal and Torres Strait Islander women’s access to Mothers and Children program</p> <p>The Department of Justice and Regulation work with the Department of Health and Human Services, the Commission for Children and Young People and the Victorian Aboriginal Child Care Agency to:</p> <ul style="list-style-type: none"> • identify barriers to Aboriginal and Torres Strait Islander women participating in DPFC’s Mothers and Children program • develop strategies and programs to support Aboriginal and Torres Strait Islander women’s participation in the program. | <p>Accepted and in progress.</p> <p>An external provider has been contracted to develop a Mothers and Children’s Program Framework, Assessment Suite and Practice Guide. The current barriers for Aboriginal mothers will be explored during this process, and strategies will be developed in the new framework to mitigate these.</p> |
| <p>Recommendation 15 Identifying cognitive disability</p> <p>The Department of Justice and Regulation seek funding for the rollout of the preferred screening tool for cognitive disability, including acquired brain injury, in its 2018-19 budget.</p> | <p>Accepted and in progress.</p> <p>Corrections Victoria is exploring options to implement this recommendation in the 2019-20 Budget cycle.</p> |
| <p>Recommendation 16 Personal care for women with a disability</p> <p>The General Manager at DPFC identify women with a disability who need assistance with personal care, and make appropriate arrangements to provide it.</p> | <p>Accepted and in progress.</p> <p>The department is exploring the role prisoners can have in assisting other prisoners with care arrangements.</p> <p>A working group has been established and commenced meeting in February 2018. The prison is exploring the upskilling of prisoner carers.</p> <p>The Victorian Dual Disability Service commenced co-delivering staff training at DPFC on working with women with dual disabilities.</p> |
| <p>Recommendation 17 Play equipment for children</p> <p>The General Manager at DPFC fund, or partner with community organisations to fund, play equipment for children living with their mothers at the prison.</p> | <p>Accepted and in progress.</p> <p>Funding was allocated to DPFC to complete a new playground as a part of the current infrastructure works program.</p> |

| | |
|--|---|
| <p>Recommendation 18 More women officers</p> <p>The General Manager at DPFC develop a strategy for recruiting and retaining women to increase the proportion of female custodial officers at DPFC to 60 per cent by 2020, including seeking any necessary exemptions under the <i>Equal Opportunity Act 2010</i> (Vic).</p> | <p>Accepted and in progress.</p> <p>52 per cent of current custodial staff at DPFC are women. Advice was sought from the Victorian Equal Opportunity and Human Rights Commission as to whether specific recruitment of women for employment at DPFC is covered under the existing exemptions specified in the Act. The department is now required to seek further advice from the Victorian Government Solicitor's Office.</p> |
| <p>Recommendation 19 Equipping officers to work with a diverse population</p> <p>The General Manager at DPFC ensure training for all custodial officers at DPFC from 2018 about:</p> <ul style="list-style-type: none"> • women with a disability • women with mental health conditions or personality disorders • Aboriginal and Torres Strait Islander women. This training should also be extended to Correct Care Australasia staff • transgender prisoners • for officers working in the Mothers and Children unit - working with mothers and children. | <p>Accepted and in progress.</p> <p>These training suggestions for staff will be included as part of the Women's System Reform Project, which is more broadly considering the training needs of staff working with women prisoners.</p> <p>Justice Health has funded Victorian Community Controlled Aboriginal Health Organisation to provide cultural safety training to Justice Health's contracted health service providers over the past two years.</p> |

Additional report



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

Why I investigated

On 25 November 2015, the Parliamentary Legislative Council referred for my investigation, allegations that Australian Labor Party (ALP) members of the Victorian Parliament misused members' electorate entitlements for party and political activities, in breach of the Parliament of Victoria Members' Guide. This was only the fourth referral received from Parliament since the creation of the Ombudsman's office in 1973.

I am required by section 16 of the Ombudsman Act to investigate referrals from Parliament 'forthwith'. My investigation was delayed by legal proceedings, which finally concluded in April 2017.

What I found

I found that 21 current or former Members of Parliament breached the Members Guide.

What has happened since

As a result of my investigation report, the ALP has repaid \$387,842 to the Department of Parliamentary Services.

In March 2018, the Parliament directed the Privileges Committee of the Legislative Council, to conduct an inquiry into matters relating to the misuse of electorate office staffing entitlements. The committee is due to report its findings by 23 August 2018.

My office will seek an update on implementation of the recommendations six months after the tabling of the report.

Status of my recommendations to Parliament, its Presiding Officers and the Secretary of the Department of Parliamentary Services

| | |
|---|------------------|
| <p>Recommendation 1</p> <p>Revise the limitation in the Members' Guide on Electorate Officer duties to:</p> <p>1.1 remove the prohibition on political activity but emphasise the prohibition on party-specific activity</p> <p>1.2 provide guidance and examples to Members about the types of activities which Electorate Officers may not be directed to perform</p> <p>1.3 include a statement about the effect of section 30(4) of the <i>Parliamentary Administration Act 2005</i> (Vic) (see Recommendation 2).</p> | <p>Accepted.</p> |
| <p>Recommendation 2</p> <p>Review section 30(4) of the Parliamentary Administration Act.</p> | <p>Accepted.</p> |
| <p>Recommendation 3</p> <p>Ensure the proposed Parliamentary Integrity Adviser has a training and guidance function that is appropriately supported by the Department of Parliamentary Services.</p> | <p>Accepted.</p> |
| <p>Recommendation 4</p> <p>Adopt the recommendation of the Hazell Review to create a separate allowances and entitlement handbook, publicly available and kept up to date.</p> | <p>Accepted.</p> |
| <p>Recommendation 5</p> <p>The Department of Parliamentary Services review current pooling arrangements and propose guidance for the consideration for the Presiding Officers.</p> | <p>Accepted.</p> |
| <p>Recommendation 6</p> <p>Establish clear investigative capacity and pathways to refer alleged misuses of parliamentary resources for examination by an independent agency as appropriate, with information available on Parliament's website.</p> | <p>Accepted.</p> |



Victorian Ombudsman's Parliamentary Reports tabled since April 2014

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 03 9613 6222
Email ombudvic@ombudsman.vic.gov.au
www.ombudsman.vic.gov.au