VICTORIAN ombudsman

Annual Report 2012

Part 1

Ordered to be printed
Victorian government printer
Session 2010 - 12
P.P. No. 166

1973 - 2012

four decades working to improve public administration in Victoria

200,000 complaints

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107,000 investigations and enquiries

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94 reports to Parliament

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Over 7,000 reports to Agencies

Trends that have emerged over the last decade:

Top five issues:

- Complaint handling
- Service delivery
- Regulation and Enforcement
- Custodial services
- Financial/procurement/facilities

Top five complaints:

- Deficient action
- Deficient decision
- Improper conduct
- Deficient advice
- Unfair policy

Top five respondents:

- Department of Justice
- Local government
- Department of Human Services
- Department of Transport
- Education and Early Childhood Development

Top five outcomes:

- 92% recommendations to Agencies accepted
- Agency provides explanation
- Agency resolves complaint by taking action
- Agency's action is appropriate/reasonable
- Agency's action is inappropriate/unreasonable

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to the Parliament Part 1 of the annual report of the Ombudsman for the year 2011-12 which relates to my statutory functions.

In order to provide Parliament with a timely report of the activities of my office over the past year, I am tabling my report in two parts:

Part 1 – dealing with my statutory functions

Part 2 – providing statistical details and the financial statements for my office.

I shall be tabling Part 2 of the annual report shortly.

G E Brouwer
OMBUDSMAN
14 August 2012

Contents

1. Introduction

In the almost four decades since the office of the Victorian Ombudsman was established, its work has led to many improvements in public administration in this State.

Since I was appointed to the office in 2004, over 100,000 complaints within my jurisdiction have been the subject of enquiry or investigation by my officers. Hundreds of formal investigations have been conducted, resulting in reports and recommendations which in turn have led to far reaching changes in the Victorian public sector, reducing administrative deficiencies and maladministration.

My parliamentary reports are publicly available and the recommendations contained in them are publicly reported. In response to recommendations made in these reports, I have observed important improvements in the delivery of public services. Many of these investigations have been undertaken using my 'own motion' power. This power allows me to move beyond individual complaints and investigate systemic problems, to examine the underlying causes of maladministration and misconduct. Many of these investigations have had far reaching consequences for public administration. For example:

- ***Preventing fraud***

  In my 2007 report of my own motion *Investigation into VicRoads driver licensing arrangements*[1] I concluded that urgent action to improve the security of Victorian drivers licences was required. I commented that:

  > Identity fraud is a growing problem for the Australian community. The use of the driver licence to commit such fraud requires VicRoads to be proactive in dealing with the issue.

  As a result of this investigation VicRoads has introduced a more secure centralised licence production process and included additional security features in licences.

- ***Protecting public revenue***

  My investigations assist in guarding against the loss of public revenue to fraud, corruption or maladministration.

  For instance, my 2009 report *An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing*[2] found weaknesses in the procedures of both the TAC and WorkCover. These weaknesses created the risk that public funds could be lost through deliberate or inadvertent overcharging by medical practitioners who provided services to the schemes' beneficiaries. My own motion investigation concluded in respect of both organisations that:

1 Victorian Ombudsman, *Investigation into VicRoads driver licensing arrangements*, December 2007.

2 Victorian Ombudsman, *An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing*, July 2009.

- their electronic payment systems and associated controls failed to detect billing practices that were inconsistent with the Commonwealth Medical Benefits Schedule (MBS) rules
- there were inadequacies in the TAC's and WorkSafe's[3] audit frameworks for detecting and dealing with outlier medical practitioner billing behaviour
- adequate civil recovery strategies were not in place.

The need to strengthen these processes is evident when considering that total gross claims incurred in 2008 by the TAC were $1,119,432,000 while those incurred by WorkSafe amounted to $1,236,686,000.[4] Both organisations took action in response to my report and its recommendations for improved oversight of medical practitioner billing practices.

I am pleased that the TAC's Annual Reports 2010 and 2011 affirmed its commitment to ensuring that payments made to service providers are accurate. As a consequence, reviews of claims have led to reimbursements to the TAC of $343,612 in 2010 and $202,396 in 2011.

Other reports have exposed inappropriate or corrupt procurement practices within the public sector. Lax procurement policies and procedures have the potential to lead to the substantial loss of public funds. Examples include my own motion investigations into hospital procurement, purchasing of toner cartridges and Victoria Police Information and Technology Services.[5]

Lack of leadership and a failure to apply sound management practices was the focus of my *Own motion investigation into ICT-enabled projects*[6], which I conducted in consultation with the Auditor-General. My investigation examined 10 projects which had overrun their budgets by $1.44 billion and had also been beset by delay and failure to deliver expected results. My report outlined a practical framework for agencies and government to apply to future projects.

The Assistant Treasurer and Minister for Technology has implemented a high-value high-risk unit within Treasury to improve scrutiny of major projects.

3 WorkSafe is the trading name of WorkCover.

4 *An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing*, op cit, paragraph 118.

5 Victorian Ombudsman: *Probity controls in public hospitals for the procurement of non-clinical goods and services*, August 2008; *Corrupt conduct by public officers in procurement*, June 2011; *Own motion investigation into the tendering and contracting of information and technology services within Victoria Police*, November 2009.

6 Victorian Ombudsman, *Own motion investigation into ICT-enabled projects*, November 2011.

- ***Promoting integrity***

  My 2008 reports of two own motion investigations – *Conflict of interest in the public sector* and *Conflict of interest in local government*[7] – have continued to generate interest within the broader public sector and stimulated discussion within agencies as to how conflicts of interest are best managed.

  In response to my recommendations, the Public Sector Standards Commissioner and the Victorian Government Purchasing Board have provided a greater degree of guidance to public officers about their responsibilities and the appropriate processes to adopt. The standard of behaviour expected from public officers has also been clarified through amendments to the *Local Government Act 1989* and revised Codes of Conduct issued by the Public Sector Standards Commissioner.

  Conflict of interest is a recurring theme in my investigations and requires constant attention from government and officials alike to ensure a strong appreciation of the issue is firmly embedded within the culture of all public bodies. My reports provide a framework within which agencies can pursue that objective.

- ***Better administration***

  Providing good services to the public requires competent administration of government programs and services. Record keeping is an area which is frequently identified as deficient in many of my investigations. My public reports assist in setting the standard for the public sector in terms of good record keeping practices.

  My 2011 own motion *Investigation into record keeping failures by WorkSafe agents*[8] established that poor administrative processes were creating hardships for injured workers as well as presenting financial difficulties for service providers. The absence of rigorous processes also allowed one agent to claim significant incentive payments to which it was not entitled.

  In another example of poor record keeping, I reported earlier this year on the failure of the Department of Human Services to adequately manage records concerning people who have been wards of state and the consequence of this mismanagement on individuals seeking information about their past.[9]

7 Victorian Ombudsman: *Conflict of interest in the public sector*, March 2008; *Conflict of interest in local government*, March 2008.

8 Victorian Ombudsman, *Investigation into record keeping failures by WorkSafe agents*, May 2011.

9 Victorian Ombudsman, *Own motion investigation into the management and storage of ward records by the Department of Human Services*, March 2012.

- ***Protecting the vulnerable***

  Services to vulnerable Victorians include some of the most complex areas of public administration. Child protection, disability services, youth justice and mental health are amongst those emotionally charged areas which present particular challenges to legislators, service providers, policy makers and the community. Historically, debate regarding these systems has been less effective than desirable because the Parliament and the public have had access to limited information about how these services interact with those who rely upon them.

  However my investigations in these areas have resulted in reports tabled in Parliament that have contributed to the information that is available to inform that debate. They combine objective analysis of the key issues with detailed insights into the care and treatment provided to vulnerable people. I believe that this scrutiny ultimately benefits those who rely on the state for care and protection; and indeed all citizens, as we all have a vested interest in how services provided by the state are delivered. While my investigations have also remedied particular problems in these systems, this broader exposure and scrutiny underpins and enables long term change.

  My series of *Child Protection* reports[10] are a case in point. While the Department of Human Services is the lead child protection agency in Victoria, these reports have identified that a whole of government approach to child protection is necessary. The active involvement of agencies with responsibility for mental health, education, disability services, health, corrections and policing is required to ensure that child protection services are effective. My conclusions were subsequently reiterated in the report of the Protecting Victoria's Vulnerable Children Inquiry[11], which also observed that:

  > It is critical that relevant government departments are required to accept their existing responsibilities to vulnerable children and their families and are held accountable for doing so. The Department of Human Services, acting alone, cannot adequately reduce the level of vulnerability for Victoria's children and young people. The Inquiry has found that some government departments, particularly Education and Early Childhood Development and Health, have given insufficient regard to the needs of Victoria's vulnerable children and young people.[12]

10 Victorian Ombudsman:
Investigation into the Department of Human Services Child Protection Program, November 2009;
Own motion investigation into Child Protection - out of home care, May 2010;
Investigation regarding the Department of Human Services Child Protection Program (Loddon Mallee Region), October 2011.

11 *Report of the Protecting Victoria's Vulnerable Children Inquiry*, volumes 1-3, January 2012, see for example volume 2, pages 83-87.

12 ibid page xxxv.

In my 2011 report, *Investigation into the failure of agencies to manage registered sex offenders*[13], I again informed the Parliament of these critical issues regarding the performance of agencies responsible for the protection of Victoria's most vulnerable citizens.

This investigation identified 376 offenders whom Victoria Police knew had had contact with children, yet were not reported to the Department of Human Services Child Protection Program. I considered that the protection of children had been compromised by poor management of the register, a lack of coordination between agencies, inadequate resourcing and excessive concern for the privacy of offenders. I concluded that the legislative arrangements for the register required review.

In response to my report the government commissioned the Victorian Law Reform Commission (the Commission) to review and report on the registration of sex offenders under the Sex Offenders Registration Act 2004. The Commission also examined the management and use of information about registered sex offenders by law enforcement and child protection agencies. The Commission has now delivered its report to government. The government also announced $8.8 million in funding over four years in the 2012-13 budget to boost Victoria Police's capacity to manage and oversee offenders listed on the Sex Offenders Register.

These systemic issues may not have been addressed if they had not been subject to investigation by my office. As the Commission noted in its final report:

> This report, and the Ombudsman's report, have permitted the Victorian Parliament to receive some information about the operation and impact of the sex offenders registration scheme. Such opportunities for review are not built into the Sex Offenders Registration Act.

Many other investigations by my office have also ensured that the Parliament and the Victorian community are made aware of services and systems that have failed to provide the level of care expected by the community. These have included investigations into the assault of a disability services client at a Community Residential Unit and subsequent cover-up, and conditions at the Parkville Youth Justice Precinct. The latter report, and the actions taken by the department in response, provide a useful illustration of how the work of my office can affect the way in which government conducts itself and delivers its services to Victorians, particularly those without a voice, like young people in detention.

13 Victorian Ombudsman, *Whistleblowers Protection Act 2001 - Investigation into the failure of agencies to manage registered sex offenders*, February 2011.

CASE STUDY 1 – Youth Justice Precinct, Parkville

In 2010, I conducted an investigation into the Youth Justice Precinct at Parkville, which is operated by the Department of Human Services.

In October of that year, I tabled a report in Parliament that was highly critical of the condition and management of the precinct. The criticisms contained in my report dealt with: the shocking physical state of the complex, which was damaged, deteriorated and unsafe; the conduct of staff in relation to the detainees; the lack of access to formal education for detainees; and the management of the precinct overall.

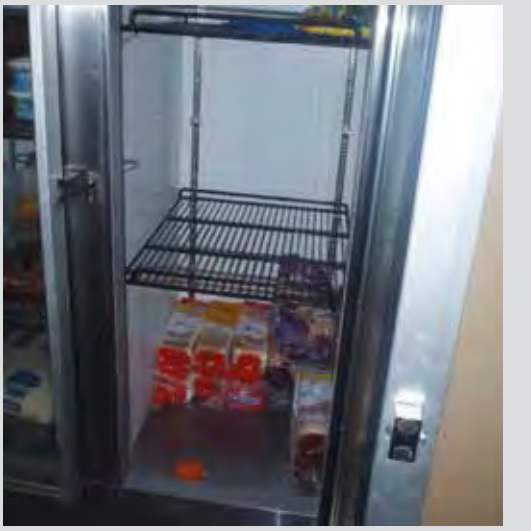
Pictures were taken by my officers in the course of investigating the precinct, and were contained in the report of this investigation, as follows:

Before

In April this year, some 18 months later, an event was held at the precinct by the department, announcing numerous changes that had been implemented, and others that were in the pipeline, addressing the concerns I had raised. A representative from my office attended this event and was given the opportunity to inspect the physical structure of the precinct and observe how it had been altered.

Pictures demonstrating some of these improvements are below.

After



The department has made considerable changes to enhance the facilities at the Precinct and maintain a standard of cleanliness that is expected of a youth justice facility in Australia. A new education system has been implemented allowing detainees access to formal education. Since the tabling of my report a new Director of Youth Justice Custodial Services has been appointed, who has played a fundamental role in implementing the changes and has advised my office that further enhancements to the Precinct, and solutions to overcrowding, will occur in due course. My office will continue to monitor the recommendations made in my report to ensure they are implemented.

2. Investigation reports

This year I have tabled in Parliament 12 reports of investigations conducted by my office.[14] Some, such as the report into *The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria*[15], were the subject of considerable coverage in the media. Others, such as my reports of investigations into prisoner access to health care and universities' dealings with international students[16], were not canvassed in the public arena to the same extent. However, in every case, I considered the matters identified by my office in the course of these investigations were of such public interest that they clearly warranted my tabling a report in order that the Parliament and the public might be made aware of that information.

Dealing with enquiries, investigations, reports and recommendations is the core work of my office. Some of it, such as those investigations mentioned above, enters the public domain through the process of tabling reports of those investigations in Parliament. However, my tabled reports represent only a small portion of the investigation reports I complete each year. The majority of the reports I make are not tabled. This is because only matters I determine are in the public interest result in tabled report. The remainder of my investigations and enquiries – the lion's share of the work of my office – are conducted in private, as is mandated by sections 17 and 20 of the *Ombudsman Act 1973* and section 22 of the *Whistleblowers Protection Act 2001*.

The legislation governing the work of my office contains sufficient flexibility in relation to the exercise of my discretion that every investigation can be dealt with on its own merits, and have an appropriate outcome. Every investigation[17] conducted by my office is reported to the relevant public authority: the relevant Minister; departmental secretary; agency head (such as a CEO); or Mayor (in the case of local councils).

As with my parliamentary reports, these reports generally contain recommendations. Of course, every case is different, but where the results of my investigation lead me to consider that it is appropriate, I make recommendations to address the problems that I have identified. Over the last eight years, these reports have contained recommendations for changes in numerous areas. Many of these have been implemented, resulting in significant improvements in the agencies concerned. For example I have recommended:

- stronger procedures for identifying and managing conflicts of interest
- improved record management procedures
- greater guidance for council officers regarding how they should deal with inappropriate attempts by councillors to influence administrative decisions

14 A full index of all my parliamentary reports is at the end of this report.

15 Victorian Ombudsman, *The death of Mr Carl Williams at HM Barwon Prison - investigation into Corrections Victoria*, April 2012.

16 Victorian Ombudsman, *Investigation into prisoner access to health care*, August 2011; *Investigation into how universities deal with international students*, October 2011.

17 This applies to investigations conducted under section 14 of the Ombudsman Act. The majority of complaints made to my office are dealt with under section 13, by way of enquiry. Enquiries usually do not result in reports to agency heads. Enquiries are discussed further in Chapters 10 and 11.

- that councillors receive training about probity issues
- the review of a statutory board's governance arrangements.

As well as improving public administration my investigations also make recommendations about how an agency can remedy problems caused for individuals by maladministration. In many cases this requires minimal investigation as the agency quickly recognises the problem and is prepared to take action. My guiding principle is that, as far as possible, the person concerned should be returned to the situation they would have been in had the problem not occurred. In these cases I may recommend reimbursement of expenses, compensation for a quantifiable loss that can be objectively attributed to maladministration or expediting the provision of a service. I also recommend that agencies apologise to people adversely affected by their errors.

The overwhelming majority of the matters I look into each year arise and are dealt with in private. From the beginning - whether that be a complaint raised by an individual, a whistleblower bringing their disclosure to my office, or an investigation I launch on my own motion into a systemic problem I have identified in the public sector - the actions I undertake to look into the issues and resolve them by whatever means I deem appropriate, often remain unknown to the general public.

This year, in my Annual Report, I propose to canvas some of these usually private processes, so that the public and the Parliament, to which I ultimately report, may increase their understanding of the role my office plays in the public affairs of this State. There are many approaches I could take in order to tell this story. I have decided to start with the simplest point of entry: Intake, where the process most often begins.

3. Intake

The first point of contact for complainants to my office is our Intake and Assessment team. Each year, the number of approaches to the Ombudsman increases: in 2011-12, 29,773 people contacted my office for assistance, an increase of 16.5 per cent over the previous year. At the present rate of increase, the number will exceed 34,500 next year. The number of complaints has increased 22 fold over the last four decades. However, the number of Ombudsman staff has increased only eight fold in that time. In 40 years, the output of this office has increased enormously; so too has the productivity of the office.

I have four intake teams, totalling 30 officers. Each team consists of two frontline staff whose main role is to receive complaints, whether by phone, email or letter (or any other means), and five or six more senior officers who provide advice, make enquiries or conduct investigations. The frontline duty rotates between these teams throughout the week, but in essence eight frontline staff, with support from 22 more senior officers, deal with an average of about 600 approaches to my office each week.

This level of incoming matters requires efficiency in dealing with them and resolving them quickly, else a backlog of cases needing attention would quickly build up. My staff achieve this efficiency in a way which I commend. In terms of the many ways in which I fulfil my duty to the State, the quality, efficiency and work ethic of the staff in my intake teams is a significant factor.

Victorians bring all manner of issues to my office and, where there is help available, whether from my staff or another organisation, we ensure they are armed with the appropriate knowledge to address their concerns. This 'clearing house' process is a service my staff have performed for many years, assisting complainants to navigate the array of complaint bodies, both State and Commonwealth. It is a service I discuss further in chapter 5.

Approximately 52 per cent of complaints I received this year were about matters within my jurisdiction, and 48 per cent related to matters outside my jurisdiction. Many complainants come to my office because they simply do not know where to go. My office assists these people by directing them to the appropriate agency.

By way of example, the following table is a log of calls received on a typical morning in my office's intake unit - in this case, four months ago, on 12 April. That morning saw the usual array of matters brought to my office; some within my jurisdiction and others not. In every case, assistance was provided by my intake staff, or the complainant was directed to the authority with jurisdiction in that area.

Table 1 – Log of calls received on 12 April 2012 9:00am – 12:00pm	
9:06	Complainant (C) called regarding involuntary ECT treatment for depression
9:10	Complaint about the installation of a rain water tank and neighbour syphoning water from the tank.
9:11	C requested a review of the Legal Services Commission decision. C to send in documents for assessment, outlining the administrative error.

9:16	Complaint about car dealership.
9:20	Complaint that State Trustees Ltd has imposed excessive charges and conditions.
9:28	Complaint about a medical practitioner regarding failure to act or provide advice regarding her husband's health.
9:34	Complaint about car insurance.
9:37	Complaint about a solicitor.
9:42	Complaint about psychiatric treatment.
9:47	C concerned that council may enforce an unreasonable condition imposed on a heritage overlay planning permit.
9:47	Complaint about Foxtel.
9:52	C calling on behalf of his brother in prison, complaining that he has been unfairly denied legal aid.
9:56	C dissatisfied with her landlord regarding authorisation for a film crew to use her apartment building in the CBD.
10:02	Complaint about a student's exclusion from RMIT.
10:11	Complaint about motor vehicle insurance.
10:12	Complaint about a nurse declining to provide a doctor's certificate.
10:16	Complaint about Telstra regarding a phone service.
10:24	Complaint about overcrowding at Melbourne Custody Centre and poor cell conditions.
10:38	Complaint about credit card company.
10:40	Complaint about the actions of Police Officers; seeking information about C's rights/ responsibilities.
10:41	Complaint about police officers' treatment of C's son.
10:43	Complaint about VCAT tribunal member.
10:45	Complaint about energy company.
10:46	Concern about Sheriff's Office overcharging.
10:46	Complaint about the decision of a judge in relation to an award of costs.
!0:51	Complaint about a possible scam phone call.
10:56	Complaint about ex-wife, alleging fraudulent use of son's Medicare card.
11:13	Complaint that Office of Housing has failed to fix the fence which C considers a potential hazard. C has complained to the relevant office of housing but it lost his correspondence.
11:30	Complaint about motor vehicle insurance.
11:32	Complaint that C's prison is in a lockdown today and he has not been able to see a doctor. He has symptoms including not being able to swallow, puffy eyes and a rash.
11:32	C called on behalf of her husband regarding a recruitment process at Victoria Police, specifically the way it administered a psychological assessment.
11:38	C experiencing difficulties with the order process for trainers in prison.
11:41	Complaint about purchase of unreliable motor vehicle.
11:50	Complaint about energy provider.
11:53	Complaint about Sheriff's Office seeking to recover fees that had been revoked.

That afternoon, my intake team received 67 more telephone complaints; over the day, there were 14 complaints lodged electronically and 6 by ordinary post. A total of 122 matters came to my office that day.

As the above demonstrates, Victorians bring all manner of issues to my office. The first task for my officers is usually to explore whether or not the complaint lies within my jurisdiction.

4. Jurisdictional complaints

Under the Ombudsman Act, I have jurisdiction over the administrative actions of state government departments, public statutory bodies and staff of municipal councils. The majority of complaints brought to my office fall within that ambit: they concern the full array of departments, agencies and statutory authorities, along with Victoria's 79 Councils.

The following table is a summary of the most common complaints, and the bodies most frequently involved.

Table 2 – Top 10 areas of complaints

Most common complaints	Number	Agencies most often involved
Service Delivery: Failure to act/provide Quality Assessments	2265	Departments and Authorities
Complaint handling Wrong conclusion Inadequate remedy Delay Inadequate processes	2147	Departments and Authorities
Planning and parking	683	Local Government
Correctional Services Health Matters	534	Custodial Services
Infringements	448	Departments and Authorities
Correspondence/ Records/ Communications Delay No Response	424	Departments and Authorities
Enforcement Action	393	Departments and Authorities
Misconduct	328	Departments and Authorities
Discourtesy	291	Departments and Authorities
Custodial Services Property	241	Correctional Services Matters

The most common outcome for these complaints is the complainant being advised that, where they have not already done so, they should try to exhaust their avenues of redress with the agency involved, before coming to this office. Once that avenue has been pursued, their complaint may be resolved without requiring my involvement. If not, the complainant often returns to this office.

Other common outcomes include: agencies resolving the complaint by taking action; complainants referred to other more appropriate bodies; and resolution of the complaint by the agency providing the complainant with clarification about the decision or action concerned.

The following table lists the agencies involved in complaints that were dealt with this year.

Table 3 – Complaints[18] by agency	
Respondent Agency	**Total**
Department of Business and Innovation	
Skills Victoria	8
DBI FOI Unit	1
Victorian Small Business Commissioner	1
Other	5
TOTAL	**15**
Department of Education and Early Childhood	
Universities	665
Schools	287
TAFEs	123
Other	157
TOTAL	**1232**
Department of Health	
Hospitals & Health Services	328
Health Services Commissioner	126
Ambulance Victoria	62
Mental Health Services	53
Cemeteries & Crematoria	18
Community Health Services	8
Health Registration Boards - Chinese Medicine Registration Board of Victoria	4
Hospital and Health Service Performance Division	2
DoH FoI	1
Other	71
TOTAL	**673**
Department of Human Services	
Child Protection	843
Office of Housing	666
Juvenile Justice Centres	90
Disability Services	79
FoI Unit	42
Child Protection NGOs	42
Victorian State Concessions (Home Wise)	13
Housing Appeals Office	11
Regional Office Functions	5
Other	54
TOTAL	**1845**
Department of Justice	
Including:	
Corrections	2583
Victoria Police	1156
TOTAL	**4892**

Department of Planning and Community Development	
Including:	
Building Commission	85
TOTAL	**169**
Department of Premier and Cabinet	
TOTAL	**68**
Members of Parliament	
TOTAL	**35**
Department of Primary Industries	
Including:	
Energy Safe Victoria	33
Fisheries Victoria	4
TOTAL	**122**
Department of Sustainability and Environment	
Water & Catchment Management	174
EPA	61
Plumbing Industry Commission	28
Parks Victoria	24
Regional Offices	10
NVIRP	6
VicForests	4
DSE FOI Unit	3
Other	86
TOTAL	**396**
Department of Transport	
VicRoads	741
Public Transport Division, including:	137
Metlink	11
Metro Trains	29
Victorian Taxi Directorate	52
Yarra Trams	15
VicTrack	9
V-Line Passenger Corporation	7
Transport Ticketing Authority	27
VicUrban	13
Public Transport Safety Victoria	3
Port of Melbourne Corporation	3
Other	229
TOTAL	**1153**

18 This data includes 12 matters investigated on my own motion.

Department of Treasury and Finance	
Including:	
WorkCover Authority and Insurers	659
State Trustees Ltd	334
TOTAL	**1295**
Local Government	
Including councils with over 80 complaints:	
Melbourne City Council	141
Yarra Ranges Shire Council	139
Casey City Council	131
Greater Geelong City Council	116
Hume City Council	113
Brimbank City Council	107
Moreland City Council	99
Glen Eira	91
Darebin City Council	89
Mornington Peninsula Shire	82
Knox City Council	81
Kingston City Council	81
TOTAL	**3441**

As can be seen from the above, most departments and councils and a large number of associated authorities and agencies are the subject of complaints brought to my office. These matters are within my jurisdiction and are dealt with by way of enquiry or investigation. These are discussed further in Chapters 9 – 12.

These complaint data are similar to those reported in previous years. Whilst there is no significant change in trends, some worth noting are:

- The complaints against several agencies have decreased this year, as a percentage of all complaints:
    - Department of Health
    - Local government
    - Department of Human Services
    - Department of Transport
    - Department of Education and Early Childhood Development
- However, complaints against the Department of Justice and the Department of Treasury and Finance have increased as a percentage of total complaints. The Justice increase is notable. Prison related complaints have increased by approximately 20 per cent on last year's figures, a greater rate of increase than the average across all complaints (approximately 15 per cent).

5. Non-jurisdictional complaints

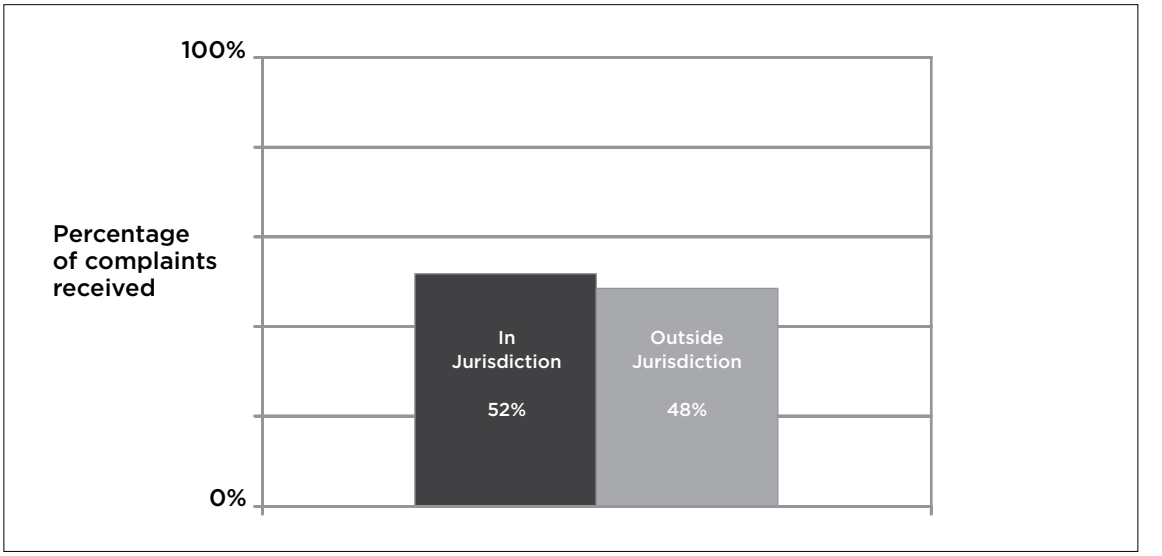
My office is an office of last resort. This means that complainants generally need to raise their concern with the organisation they are complaining about before bringing the matter to me.[19]

However, my office also is a point of first contact. This is because it has high recognition in the community – 73 per cent of Victorians are aware of the Ombudsman.[20] This recognition means that complainants' first port of call is often this office. It is not surprising that many complainants are unsure of which body to turn to: new complaint bodies are created from time to time; jurisdictions are sometimes amended by statute; services previously provided by government may be privatised; and the administration of some services is divided between State and Commonwealth, or public and private bodies.

While my jurisdiction under the Ombudsman Act relates to state and local government, almost half of the complainants who approach my office are complaining about a company or other organisation that is outside that ambit. My officers play a clearing house role, assisting them to navigate the complicated terrain of complaint bodies. The triage process adopted by my staff quickly identifies which is the appropriate body to handle each complaint. My officers have a good working knowledge about the various complaint bodies and their different jurisdictions, and are therefore able to assist many thousands of complainants each year by setting them on the appropriate path and advising them about the relevant complaint procedure.

This clearing house role, which is a significant and increasing part of the work of my Intake and Assessment officers, is one for which my office is not funded. However, it serves a highly beneficial purpose for citizens who are at a loss as to what steps they should take to have their complaint addressed.

Figure 1 – Non-jurisdictional complaints



19 In appropriate circumstances, this requirement can be waived. This is discussed further in Chapter 8.

20 This figure was contained in research commissioned by the Department of Justice: *Dispute Resolution in Victoria: Community Survey 2007*, Ipsos Australia Pty Ltd.

The above illustration shows that, although the majority (52 per cent) of complaints brought to my office are within my jurisdiction, there are nonetheless a great number (some 48 per cent) that concern matters I cannot look into. In these cases, we assist complainants to find the right body, so that they are not sent from pillar to post. The following case studies illustrate this.

CASE STUDY 2 – Medicare

A husband and wife returning to Australia after a short trip to Sri Lanka were refused Medicare Levy Exemption Certificates for two years as they did not have an 'arrival stamp' on their passports. The Department of Immigration and Citizenship (DIAC) advised that the arrival stamp was not necessary as arrivals were recorded electronically and kept on DIAC's database. DIAC indicated that Medicare could contact DIAC direct if further clarification was needed.

My officers provided the complainants with this information and advised that Medicare Australia, as a Federal agency, did not fall under my jurisdiction. We referred them to the Commonwealth Ombudsman.

CASE STUDY 3 – Energy provider

The complainant had solar panels and a water tank installed at her property in May 2011. Thereafter, she continued to receive incorrect billing from her energy provider. Before complaining to my office, she had made eight phone calls to the provider about this, but she continued to receive incorrect bills.

My officers referred her to the Energy and Water Ombudsman.

CASE STUDY 4 – Car purchase

A 72 year old complainant contacted my office about a second hand vehicle he had bought from a dealership. The car developed a rattling noise in the roof area a day or so after he bought it. As the car was under warranty he took it to a related dealership to have it repaired. He was advised that the part needed would need to be shipped from Europe and would take six weeks to arrive. A series of delays ensued that were out of his control during which time his warranty expired. The complainant advised that, owing to his age, this was likely to be his last car, and he was not in a financial position to replace it.

My officers referred him to Consumer Affairs Victoria and the Australian Competition and Consumer Commission.

In response to the ever-increasing number of people who need assistance navigating this terrain, I have recently introduced changes to our telephone message system to provide complainants with accurate advice quickly, reducing any delay they may experience in identifying the appropriate authority for their complaint, and freeing up my officers' time to deal with jurisdictional complaints.

I am also introducing changes to the online complaint form on my website. This will build on our improvement in efficiency, providing complainants immediately with accurate referral information, when it is relevant to them, without needing to wait even a matter of seconds to speak to one of my complaints officers.

6. Avoidable complaints

This year, as in previous years, numerous complaints were made to my office regarding a failure to respond by a government body or agency when a complaint was made to it.

Generally, complainants first raise their concerns with the agency involved. When they do not receive a satisfactory response, they come to my office. Having assessed the complaint my officers will often make enquiries with the relevant agency. In a high proportion of cases my officers are able to resolve the complaint promptly, with 87 per cent of complaints dealt with within 14 days. This is particularly the case when the issue is a lack of response by the agency, or delay in responding, to the complainant.

In these cases, the whole process was usually avoidable. If agencies dealt with complaints promptly on their merits when they were first raised, there would often be no need for the involvement of my office.

CASE STUDY 5 – Marngoneet Prison

A prisoner at Marngoneet Correctional Centre complained that he had been incorrectly classified as an intravenous drug user. This affected his visiting rights and other entitlements. He also complained that prison staff had given this information to visitors, breaching his privacy.

He raised his concerns with the prison's General Manager in June 2011, but did not receive a response. When my office made enquiries with the prison in mid-July, it undertook to respond to his concerns within 12 days. That deadline passed with no response provided. Further enquiries led to a second undertaking, to respond by mid-August. This deadline was met, with the prison acknowledging its delay.

CASE STUDY 6 – University of Ballarat

A student complained to my office that the University of Ballarat had rejected her application for special consideration. It had told her that, as all her assessments had been submitted, special consideration could not be given. She had also been advised that the university did not have an internal appeals process through which she could challenge this decision.

My office investigated and established that under the university's policy a student could request that an assessor take into account an ongoing medical condition when marking students' work; and the university had an internal appeals process to which the student should have had access.

The university reconsidered the student's special consideration application, and provided an avenue of internal appeal. It also advised it was taking steps to ensure that students were properly informed of their appeal rights in future.

Of greater concern are complaints about conduct that I have previously criticised in a report to Parliament. If agencies implemented the changes that I previously recommended (and they have usually undertaken to do so) these complaints would not arise. This was the case this year with the conduct of authorised officers on Melbourne's train network.

In December 2010, I tabled in Parliament a report of an investigation dealing with the conduct of public transport authorised officers: *Investigation into the issuing of infringement notices to public transport users and related matters*. This report contained CCTV footage, demonstrating instances of inappropriate use of force by authorised officers in their dealings with commuters. Public reaction to this footage was considerable, and the Department of Transport, and its contractors, undertook to change their processes to address authorised officer conduct. Twelve months later, in December 2011, a commuter contacted my office complaining of similar excessive use of force by an authorised officer, as follows:

CASE STUDY 7 – Metro Trains

A complainant alleged that authorised officers on a Metro train had used unreasonable force against her and another passenger whom she had not previously met.

I made enquiries with Metro Trains (Metro) and the Department of Transport and viewed the relevant CCTV footage. This revealed:

- On 27 November 2011, four authorised officers on the Sydenham Line approached a passenger and confiscated his train ticket without his consent. The passenger stood up to remonstrate.
- An authorised officer then pushed him against the train wall and into his seat, twice, with considerable force.
- At North Melbourne railway station he was asked to leave the train. While in the doorway of the train, he was pushed to the ground by two authorised officers, and dragged off the train.

The complainant was concerned about the treatment the passenger was receiving, and intervened on his behalf. Both the complainant and the passenger were then threatened with criminal charges: the complainant for hindering authorised officers; and the passenger for failing to have a valid ticket, behaving in a disorderly manner, and related charges.

Metro had investigated the actions of the authorised officers and concluded they had acted appropriately. However, it also concluded 'it is clear the violent end to this incident was avoidable'.

I formed a different view. I considered the authorised officers had used unreasonable force against the passenger and had not followed Metro procedures when confiscating his ticket. I concluded that Metro's investigation was flawed. Of further concern was the Department of Transport's failure to investigate the use of unreasonable force adequately.

I proposed that the Department of Transport complete an investigation into the incident. I also recommended that it not proceed with charges against the complainant.

The Secretary accepted my proposals and advised that:

- no charges would be laid against the complainant
- one of the authorised officers had had their authorisation suspended and another had been reprimanded.

7. Old complaints

In some instances, even where a complaint concerns a matter that is within my jurisdiction, it may be that I still decline to investigate it. This can be for several reasons: because it concerns an administrative decision that the Ombudsman Act indicates should not ordinarily attract my attention, such as employment related issues, or where the complainant has raised the matter prematurely (see Chapter 8), or has delayed a year or more before complaining.

I will usually not look into matters that concern actions and decisions that were known to the complainant over a year before a complaint was brought to my office. This is in accordance with section 15(b) of the Ombudsman Act, which states that "where the complainant ha[s] had knowledge for more than twelve months of the administrative action complained about, and fails to give a satisfactory explanation for the delay in making the complaint", I may, in my discretion, decide not to entertain the complaint. The rationale underpinning this provision is that the office of the Ombudsman was not created as a forum for the ventilation of old grievances, but rather to contribute to the fast and efficient resolution of complaints about decisions and actions of government agencies. I also need to consider the appropriate use of my limited resources.

However, in some circumstances, where the delay was not the result of the complainant's inaction, or where the harm suffered is considerable, I may exercise my discretion and enquire into the matter.

CASE STUDY 8 – Removal of caveat from title

A complainant purchased a property in 1994 at an executor's sale. It was not until 2009 that he became aware that a caveat remained on the title, which should have been removed following the death of the previous owner. The Registrar of Titles was prepared to remove the caveat, on the provision of a death certificate. However the Registrar of Births Deaths and Marriages was not prepared to issue a death certificate to the complainant for privacy reasons. The complainant was caught between the proper but conflicting regulations of the two authorities.

While the complainant had waited two years before raising the matter with my office, he had taken appropriate steps during that period and I considered that his entitlement to an unencumbered title warranted my involvement. I made enquiries and the Registry of Births Deaths and Marriages agreed to provide the complainant with an abridged version of the death certificate which the complainant could then provide to the Registrar of Titles. The caveat was removed.

8. Premature complaints

Matters that have not first been raised with the public body involved are ones which I will in most cases decline to investigate. Other than in exceptional circumstances, I do not enquire into or investigate complaints when the public body has not been given an opportunity to resolve the complaint direct with the complainant.

The morning's log of calls – 12 April 2012, set out in Chapter 3 – contains numerous examples of complainants who raised their complaints prematurely, and who were advised to approach the agency involved before coming to my office. In fact, premature complaints are so common, that they constitute 45 per cent of all complaints made to my office.

However, my discretion allows me to waive this requirement where I consider it appropriate, for example:

CASE STUDY 9 – Accessible correspondence for vision impaired client

I received a complaint concerning an officer of the Ballarat Housing Office. The complainant suffers from vision restrictions and claimed that the officer had refused his request to use a larger sized typeface when corresponding with him.

Although there was no evidence that the complainant had raised this matter formally with the agency, I decided it would be overly bureaucratic to suggest he do so. I resolved the matter informally by contacting the agency direct. It agreed that it would write to him to confirm that all future correspondence from that office would be provided in the format he had requested.

9. Complaints involving divided responsibilities

Some complaints fall between two or more stools, where responsibility for the action or decision is divided between different bodies – whether government, private or a mixture of both. This is often the case where there has been subcontracting of government or council services. Recent reports of investigations that I have tabled in Parliament have demonstrated how this divided responsibility can have particularly harmful consequences for individuals.

My *Prisoner access to health care* report[21] examined the standard of health care provided to people incarcerated in Victoria's prisons. This investigation involved a number of responsible parties including Private Health Providers; Justice Health; and the Health Services Commissioner.

My investigation identified serious deficiencies in the health care provided to Victoria's prisoners. Specifically:

- insufficient time allowed for health assessments
- inadequate resources for transportation for medical treatment
- insufficient medical resources
- inadequate communicable disease prevention and treatment
- grossly inadequate mental health services.

I concluded that Justice Health failed to provide adequate oversight of the health care delivered to Victorian prisoners. An audit of Justice Health's complaint files identified cases where Justice Health had failed to:

- act in a timely manner
- address the substance of complaints
- verify or evaluate the service provider's response to enquiries.

My investigation also identified that the Health Services Commissioner had never undertaken a formal investigation into the health care provided in Victorian prisons. Given the 'revolving door' between our prison system and the community, I considered these deficiencies are likely to affect the wider public detrimentally.

The Department of Justice has since advised that it has undertaken a comprehensive review of its management of health complaints. This has led to a new framework for complaints management and the execution of a Memorandum of Understanding with the Health Services Commissioner outlining roles and responsibilities and a commitment to improved information sharing. The department advises that the changes have led to a 70 per cent reduction in the time taken to close prisoner complaints. A trial of a complaints telephone line to the Health Services Commissioner is also underway.

My parliamentary reports represent a small portion of the cases where I found divided responsibility resulted in individuals falling between the cracks. The Ombudsman, by virtue of the authority of Parliament, can deal with complaints involving public bodies, but it is more difficult where there is a mix of public and private authority, some aspect of which lies outside my jurisdiction. In these instances, my office devotes considerable time and effort merely to the task of sorting out who is responsible.

21 Victorian Ombudsman, *Investigation into prisoner access to health care*, August 2011.

CASE STUDY 10 – Tripping accident, divided responsibility

In July 2011, a complainant tripped over a steel safety fence lying on the ground next to a bus stop outside Hallam Station, fracturing her left arm. The complainant was required to take four weeks off work due to the injury and wished to be compensated for her loss of sick leave and medical expenses. She contacted the Department of Transport, VicTrack, Casey Council and VicRoads, all of which denied responsibility and referred her on to another agency. By April 2012, in considerable frustration, she complained to me.

My officers made a number of calls over the following month to all the parties involved, and were able to narrow responsibility to Metlink, as a contractor to the department, and VicRoads. At that point the department agreed to discuss the matter direct with VicRoads to ascertain which agency was responsible for considering the complainant's claim. VicRoads has since advised that the investigation has clarified responsibility.

Divided jurisdiction is also relevant to the question of which authority should investigate a matter. From time to time, complaints are brought to my office which might be investigated by a range of different authorities. An example occurred this year:

CASE STUDY 11 – Mishandling report of sexual assault

Last November, a woman reported to my office that she had been sexually assaulted the previous year while held as an involuntary patient at Bendigo Health's Alexander Bayne Centre. The alleged perpetrator was another patient. Her complaint was that:

- she had been denied the opportunity to report the assault to Victoria Police
- neither had the hospital reported the assault to police, even though its policy required staff to report assaults to Victoria Police
- the hospital had responded to her complaint by placing her in a locked ward, while the assailant was left in an open ward.

My enquiries confirmed that:

- Bendigo Health was aware of the alleged assault
- the incident had been poorly documented by staff
- the allegation was not reported to Victoria Police by staff. The hospital has since advised that the requirement of staff to report assaults to police depends on the mental state and legal status of the patient. It has also has advised that the matter was reported to police by the patient's partner.

I requested that Bendigo Health write to the complainant to apologise and that it take steps to address the deficiencies identified as a result of the complaint. My recommendations were accepted. The hospital has since acknowledged that its handling of the matter was deficient in a number of areas.

Victoria Police, which was the appropriate agency to deal with allegations of a criminal nature, was investigating the matter. There was therefore no further role for my office.

Police Jurisdiction

Jurisdiction in relation to complaints about police conduct in Victoria is complex. Put simply, the current arrangement is as follows:

- sworn police officers, misconduct and serious misconduct – Ethical Standards Division, Victoria Police or Director, Police Integrity[22]
- unsworn police employees administrative actions – Victorian Ombudsman
- *Whistleblowers Protection Act 2001* disclosures about sworn and unsworn police improper conduct – Victorian Ombudsman:
    - determines Public Interest Disclosures;
    - investigates Public Interest Disclosures;
    - refers public interest disclosures to police or the Director, Police Integrity for investigation;
    - oversees referred investigations.
- deaths caused by police – the Coroner
- complaints about the Office of Police Integrity – Victorian Ombudsman.

Because of this complexity, and in line with my 'clearing house' philosophy, my office plays an important role in providing advice to complainants concerned about police conduct. When we receive police-related complaints, we assist the complainants in identifying the correct authority to deal with their concerns.

CASE STUDY 12 – Police engagement with a driver

A mother contacted my office about her daughter's treatment by police. She stated that her daughter had been pulled over by police for driving in the right hand lane when not overtaking. Police undertook a registration check and found that the car was unregistered. The daughter was instructed by police that she was not able to drive the vehicle home and must wait for someone to pick her up. The police left her alone by the road at 10:30pm, advising her she would receive a fine.

The daughter then waited alone for some considerable time until she was collected.

The mother explained that the car was a courtesy car and she was unaware of its registration status. It subsequently transpired that the car's registration had been part-paid, but not fully paid, on the day in question. Police later claimed that they had advised the daughter to drive into a local township, a claim she denied.

I recommended that a complaint be made to the Ethical Standards Department or the Office of Police Integrity. A fine was issued for the right hand lane infringement; however the matter of the registration was not pursued by police.

While the majority of matters raising complaints about police conduct are handled by other organisations, my office nonetheless has carriage or oversight of some matters, for example those relating to administrative decisions by police and unsworn employees.

22 Parallel with this and other processes in this list is the internal police disciplinary system.

An example of an administrative decision made by police is my investigation concerning a Freedom of Information request to Victoria Police: SafeStreets Documents - Investigation into Victoria Police's handling of a Freedom of Information request, tabled in Parliament in September 2011.

Another complaint I investigated this year is as follows:

CASE STUDY 13 – Victoria Police Manual

A police officer complained about an aspect of the Victoria Police Manual Articles (the manual). His concern was that, under the manual, police with a complaint against them or who were under investigation were deemed unsuitable for transfer or promotion.

My office looked into the matter and found that:

- if an investigation into an applicant has not been finalised, then their application may proceed as normal until such time as they are cleared or found guilty
- each applicant is able to make representations to the relevant panel before a final decision is made
- the recommendation of the panel is then reviewed by a delegate, who may approve or reject the recommendation based on the provisions of the manual
- dissatisfied applicants can appeal to the Police Appeals Board
- applicants who are charged with any criminal or disciplinary offence are ineligible for promotion.

Having reviewed the matter I advised the complainant that I considered Victoria Police had sufficient mechanisms to allow eligible candidates to be promoted. I was also satisfied with the decision to exclude those who are subject to criminal or disciplinary charges from promotion.

Other examples of my jurisdiction over police matters are investigations arising out of whistleblower disclosures, discussed in greater length in Chapter 13.

As noted, I also have jurisdiction over the Office of Police Integrity. The following case illustrates the outcome of a matter my office dealt with this year.

CASE STUDY 14 – Office of Police Integrity

My office received a complaint that investigators at the Office of Police Integrity (OPI) had inappropriately contacted a witness's wife during an investigation. The complainant alleged that this conduct was undertaken in order to intimidate him in the course of giving evidence at an OPI hearing. His wife was pregnant at the time.

I raised the matter with the OPI. It acknowledged that it was inappropriate for contact to have been made with the witness's wife and that this was an error of judgment.

In light of this, I proposed to the OPI that it apologise for its actions, which it did.

10. Complaints resolved in private

Only a small proportion of the complaints dealt with by my office result in a report which I determine should be tabled in Parliament in the public interest. The ratio is approximately a thousand to one. The remaining matters are resolved in private. This is in accordance with provisions in the Ombudsman Act which provides only one means by which my investigations become known to the public – that of tabling a report in Parliament. For all other investigations, any disclosure of information obtained by my office in the course of such an investigation, other than for the purposes of the investigation, is a criminal offence.[23]

Most commonly, matters are resolved after my office has made enquiries, without recourse to using my coercive powers of investigation. These resolutions often involve suggested remedial steps to be taken by the agency involved, which satisfy the complainant. Over 99 per cent of the 15,336 thousand complaints handled this year[24] were resolved this way.

Table 4 – Top 10 categories of cases resolved privately

Top 10 complaints against agencies	Number
Departments and Authorities – complaints about service delivery	3093
Departments and Authorities – complaints about their complaint handling	2392
Correctional Services Matters – complaints about custodial services	1586
Local Government – complaints about regulation and enforcement	1316
Departments and Authorities – complaints about regulation and enforcement	1088
Departments and Authorities – complaints about correspondence/ communications/records	713
Departments and Authorities – complaints about conduct	704
Local Government – complaints about their complaint handling	692
Local Government – complaints about financial/procurement/facilities	692
Departments and Authorities – complaints about roads and traffic	512

Private resolution of matters can have a significant effect for the complainant. Below are examples of good outcomes that can be achieved in such circumstances.

23 The Ombudsman Act provides:
Section 17
(2) Every investigation under this Act shall be conducted in private.
Section 20
(1) A person (other than the complainant) who obtains or receives information in the course or as a result of the exercise of the functions of the Ombudsman under this Act-
(a) shall not disclose that information except-
(i) for the purposes of the exercise of the functions of the Ombudsman and of any report or recommendation to be made under this Act; or
(ii) for the purposes of any proceedings in relation to an offence against this Act or section 19 of the Evidence (Miscellaneous Provisions) Act 1958; or
(iii) for the purposes of any communication authorized under section 20A of this Act; and
(b) shall not take advantage of any knowledge gained from that information to benefit himself or any other person.
(2) A person who in contravention of this section discloses information or takes advantage of knowledge gained from information shall be guilty of an offence against this Act.

24 These data exclude complaints under the WPA, own motion investigations and approaches classified as information requests.

CASE STUDY 15 – CGU

In July 2011 I received a complaint about CGU Workers Compensation (CGU). Three months before, the complainant's leg had been amputated as a result of a workplace injury. CGU had agreed to pay for the surgery and pharmaceutical costs. Despite numerous requests from the complainant, CGU had not yet paid the pharmacy costs. The hospital wrote to the complainant advising that it would initiate legal action if payment of the pharmacy costs was not received immediately.

My office contacted CGU asking when the payment would be processed and advised that the complainant had been threatened with legal action. The following day, CGU responded that it had processed the payment, and undertook to notify the hospital and send the complainant a written apology for the delay.

CASE STUDY 16 – University of Melbourne

I received a complaint from a PhD candidate at the University of Melbourne (the university). The complainant had been enrolled in the School of Historical Studies and had received a fail for his PhD dissertation. The complainant stated that the two round marking process was biased as examiners in the second round had been provided with the assessment report from the first round. I considered that there was a reasonable perception that the marking process had not been impartial.

I proposed that the university arrange for the dissertation to be independently marked by new examiners who were not provided with any previous reports. This took place and the student subsequently passed his dissertation in November 2011.

CASE STUDY 17 – Ambulance Victoria

A 22 year-old migrant to Australia required urgent medical treatment, and was transported to hospital by ambulance. As he did not have a Centrelink or similar concession, he was charged a fee of $924 for the trip. His employment ceased shortly after and he requested that the fee be waived on the basis of financial difficulties. Ambulance Victoria refused to waive its fee, on the basis that he was not a concession or healthcare card holder at the relevant time. He had been granted Centrelink assistance one week after the invoice for the ambulance service was issued.

I considered that although Ambulance Victoria had acted in accordance with its policy for waiving fees, it had not exercised its discretion in the spirit of the policy to assist those in financial need. Following my enquiries Ambulance Victoria agreed to waive the fee.

CASE STUDY 18 – Civic Compliance Victoria

I received a complaint from a woman regarding a speeding infringement for $149 issued in June 2011 by Victoria Police. The car, which had been driven by her son, was registered in the name of her late husband's company. Her husband had died some months before. She informed Civic Compliance Victoria that her husband had died. As required the complainant tried to nominate her son as the driver at the time of the offence. She did this on two occasions, and had also written to Victoria Police seeking to nominate her son. All of these nominations were rejected for being incorrectly completed. As a result a second fine of $733 was issued for the company failing to nominate a driver. She then complained to this office.

While the complainant had made errors in completing the nomination forms, these forms along with her letter contained all the information necessary to nominate her son as the driver.

I made enquiries with CCV regarding this matter. CCV reviewed the case again with Victoria Police. Following my enquiries and the review both fines were withdrawn in view of the complainant's circumstances.

As a large number of complaints to my office concern local government, it follows that a large number of matters dealt with and resolved also involve local government. This trend, noted in numerous previous reports, is a consequence of the frequency with which local councils interact with the public, not (necessarily) the quality of the service provided.

Table 5 – Local Council complaints

Councils most often complained about	Most frequent complaints	Most common issues (across all complaints)
Melbourne City Council (141)	Deficient action (66) Deficient decision (59) Deficient advice (9)	Parking (58) Infringements (10) Delay (5)
Yarra City Council (139)	Deficient action (52) Deficient decision (27) Improper conduct (4)	Planning (15) Facilities owned by authority (14) Building (14)
Casey City Council (131)	Deficient action (80) Deficient decision (44) Improper conduct (3) Deficient advice (3)	Rates (19) Inadequate remedy (14) Planning (10) Facilities owned by authority (10)
Greater Geelong City Council (116)	Deficient action (74) Deficient decision (32) Deficient advice (9)	Rates (13) Planning (11) Inadequate remedy (10)
Hume City Council (113)	Deficient action (76) Deficient decision (39) Deficient advice (4)	Compensation & damage (12) Building (12) Delay (10) Animals (10)
Brimbank City Council (107)	Deficient action (72) Deficient decision (18) Deficient advice (7)	Delay (11) Planning (11) Compensation & damage (10)
Moreland City Council (99)	Deficient action (71) Deficient decision (23) Deficient advice (9)	Building (10) Inadequate remedy (8) Local laws (7) Rubbish/recycling collection (7)
Glen Eira (91)	Deficient action (62) Deficient decision (24) Deficient advice (3)	Facilities owned by authority (10) Nuisance (10) Planning (10)
Darebin City Council (89)	Deficient action (54) Deficient decision (31) Deficient advice (3) Improper conduct (3) Unfair policy (3)	Planning (15) Rates (12) Parking (8)
Mornington Peninsula Shire (82)	Deficient action (57) Deficient decision (21) Improper conduct (4)	Inadequate remedy (9) Planning (9) Delay (7)

As this data clearly demonstrates, the main complaints made about local government are that their actions, decisions or advice are deficient. Such complaints are often resolved quickly by my officers making enquiries of the council involved. The following case studies are just two of over 3,400 similar complaints involving local government resolved in private this year.

CASE STUDY 19 – Hindmarsh Council infringement notice

A complainant received an infringement and invoice from Hindmarsh Shire Council for not clearing her block to minimise fire hazard. She had previously received a notice from the council regarding the lawns. Her son had died a few days prior, and she had made an effort to attend to the lawns by hiring a private contractor. The contractor had mown the majority of the lawns (3 1/2 acres) but had been unable to complete the last half acre as a result of rain.

The complainant was issued with a fine for $317 and an invoice for $404, including an administration fee of $140, for a council contractor to finish mowing the lawn. I did not consider that these amounts were reasonable and made enquiries with the council regarding the fines and contractor fees. When the council was made aware of the son's death, it withdrew the infringement ($317) and reduced the invoice from $404 to $264 for the services of the council's contractor.

CASE STUDY 20 – Moreland Council rates

In August 2011 I received a complaint from a Moreland Council resident that rates had been levied on her property incorrectly since 1982. The council had recognised its error – in miscalculating her land value and size – however, it had refused to consider the period prior to 2007, or to refund the rates charged during that period.

I made enquiries with the council and discovered that, in 2000, when it introduced a new data system for land valuation, the land size information for the property had been converted incorrectly. Under legislation the council had discretion to make an adjustment in her favour where the rates were changed because of an error on the council's part.

Following my enquiries the council agreed to revalue the rates from 2000 based on the correct land and building areas. The complainant was reimbursed $1,021 by the council.

Prisons are another area where I receive a high number of complaints. All Victorian prisoners are able to contact my office and speak to my officers by telephone, unmonitored by the prison. This is a significant safeguard against the loss of human rights that can occur in closed environments.

The table below provides details of the 10 most common prison-related complaints handled by my office this year.

Table 6 – Prisoner complaints		
Prison	**Total**	**Most common complaint**
Port Phillip (G4S Australia)	678	Health services (156)
Metropolitan Remand Centre	332	Health services (64)
Dame Phyllis Frost	247	Health services (55)
Fulham Correctional Centre	245	Health services (54)
Marngoneet Correctional Centre	157	Health services (31)
Hopkins (Ararat Prison)	155	Health services (14)
Melbourne Assessment Prison	145	Health services (37)
Barwon Prison	124	Health services (17)
Melbourne Custody Centre	114	Health services (29)
Loddon Prison	90	Health services (16)

As in recent years, the highest number of complaints received about prisons this year related to Port Phillip Prison. The prevalence of complaints about access to health services, demonstrated in the above table, underpinned my investigation, tabled in August 2011, into prisoner access to health care.[25]

The following case studies demonstrate the results that can be achieved by my office when resolving complaints privately, in these instances concerning prisons.

CASE STUDY 21 – Prisoner access to funds

A prisoner complained that his access to his funds had been refused, in contravention of the prison's policy. He wanted to help his partner buy a washing machine. He made the funds request under a policy that allowed prisoners to access their funds in exceptional circumstances. The prison denied the request.

Following enquiries by my office the prison reconsidered its decision and released the funds to the prisoner's partner.

CASE STUDY 22 – Prisoner safety

I received a call from a distressed prisoner at Dame Phyllis Frost centre. It was her first time in prison and she was five months pregnant. She said she had been threatened by prisoners from her unit earlier that day and was concerned for her safety. She had raised her concern with prison management but her request to be moved had not been actioned. Lock-down was due at 7:30pm that night, and she was housed in an open unit. She feared she would not be safe overnight. Following urgent enquiries by my office, the prison removed her to the medical unit overnight, and relocated her to another unit the following day.

25 op cit.

CASE STUDY 23 – Prisoner clothing

My office received a complaint from a prisoner that his clothing had been misplaced during his transfer from Marngoneet Correctional Centre (Marngoneet) to Port Phillip Prison (Port Phillip) in May 2011 leaving him with only a pair of shorts. He made a claim with Marngoneet who advised my office it would assess his claim for the missing items.

The complainant contacted my office again in August advising that Marngoneet had yet to finalise its assessment and he was due for release (from Port Phillip Prison, where he was now held) shortly. His need for clothes was now pressing.

My office again contacted Marngoneet which confirmed that the claim form had been received but had been overlooked during a transition period when a new general manager was appointed. I asked that Marngoneet finalise the claim within seven days.

My office also spoke to Port Phillip Prison, which arranged for emergency clothing and other items to be provided to the prisoner prior to his release. The complainant expressed gratitude to my office for the assistance provided.

CASE STUDY 24 – Prisoner access to health care

A prisoner at the Dame Phyllis Frost Correctional Centre raised concerns with my office about not receiving adequate access to medical care. She was concerned that she was pregnant. She had developed a large bulge, resembling pregnancy, and explained that she was experiencing other pregnancy symptoms. A urine test had returned positive for pregnancy; however a blood test had returned negative. The prisoner stated that the prison medical centre refused to undertake further tests to determine if she was pregnant. She was afraid that, if not pregnant, she may be suffering from another condition, such as a tumour.

My office contacted Justice Health. As a result of these enquiries, further tests were arranged for the prisoner. These tests showed that she was not pregnant but was suffering from another condition, and in turn required further tests and treatment.

In many privately resolved cases, my officers' enquiries reveal that the agency acted in accordance with its policies and procedures, but that the procedures themselves are deficient. In these instances, I make recommendations to the agency that new policies and procedures be put in place. For example:

CASE STUDY 25 – Department of Sustainability and Environment

In September 2011 a member of a wildlife protection group complained to my office that an officer at the Department of Sustainability and Environment (DSE) had a conflict of interest between his professional role and his private interest in duck shooting and membership of a hunting organisation. The officer had also been involved in 'Operation Bolte' which had taken court proceedings against the group's members two months earlier.

While it was not my role to consider the charges, my office made enquiries in relation to the conflict of interest issue. I established that the department had rules in place to deal with conflicts of interest and the officer had acted in accordance with those rules.

However, I had concerns that the department's rules were inadequate as they did not require declarations of potential conflicts of interest to be formally documented. I raised my concerns with the department and asked that it amend its rules to address this issue. The department confirmed that it would implement my proposal as part of a planned program to review all of its business rules.

Subsequently, the game management function was moved from DSE to the Department of Primary Industries (DPI). I reviewed DPI's procedures for managing conflicts of interest and was satisfied that it had systems in place for recording and documenting conflicts of interest.

Sometimes in cases resolved in private, my enquiries reveal that the agency acted reasonably and appropriately and the complaint is not substantiated. In these cases, agencies derive satisfaction from the fact that their processes have been tested and stood up to scrutiny. Complainants may take comfort from the knowledge that the issue that concerned them has been independently assessed; in other instances they may remain dissatisfied, but are at least in the position to know their options if they wish to take the matter further.

CASE STUDY 26 – City of Melbourne, infringement notice

In October 2010, a group of protesters conducted a demonstration outside a fertility control clinic in East Melbourne. The purpose of the demonstration was to advocate for women's rights. During the demonstration the City of Melbourne (the council) issued a notice to the demonstrators to comply with a direction not to erect a 'portable advertising sign or other thing in, on or over a public place'.

The background to the complaint was that, over many years, anti-abortion advocates had also demonstrated outside the clinic. The women's rights advocates commenced their protests some five years earlier. Clearly, the site is highly contested.

The demonstrators made a complaint to my office about the notice to comply. Prior to the complaint being made, the council had withdrawn the notice, saying it had 'served its purpose in identifying the council's requirements'. However, the demonstrators considered that their right to free speech had been infringed by the issuing of the notice.

My office investigated the decision to issue the notice, and the complex background to the case. The demonstrators involved had fixed their banner to a nearby structure, and in doing so had breached the local law on which the notice was based. The council asserted that its decision was not in response to the content of the banner and no notice would have been issued had it merely been hand-held. It also said that it had been at pains to ensure that it did not impinge on the rights of people to protest reasonably, and that enforcing provisions of the local law in respect of the placement of objects, as occurred in this case, did not prevent lawful protest.

Having considered the matter I formed the view that the notice was lawful and the council had therefore acted reasonably.

CASE STUDY 27 – Environment Protection Authority, Cairnlea Estate

A complaint was made to my office about inaction by the Environmental Protection Authority (EPA) in relation to alleged soil contamination at the Cairnlea Estate (the estate), the former Albion Explosives Factory site. The complainant had been a labourer at the site in 2003 and was concerned that exposure to contaminated soil had led to his suffering ill health. Soil decontamination works had been undertaken at the estate in 1999 and samples were tested by an environmental auditor and audited by the EPA in the early 2000s.

The complainant believed that the decontamination and testing were not completed to a satisfactory standard and that parts of the estate had not been adequately remediated. He asked that my office investigate the matter.

My review of the history and relevant records identified concerns about a number of issues relating to the remediation of the site and the EPA's monitoring and auditing of the remediation. It was not my role to form a view as to whether the site had been contaminated or whether any contamination at the site had led to the health concerns experienced by the complainant. Nevertheless, I recommended that the EPA undertake re-testing of soil in the audited areas and review its policies and procedures for the monitoring and auditing of environmental auditors.

The EPA accepted my recommendations and re-tested the soil in May 2011. The results indicated that the site was 'unlikely to pose an unacceptable risk to either current or future users of the area'. The EPA also made significant changes to its approach in assessing the work and reports of environmental auditors.

CASE STUDY 28 – Footscray City Primary School, Steiner stream

I received a complaint about the Department of Education and Early Childhood Development's decision to abolish the Steiner Stream (an alternative learning curriculum) at Footscray City Primary School. The complaint concerned, amongst other things, the decision itself and a claim that the department had failed to consult adequately with parents.

My office made enquiries regarding the matter. Some material relied on by the department in making its decision was confidential and not available to the parents. However, I was able to review this material and I considered the decision was reasonable. I also concluded that the department had provided numerous avenues for parents to discuss the decision and find alternative Steiner or mainstream enrolment for their children, and that its actions in this case had been reasonable.

11. Enquiries leading to systemic change

The fact that a matter is handled as an enquiry - without my conducting a formal investigation - does not limit the scope or potential impact of the case. Complaints that are resolved privately can often result in broad systematic change in an agency. The following case studies are examples.

CASE STUDY 29 – VicForests, log export

In June 2011 I received a complaint from a Member of Parliament regarding the exporting of unprocessed whole logs by a private company contracted to VicForests. The concerns were that the company had been exporting unprocessed whole logs in violation of the contract and that VicForests was aware of the company's actions but had not enforced the contract conditions.

My office contacted VicForests. It confirmed a company (but not the company complained about) was engaging in action that breached the contract by exporting unprocessed whole logs. As a result VicForests suspended the company and issued a notice giving the company 30 days to remedy the breach.

In the course of my enquiries it became apparent that VicForests did not consider it had an obligation to actively monitor compliance with Government policy on domestic processing of logs. It argued it had a commercial function under its governing legislation and compliance monitoring was 'beyond its remit'. I did not agree. While I acknowledged that the relevant Order in Council established the commercial nature of VicForests' role, I considered it was also responsible for ensuring compliance with government policy.

Following my enquiries VicForests agreed to monitor 'at risk' customers for compliance by auditing 'high risk' customers quarterly and 'low risk' customers annually. If non-compliance is detected an investigation will be conducted by VicForests and the outcome reported to its CEO within five working days. I am satisfied that VicForests is now better informed about its broader roles and responsibilities.

CASE STUDY 30 – Department of Human Services, custody decision

In 2010, a father applied for custody of his 15 month old child and the child's six year old half-sister. Criminal record checks were conducted in Victoria and interstate. Those checks found the father had no criminal record in Victoria. But no response was obtained to the interstate request. The father was granted custody in late 2010. A complaint was made to my office about the custody decision. I made enquiries with the Department of Human Services (DHS) which confirmed that:

- it had not complied with its criminal records check procedures; and
- it had now confirmed that the father had an extensive interstate criminal record for sexual assaults and violent crimes.

As a result I made recommendations to DHS including that it ensure all relevant staff were provided with training on the practice standards for criminal records checks.

My recommendations were accepted. DHS has since made changes to its criminal records procedures which will result in better tracking of criminal history checks. It has also undertaken training for staff in all regions about criminal records checks.

CASE STUDY 31 – Municipal Councils, multiple parking infringements

Early last year, it was drawn to my attention that parking officers at the City of Melbourne had been issuing multiple infringements to vehicles for the same parking offence. For example, a car left in a parking zone for longer than the permitted period might receive several parking tickets for that one offence. The issue was whether this was permitted under the regulations.

I sought legal advice and concluded that multiple infringements had not been permitted since 1999. The council has since advised that it:

> has had procedures in place for many years to minimise the risk of multiple infringements being issued to vehicles. Although the issuing of any multiple infringement is unacceptable, it does happen from time to time due to human error, and Council is attempting to minimise occurrences.

I conducted enquiries on my own motion with the other 78 municipal councils in Victoria, and established that some, particularly larger metropolitan and regional councils, had also adopted the practice of issuing multiple parking infringements for the one offence.

I wrote to the Secretaries of the Department of Transport and Department of Planning and Community Development to request that they advise the relevant Ministers of this issue. I am of the view that this practice should cease as it has not had a legislative basis for over 10 years.

In the following cases, the outcome of the enquiry benefitted not merely the individual complainant(s), but also future clients of the agencies involved.

CASE STUDY 32 - Port Phillip Prison - Prisoner assault

A protection prisoner at Port Phillip Prison (the prison) contacted my office stating he had been assaulted by a mainstream prisoner while his methadone was being administered. He alleged that this had occurred because a prison officer had failed to lock a door that separated the two prisoners.

I made enquiries with the prison which advised it was unable to identify the officer responsible. I was dissatisfied with this advice and viewed the prison's evidence. Having done this I was able to identify the staff member involved and requested the prison investigate the matter further.

As a result of that investigation the prison told my office it had; counselled the officer involved; reminded staff of their responsibility to separate mainstream and protection prisoners; and updated its operating procedures.

CASE STUDY 33 – Geelong City Council, public holiday parking infringements

My office received information in early 2011, alleging that the Greater Geelong City Council had charged motorists a fee to park cars on public holidays, in contravention of Victorian legislation. My office made enquiries with the council and ascertained that the council had failed to configure parking meters to reject parking fees on public holidays and that $147,547 had been wrongly collected as a result.

I made recommendations designed to resolve the matter, without the need to have recourse to a formal investigation and report. These recommendations included:

- an annual review of the electronic programming of all parking machines take place to ensure that the relevant public holidays for each year are entered
- a regular and formal audit system for monies collected by council parking machines be incorporated
- signage and publications be reviewed to improve information to the public about the rules in relation to parking on public holidays
- that legal advice be obtained regarding whether the council is legally entitled to retain monies, including the sum of $147,547, collected by the parking meters on public holidays and, if not, to determine what should done with the money collected.

The council accepted my recommendations and confirmed that a business plan had been created to monitor compliance with the rules. The council also undertook to offer a day of free parking in lieu of giving motorists refunds for previously incurred costs.

However, in April 2012, the Geelong Advertiser[26] reported that Anzac Day had again seen parking meters in Geelong accepting fees, with no signage indicating that parking was free that day.

I raised concerns with the council that this issue had apparently recurred. The council advised me that human error was the cause this time, rather than a systems fault. It undertook to reimburse parking fees charged that day, and to allocate any fees not reimbursed to a range of Central Geelong revitalisation activities. I accepted the explanation and considered the proposed actions reasonable in the circumstances.

However, there are instances when a resolution agreed to by an agency is not implemented by it. In such circumstances I may decide to commence a formal investigation.

26 *Geelong Advertiser*, 'Parking meter holiday rip off again', 26 April 2012, Peter Begg.

12. Resolution following investigation

I can conduct formal investigations under two pieces of legislation, the *Ombudsman Act 1973* and the *Whistleblowers Protection Act 2001* (the WPA). This chapter will focus on investigations conducted under the Ombudsman Act. The following chapter will detail my investigations under the WPA.

Under section 14 of the Ombudsman Act, I can conduct a formal investigation either in response to a complaint made to my office or on my own motion. I must report the outcome of such investigations to the complainant (if any), the head of the agency involved and the responsible Minister or Mayor. Such outcomes often include recommendations to alter the original decision in some way; to set in place processes and procedures that will guard against the likelihood of a repetition of the error in question; or to make some restitution to the complainant.

This year, I conducted 13 investigations using my statutory powers, of which nine were reported to Parliament (along with three whistleblower investigations). The remaining four investigations were finalised in accordance with the legislation, in reports provided to the relevant individuals and agencies.

Enquiries into complaints conducted under section 13 of the Ombudsman Act are usually resolved informally. However, where appropriate, I may decide to make a formal report to the agency involved, containing my recommendations for action or, often, systemic change.

The following case study is an example of an investigation into a complaint conducted this year under the Ombudsman Act.

CASE STUDY 34 – Department of Human Services, care decision

A foster carer who held concerns for the welfare of two children in her care contacted my office. The children had been removed from their mother at a young age when they were found to have had significant and unexplained injuries. The Department of Human Services now proposed to return them to their mother.

On investigating the matter, my officers learned that a number of professionals involved with the family, including paediatricians, had expressed concerns regarding the department's decision.

I requested that the department immediately review its handling of the matter After some initial reluctance, it agreed to do so, and subsequently acknowledged that there were 'significant shortfalls related to the management of this case, particularly in relation to the lack of departmental engagement, action and support'. The department also acknowledged that it had not undertaken an appropriate assessment prior to deciding to return the children to their mother.

The department then changed its decision. Rather than working towards reunification in the immediate future, it proposed assessing the viability of reunification over a six month period before making any further decision.

I was particularly concerned about the decision made in this case given the significant injuries sustained by the children prior to departmental involvement. Despite the number of reports into child protection completed by my office, including several tabled in Parliament over the last three years, I continue to receive complaints which highlight shortcomings in the decisions and assessments made by the Department of Human Services.

This case is an example of a department continuing to repeat poor conduct and failures that I have previously identified in a number of parliamentary and annual reports. Those reports identified poor leadership, lack of courage and failure to perform statutory duties as the core underlying problems that lead to bad outcomes in the delivery of services by the State.

However, I am encouraged that the government and the Department of Human Services have taken action in response to some of the critical issues I have identified. For example:

- The Minister for Community Services, Mental Health and Women's Affairs has taken significant steps to improve child protection. Those steps include increasing numbers of frontline workers and residential care places, and trialling reform of the Children's Court.
- The Department of Human Services has undertaken significant change and improvement at the Parkville Youth Justice Precinct, with more planned, following my investigation into the precinct. This is discussed further in Chapter 1.
- The Deputy Premier has committed an extra $8.8 million to address the concerns I reported about the Sex Offenders Register and assist police in their management of the register and individuals listed on it.

My own motion powers add flexibility to the operations of my office. They permit me to conduct investigations into systemic issues within an agency or across the public sector in general, even if there has been no specific complaint made to my office. The following investigation was conducted this year using my own motion powers.

CASE STUDY 35 – Governors Hearings

In late 2010 I commenced an own motion investigation into the manner in which Governors Hearings were conducted at Victorian prisons. Governors Hearings are internal disciplinary hearings for prisoners who are charged with breaching prison rules. If found guilty prisoners can face sanctions such as fines, loss of privileges and restrictions on visits.

My investigation revealed that these hearings were conducted in a manner that did not guarantee prisoners a fair hearing. Prisoners were not made aware of their rights to support and to representation. I also considered that Corrections Victoria was not providing adequate training to its staff to ensure they were competent to hear charges against prisoners. As a result I concluded that Governors Hearings were not being conducted by prisons in accordance with their responsibilities under the *Charter of Human Rights and Responsibilities Act 2006*.

I made 11 recommendations to Corrections Victoria regarding Governors Hearings, of which 10 were accepted.

In formal investigations, as in other matters, it may be the case that part of the original complaint is substantiated, and part is not. Not every aspect of a complaint is always made out. Such is the experience of all complaint handling authorities. Victorians – both private individuals and the public sector - are therefore well served by an independent scheme such as mine which is not aimed at identifying winners and losers but rather resolving complaints and identifying scope for improvement.

13. Whistleblower investigations

By their nature, my investigations into whistleblower disclosures often deal with issues of such importance that I determine that a report of the investigation should be tabled in Parliament in the public interest.

One example this year was my I*nvestigation into an allegation about Victoria Police crime statistics*.[27] In that instance, my jurisdiction over a complaint relating to police arose under the *Whistleblowers Protection Act 2001*. In that investigation I found that police crime statistics released on 28 October 2010, just before the state election, were based on selective, incomplete and yet-to-be validated data. The then Chief Commissioner of Police made the decision to release the data, which I considered to be misleading and likely to be used in a political context.

However, as with investigations conducted under the Ombudsman Act, many investigations carried out by my office under the *Whistleblowers Protection Act 2001* (WPA), or by other investigatory authorities under referral from me, do not result in reports to Parliament. I have conducted several such investigations this year. Two of these cases are as follows:

CASE STUDY 36 – City of Melbourne, alleged corruption

In April last year, I received allegations that a council officer at the City of Melbourne had engaged in improper conduct. The allegations included that the council officer had accepted the use of a yacht from a customer of Docklands Waterfront Marina, which is administered by the City of Melbourne. His use of the yacht continued for four months, without declaration of it as a gift, or approval by the council.

Prior to bringing this matter to me, the complainant disclosed these allegations to the council officer's manager, and to a councillor at the City of Melbourne. An internal investigation was conducted. This investigation identified that the council officer's actions could reasonably have been perceived as amounting to corruption.

Melbourne City Council failed to appropriately manage this information. The result of its investigation meant that the council needed to assess whether the allegation amounted to a disclosure under the WPA, and then report the matter to my office. It did not do this.

The council subsequently admitted its mistake, and accepted my proposals to appoint a new protected disclosure coordinator, ensure the new appointee attend a workshop with my staff on the Whistleblowers Protection Act, and to update its whistleblower procedures.

The council officer whose conduct was complained about was subject to disciplinary action.

27 op cit.

CASE STUDY 37 – Department of Justice, improper relationship with a prisoner

A whistleblower made a disclosure to me about an improper relationship between an employee of the Department of Justice and a prisoner. During the relationship, the employee had given the prisoner private information about fellow prisoners by accessing their files.

My investigation identified that:-

- the staff member had a criminal record prior to her employment with the department, and this was known to the department. The rationale for its deciding to employ her in spite of this was not recorded on the file.
- induction for new staff at the department failed to address some key confidentiality and conflict issues. In particular, it did not address whether any new staff had relationships with prisoners.
- staff employed at a low level in the department were allowed high level access to confidential information, and their use of that information was inadequately monitored.

I recommended that these and other matters of concern be remedied. The department accepted and addressed my recommendations.

The range of matters disclosed to me under the WPA cannot be reduced to simple groups or classes of complaint. The table below sets out key data about the 117 whistleblower investigations conducted this year.

Table 7 – Whistleblowers Protection Act disclosures 2011-12, Key data	
Source	
Whistleblower	93
Public Body	17
Director, Police Integrity	4
Chief Commissioner of Police	3
TOTAL	**117**
How dealt with	
Investigated: by the Ombudsman	24
referred to public body for Investigation	8
referred to Director Police Integrity	3
referred to Chief Commissioner of Police for investigation	3
Not Public Interest Disclosure, not investigated	26
Not Protected Disclosure	53
TOTAL	**117**

One strength of the WPA is that it allows for any issue to be disclosed to me, and provides a framework within which I assess whether the allegation amounts to a public interest disclosure. The measure that must be satisfied is that the alleged conduct must fall within one of the very generally phrased categories of corrupt or improper conduct and must, if proven, amount to a criminal offence or grounds for dismissal. As a result, a wide variety of matters have been disclosed to me and determined to be public interest disclosures this year, as in earlier years.

The following case study demonstrates the advantage of a broadly defined jurisdiction that allowed me to investigate a serious matter that may have fallen outside a more restrictive definition of corruption.

CASE STUDY 38 – Alleged sexual assault of a prisoner

In August 2011 I received an anonymous whistleblower disclosure alleging that a young prisoner had been sexually assaulted at a prison. The whistleblower alleged that up to six prisoners were in a cell when one of them was attacked and raped with an object. The whistleblower stated that the prison had not followed its processes for responding to such incidents and expressed concern that other prisoners were at risk.

My investigation revealed that:

- the young prisoner had been identified by the prison as vulnerable to attack
- a number of the other prisoners involved had been identified by prison officers as disruptive in the days leading up to the incident, but no formal steps had been taken to manage their behaviour
- the incident occurred in a cell that should have been monitored by prison officers but was not
- prison staff contacted the police after the incident but coordination was poor. The crime scene was not preserved and a nurse at the prison examined the victim; however the prisoner did not receive a forensic medical examination by a qualified professional
- the suspected offenders were allowed to mix with each other and other witnesses for several hours before they were separated or questioned, providing an opportunity for collusion
- the victim was returned to the unit where the incident took place before police spoke to him
- police did not speak to the victim until 20 days after the attack
- witness accounts and prison intelligence were not recorded by prison officers or provided to Victoria Police; a hearsay report of an admission by one of the suspected offenders was not reported to police
- the prison did not take any disciplinary action against the suspected offenders, one of whom has since been released into the community.

I concluded that the prison failed in its duty to manage the risk of harm posed by the disruptive prisoners and, after the incident, failed to comply with its duties to the victim and the justice process.

I made a number of recommendations to the Department of Justice, including that it ensure there is a clear chain of command so officers are aware of who is in charge of managing the prison's response to incidents. I also recommended the department establish a protocol with Victoria Police regarding the referral and investigation of criminal offences, including sexual offences, so that there is coordination between the prison and police.

The department accepted my findings and recommendations, and Victoria Police also broadly supported my recommendations relevant to its operations. A Memorandum or Understanding between Victoria Police and Corrections Victoria was signed on 9 March 2012 and includes a specific protocol on reporting and investigation of criminal offences.

Procurement

Procurement continues to be a matter of concern for my office and is regularly the subject of whistleblower investigations. Each year since 2007 I have tabled reports in Parliament relating to improper procurement processes in the public sector. The themes are recurring. They include procurement processes that are:

- undertaken contrary to public sector guidelines
- inadequately planned and reviewed resulting in a significant waste of public money
- lacking in sufficient supervision by senior public officials
- conducted in a manner that is not open or transparent
- compromised by the corrupt behaviour of public officers.

Despite my raising these matters in numerous parliamentary reports, and my repeated warnings and recommendations regarding the issue, procurement continues to be central to whistleblower investigations conducted by my office. While many of these investigations have not been made public, they reveal that procurement practices continue to be poor. The following two case studies are examples of this:

CASE STUDY 39 - City of Port Phillip

A whistleblower disclosure was made to my office regarding a procurement process at the City Of Port Phillip. I investigated the matter and found that an officer in the council's IT area had intentionally and repeatedly subverted the procurement process to benefit one particular contractor. This had included: asking this contractor to write the tender specification document; lying to other bidding contractors to hide this fact; and reviewing the contractor's quotation during a moratorium period to suggest improvements. Unsurprisingly, the contractor assisted by the manager was awarded the contract.

The value of the contract was in excess of $600,000, well above the manager's spending delegation. The manager was subject to minimal formal oversight during this significant transaction. Due to the actions of the manager, the council signed a contract which it cannot be certain represented value for money and which was the result of a process that lacked transparency.

The officer involved resigned after being interviewed during my investigation and the council has changed procurement processes following my report.

Procurement for IT projects especially is a significant and growing risk area for public agencies owing to the amount of money involved and the specialist knowledge required. It is incumbent upon public officers to adhere to the policies set out by the Victorian Government Purchasing Board when purchasing IT products and services. However, the next case study demonstrates that even these fundamental principles of government procurement are at times ignored.

CASE STUDY 40 - Metropolitan Fire and Emergency Services Board

This year, I conducted a whistleblower investigation regarding a manager at the Metropolitan Fire and Emergency Services Board (the MFESB). During the investigation I found that the manager had, over several years: not declared gifts or hospitality received from contractors who had significant contracts with the MFESB; failed to declare a conflict of interest in engaging the services of an IT contractor; used his position to influence the allocation of surplus ICT equipment to particular community groups; and failed to adhere to procurement policies that resulted in one IT project management company being paid more than $3.6 million, without any public tender or a comparative quotation process.

I made eight recommendations to improve the procurement and contractual arrangements for the acquisition of IT at the MFESB, and to minimise opportunities for fraud and better manage conflicts of interest. All my recommendations were accepted and have been implemented by the MFESB. The manager involved is no longer employed by MFESB.

Whistleblowers are often employees or contractors of public bodies, and are well placed to blow the whistle on serious misconduct they have observed. All whistleblowers who make protected disclosures are entitled to protection: their identity must not be revealed. This adds an additional level of privacy to whistleblower investigations over and above the confidentiality that applies to all Ombudsman investigations.[28]

Referred investigations

Under the WPA I am able to refer whistleblower disclosures back to an agency for investigation. I do so when I consider it is appropriate for the agency to conduct the investigation itself, or when I do not have the resources to conduct it.

I commented in my 2011 Annual Report that I was not confident in some agencies' ability to conduct these referred investigations adequately. I continue to see poorly conducted investigations by agencies. The problems are the result of:

- some protected disclosure coordinators and senior management lacking the required knowledge
- failure to use my office as a source of information and guidance
- failure to support and protect whistleblowers to ensure their welfare
- insufficient visibility of and training about whistleblower policies and procedures, especially during referred investigations - I frequently find that basic whistleblower information, such as the contact details of the protected disclosure coordinator or how a person can go about making a disclosure, is not provided on agency websites.

I am currently amending my '*Whistleblowers Protection Act 2001* Ombudsman's Guidelines' in order to assist agencies to address some of these problems. However, I continue to observe in some agencies a lack of the necessary organisational commitment to the management of whistleblower disclosures and investigations. Therefore, in some instances, I recommend that an agency engage the services of an independent investigator to conduct a referred whistleblower investigation.

28 Ombudsman Act section 20 and Whistleblowers Protection Act section 22.

Unfortunately, even this measure does not always ensure that an investigation is satisfactory. The following cases are examples of this.

CASE STUDY 41 – VicRoads, investigation of whistleblower complaint

In 2010, I referred a whistleblower disclosure to VicRoads for investigation. Its subsequent handling of the investigation was poor, with the matter becoming mired in delay.

The whistleblower disclosure alleged improper conduct by VicRoads staff, including improper procurement and favouritism. After I determined that it was a public interest disclosure under the WPA, I referred it to VicRoads for investigation on 3 November 2010. I recommended that VicRoads engage an independent investigator. In December, VicRoads advised me that it intended to engage a particular firm to conduct the investigation. However, that process took five months to complete. On 6 May 2011 VicRoads finally engaged the firm. However, the task VicRoads requested it to conduct was forensic and limited in scope. VicRoads has since argued that it had to identify the most suitable data to analyse, for cost effectiveness. VicRoads conducted the majority of the required investigation itself, which took a further six months. The final report of the investigation was completed over 12 months after my initial referral.

I advised the Chief Executive that in my opinion the delay in this matter was unreasonable. I consider that members of the executive management team with responsibility for whistleblower matters should have more direct involvement during investigations.

This principle is reflected on pages six and seven of my '*Whistleblowers Protection Act 2001* Ombudsman's Guidelines'.

Delay is not the only problem I observe in referred whistleblower investigations, as the following case study demonstrates:

CASE STUDY 42 – Swinburne University, investigation of whistleblower complaint

A whistleblower made a disclosure to me about Swinburne University, alleging that a supervisor had directed a teacher to pass all of their students to ensure the university received upcoming federal government funding. After determining that this was a public interest disclosure under the WPA, I referred it back to the university for investigation, with a recommendation that it engage an independent investigator.

The university conducted the investigation with the assistance of an independent investigator and concluded that the allegation was unable to be substantiated. However, I was concerned about a number of issues relating to the investigation and the final report as follows:

- the investigation took four months to complete for what was a single-issue straight forward allegation
- the report lacked detail in all areas; for example the 'findings' were brief and only two pages
- the report did not describe the methodology used during the investigation

- additional witnesses were identified during the investigation, but the report did not disclose whether they were interviewed, or what evidence they might have given
- the conclusions did not contain any analysis of the facts and findings of the investigation; specifically, there was no discussion of evidence that appeared to support the allegation
- there was no indication of whether the whistleblower was given an opportunity to respond to the findings of the report
- the report ignored the federal funding issue mentioned in the allegation, as it was dismissed by the investigator at the outset
- the report did not make any recommendations.

My officers met with the Vice-Chancellor to discuss my concerns about the inadequacy of the investigation. At my request, the report was revised to take my concerns into account. However, even the revision was inadequate, addressing only four of the concerns I had raised.

I determined to finalise the matter in any case, as I considered that the outstanding issues were unlikely to significantly affect the outcome of the investigation, especially at such a late stage.

I have, however, been encouraged this year that some agencies have conducted thorough and appropriate investigations into whistleblower disclosures. For example:

CASE STUDY 43 - Hobsons Bay Council, investigation of whistleblower complaint

A whistleblower made a disclosure comprising nine separate allegations against two staff members at the council, including:

- misuse of a council credit card
- theft of furniture and fundraising money
- misuse of council resources for personal gain.

I determined that it was a public interest disclosure under the WPA, and referred the investigation to the council to conduct, with a recommendation that it engage an independent investigator.

The council responded promptly, engaging an investigator the same day that it received my advice. The investigation was completed within six months, a reasonable timeframe given nine allegations were involved and more than 20 interviews were conducted. During the investigation, the protected disclosure coordinator took a number of proactive measures to ensure both the whistleblower and the subjects were supported and protected, and unprompted, kept my office updated on the progress of the investigation on a fortnightly basis.

The investigation report was almost 60 pages long, attached summaries of all the interviews and evidence collected, and incorporated a thorough analysis of the findings of each allegation. It concluded that one of the staff members misused a council credit card by signing for services on another officer's credit card, and used the login of another staff member to perform online banking. The remaining seven allegations were not substantiated due to either a lack of evidence or lack of council policies.

The council added two recommendations of its own accord, in addition to the investigator's recommendations. In total, the council approved 14 recommendations, which included a disciplinary investigation, and improvements of policies and procedures of the affected program area.

In addition, the investigator identified a separate issue during the investigation, which the council acknowledged, initiating a separate review.

I consider this investigation was handled well by the council. It showed a commitment to the intentions of the WPA, whilst also showing initiative to improving its practices.

14. Protecting rights

For many years, the work of my office – inquiring into or investigating administrative actions – has incorporated human rights as an important criterion against which those actions should be assessed. For example, section 23 of the Ombudsman Act requires me to make a report and recommendations in relation to administrative actions that I conclude, upon investigation, were wrong. I have long considered that a breach of human rights is such a 'wrong'. Since 2006, section 13 (1A) of the Ombudsman Act has provided me with specific jurisdiction to enquire into or investigate whether any administrative action is incompatible with a human right set out in the *Charter of Human Rights and Responsibilities Act 2006* (the Charter).

Consideration of human rights played a role in a number of my recent investigations resulting in parliamentary reports.

These reports include:

- *Investigation into the failure of agencies to manage registered sex officers,* February 2011

  This investigation dealt with a perceived conflict between the right to privacy (section 13 of the Charter) and children's human rights (section 17 of the Charter). The investigation demonstrates the difficult task of identifying and prioritising human rights when there is a perception that they are in conflict. In this report I concluded that:

  > The failure of Victoria Police, the Department of Human Services and Corrections Victoria to work together effectively in relation to the Sex Offenders Register to advance the protection of vulnerable children is incompatible with the obligations of all Victorian public sector agencies under the *Charter of Human Rights and Responsibilities Act 2006*. For example, section 17 provides that 'every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child'.

  In relation to balancing of rights, I concluded that:

  > The practice of seeking the permission of the registered sex offender before the release of information on cases where children may have been at risk demonstrates that Corrections Victoria has opted to place the rights of registered sex offenders over the rights of vulnerable children that may be at risk of harm.
  >
  > ...
  >
  > I consider it unacceptable that the safety and protection of children was caught up in bureaucratic procedures that prolonged the process of providing critical information.

  This report describes two pilot programs: the Sexual Offence Child Investigation Team pilot project in Frankston and Mildura, and the Nexus pilot program at Frankston.[29] These programs are two examples of establishing operational frameworks that involve coordination between agencies, allowing for the balancing of conflicting human rights, whilst protecting children from abuse. As noted in my report, I first called for agency coordination along these lines in March 2006 in my report *Improving responses to allegations involving sexual assault*.[30]

29 At page 32.

30 Victorian Ombudsman, *Improving responses to allegations involving sexual assault*, March 2006.

My conclusions in my February 2011 report included the following:

> I would have expected Victoria Police, the Department of Human Services and Corrections Victoria to have worked together more effectively in relation to the Sex Offenders Register to advance the protection of vulnerable children. The failure to do so is incompatible with the obligations of all Victorian public sector agencies under the *Charter of Human Rights and Responsibilities Act 2006*.

- *Investigation into the Assault of a Disability Services Client by Department of Human Services Staff*, March 2011

  This investigation dealt with the human rights of some of Victoria's most vulnerable citizens – people living in disability residential services.

  One key consideration in this report was an individual's right to protection from cruel, inhuman or degrading treatment, set out in section 20 of the Charter. The residential client involved in this investigation (who could not speak) was subject to cruel and degrading treatment: he was severely assaulted; not given medical treatment for over 24 hours after the assault; and complaints about the incident made on his behalf were inadequately investigated and managed by the Department of Human Services and its staff. I concluded that this was a breach of his human rights.

  I recommended that the Department of Human Services reinforce with all staff and day placement Community Service Organisations their obligations under the Charter. The Department undertook to implement this recommendation.

- *Investigation into prisoner access to health care*, August 2011

  This investigation identified that there are a number of impediments to prisoner access to health care in Victorian prisons, including:

  - The failure to provide condoms to male prisoners despite the prevalence of communicable diseases and the risks of these diseases being spread when prisoners are released. Corrections Victoria failed to accept my 2006 recommendation about condoms until my 2011 investigation was underway.
  - The number of Opioid Substitution Therapy Program places at some prisons is inadequate.
  - Insufficient resources to transfer prisoners to medical appointments frequently results in specialist appointments being cancelled or deferred.
  - The level of mental health services available for the male prison population is insufficient.
  - Doctors do not have enough time to conduct appropriate assessments on prisoners.
  - Segregated prisoners, prisoners in high security management areas and prisoners with limited English or literacy often rely on prison staff to complete and submit medical request forms on their behalf. This process may risk a prisoner's medical confidentiality.

This investigation was framed within both the Charter (section 22, establishing a right of humane treatment when deprived of liberty) and my own previous investigations and recommendations.[31] In total, I made 24 recommendations for the improvement of prisoners' access to health care, which were accepted by the Health Services Commissioner; Justice Health; and Corrections Victoria.

- *Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region)*, October 2011

  This report was the fourth in a series of investigations by my office concerning child protection.[32] The failure by government bodies to protect children in their best interests and as needed by them breaches the rights created under the Charter.

  I identified:

  - failures to protect children at risk
  - the pursuit of numerical targets overshadowing the interests of children
  - a practice of providing the minimum possible response to child protection reports that could be justified.

  I concluded that the failure to investigate numerous reports was a result of an intentional policy decision by the Bendigo office of the Loddon Mallee Region of the department to reduce the number of child protection reports that it investigates. I also identified evidence of the misrepresentation of data regarding the number of children allocated to child protection workers.

  I referred the circumstances of 59 children identified during my investigation to the department for reconsideration as I considered their safety could not be assured. The department reopened the cases of 50 children which had been closed and took action to address my concerns in relation to the other nine.

Assessing complaints against human rights

All complaints made to my office are considered against the rights set out in the Charter. They are recorded on our complaints management system. Where possible breaches of the Charter are identified, whether by the complainant or my officers, they are recorded and investigated. Where they are found to have occurred, they are addressed in any one of a range of ways provided for under the Ombudsman Act.

In the period 1 July 2011 – 30 June 2012, my office dealt with 102 complaints about matters within my jurisdiction, in which human rights contained in the Charter were identified as issues.

31 See, for example, Victorian Ombudsman, *Conditions for persons in custody*, July 2006.

32 Victorian Ombudsman:
Investigation into the Department of Human Services Child Protection Program, November 2009;
Own motion investigation into Child Protection – out of home care, May 2010;
Investigation into the failure of agencies to manage registered sex offenders, February 2011;
Investigation regarding the Department of Human Services Child Protection Program (Loddon Mallee Region), October 2010.

The most common human right identified in complaints received by my office was the right to humane treatment when deprived of liberty. Recognition and equality before the law, privacy and reputation and the protection of families and children were also identified in a number of cases.

CASE STUDY 44 – Melbourne Assessment Prison, treatment of prisoner

I received a complaint from an inmate at the Melbourne Assessment Prison that prison officers had assaulted him by dragging him out of the Acute Assessment Unit. The CCTV footage showed that the prisoner had been forcibly removed from the unit by four officers, and was later escorted naked between two units. I was concerned that the actions by the prison had been in breach of its obligations under the Charter.

My officers interviewed the prisoner and relevant staff. Following these enquiries I wrote to the then Commissioner Corrections Victoria asking that he respond to this issue. He advised he had reviewed the matter and as a result would be reminding all prison General Managers to preserve prisoners' dignity as required under the Charter.

My office also regularly engages with people with disabilities. Many people with disabilities continue to struggle to live their lives and access services on equal footing with others.

CASE STUDY 45 – TAC, delayed decision about car modifications and wheelchair

A complainant contacted my office about a considerable delay by the Transport Accident Commission (TAC) in deciding if it would pay for modifications to his wheelchair and a wheelchair accessible vehicle. He said that these issues had been ongoing for several years. When my officer spoke to the TAC, it acknowledged the delay and apologised for not responding to him earlier.

It contacted the complainant immediately to address his concerns and a written response was subsequently provided by the TAC. The wheelchair modifications have occurred and the TAC have agreed to the new vehicle pending an agreement on the level of the complainant's contribution.

CASE STUDY 46 – Department of Human Services, over-night staff

The Office of the Public Advocate contacted me with concerns about a resident of a unit managed by the Department of Human Services.

The resident suffered from a severe form of epilepsy and experienced frequent nocturnal seizures and incontinence. As these seizures were silent they often went unnoticed at night. The resident was in a home where one staff member slept at night but there was no active monitoring of clients. This resulted in a loss of comfort and dignity for the resident.

The department had previously offered the resident a place in a unit that had active over-night staff. However, his family had declined the offer, as they felt that he had formed bonds with the other residents in the unit and it was his home.

My staff made enquiries with the department and conducted a site visit at the unit. Following these enquiries the department decided to convert the unit to an active night support home. The conversion was subsequently completed and the residents were monitored every hour throughout the night. This addressed the concerns identified by the Public Advocate.

15. Freedom of Information

Freedom of Information is a significant feature in the democratic and political processes in this State. Freedom of Information requests are a mechanism open to all citizens. Until this year, I have had jurisdiction in relation to some aspects of Freedom of Information decisions. With the creation of the Freedom of Information Commissioner, my jurisdiction will be transferred to that office once it is established.

This year I received an unusually high number of complaints concerning Freedom of Information (FOI) requests. The majority were from Members of Parliament, seeking departmental documents relating to government decisions.

The most frequent complaint this year was delay - 44 per cent of complaints handled. High numbers of FOI requests (matters that were brought to my attention) had not been responded to within the 45 day statutory time limit. In some of these instances, I considered that the delay was not unreasonable, resulting from a combination of a higher than usual number of requests and a lack of staff to complete them in a timely fashion. However, in other instances, the delays were unsatisfactory. I have written letters to the Secretaries of the Departments of Human Services, Justice, Premier and Cabinet, Health and Primary Industries critical of failures to deal with these requests in a timely manner.

Another common complaint was that the documents requested were not released because the agency claimed they were exempt. My officers informed these complainants that the appropriate avenue for challenging this decision was before the Victorian Civil and Administrative Tribunal (VCAT).

While reviewing the merits of an FOI decision has not been in my jurisdiction, other aspects of those administrative decisions have been. Many such examples occurred this year, including:

CASE STUDY 47 – Southern Health, mishandling a request

The Health Services Commissioner referred a complaint to me about the processing of a Freedom of Information (FOI) request by Southern Health. Southern Health had rejected a request for a patient's medical records. I identified that Southern Health's written response to the applicant (the patient's daughter) did not comply with the requirements of the *Freedom of Information Act 1982* as it:

- did not cite the relevant exemptions relied upon to reject the request
- failed to identify the authorised officer who made the decision
- did not provide the applicant with information regarding her entitlement to seek a review.

I recommended that Southern Health re-process the applicant's FOI request, apologise to the applicant for mishandling the request, and ensure that all staff involved in the handling of FOI requests are made aware of their obligations under legislation. Southern Health accepted my recommendations and documents were released when the application was reprocessed.

CASE STUDY 48 – Victoria Police

I received a complaint that Victoria Police had failed to respond to an FOI request within the required 45 days. The request was for documents relating to an aggravated burglary to use at a Victims of Crime Tribunal hearing. After waiting eight months for a decision the complainant contacted my office seeking assistance. She had been advised four months after she lodged her request that Victoria Police had received a large number of FOI applications and this was the reason for the delay.

I made enquiries with Victoria Police regarding the delay. Within three weeks of my enquiries the complainant received a decision, an apology for the delay and had her application fee waived.

Applicants for documents under the FOI Act are often journalists, who can also experience delay or other difficulties with the process.

CASE STUDY 49 - Department of Transport, altering the scope of a request

I received a complaint from a journalist about an FOI request made to the Department of Transport for documents detailing compensation payments between 2006 and 2010. The department telephoned the journalist to clarify his request. During this conversation the journalist believed that the scope of his request had been altered and the documents not released. When he complained about this to the department he was offered an internal review which he accepted. The internal review upheld the original decision and the journalist was told that he would need to lodge a new request or seek a review at VCAT.

My office made enquiries with the department and established that there had been a misunderstanding about the documents being sought.

As a result of my enquiries, the department agreed to re-contact the complainant to clarify his request. It agreed to re-process the original request, with no further steps required to be undertaken by the journalist. The department then provided the journalist with a summary document identifying compensation payments with personal information redacted.

CASE STUDY 50 – Department of Premier and Cabinet

A journalist applied to the Department of Premier and Cabinet for access to documents known as the “blue” and “red” books, prepared by departments for incoming governments at election time. The department spoke to the journalist to clarify his request, during which discussion he identified that he required the blue book only.

After nine months the request was denied. The grounds cited were that:

- the documents were deemed to have been prepared to brief the Premier on issues to be considered by Cabinet
- the documents contained high level advice, opinion and recommendation, the release of which would be contrary to the public interest
- the documents contained information which, if released, could prejudice relations between the State of Victoria and the Commonwealth or another State.

The journalist complained to my office about the decision and the delay. I advised the journalist that, as regards the claim of exemption, he should apply to VCAT. However I made enquiries regarding the delay with the department as I had observed a growing trend of departmental delay in responding to FOI requests. Following my enquiries I informed the Auditor-General about this observation for the purposes of the FOI review he was then conducting.

FOI is an important mechanism for citizens seeking information when they consider they have been dealt with unfairly by government as the following case study illustrates.

CASE STUDY 51 – Office of Public Prosecutions, handling of a request

The complainant had sought documents from the Office of Public Prosecutions (the OPP) relating to the trial of her father for murdering her mother. The trial had taken place some decades earlier. Her father was convicted, served his sentence, and subsequently deported. The complainant, having effectively lost both parents as a result of these events, had reached a stage where she wished to explore the material obtained during the trial.

Her FOI application to the OPP was not processed under the FOI Act. Instead, the OPP processed it outside the Act. Section 16 of the Act allows for the release of documents outside the provisions of the Act. While the OPP subsequently claimed that 'the decision to process the application outside of the FOI Act was a decision made jointly between our FOI officer and [the complainant]' the complainant rejects that version of events.

The applicant's request was interpreted narrowly (this is not permissible under the Act without first consulting with the applicant), and she was offered access to the trial transcript only, subject to the payment of a fee. Processing the application outside the Act meant that the applicant had no right of review of the OPP's decision.

By coincidence, the Police contacted the applicant around this time, asking her if she wished to take possession of some exhibits from the trial, including gold rings and a passport. By this means, the applicant became aware that there was a prospect that the OPP held other material in which she had an interest. However, she could not assert her right of access to this material, nor seek a review of the OPP's decision.

The applicant complained to my office. In response to our enquiry the OPP stated that it relied on section 16 to explain why she had been provided with reduced access to material. In my view, the OPP was wrong in its analysis, as the clear purpose of the section is to expand the possibility of making material available.

The OPP responded to my preliminary conclusions advising that it did not accept them, suggesting that its response was supported by internal legal opinion. Nonetheless, it agreed to implement my recommendations. It dealt with the application under the FOI Act, provided her with access to the trial transcript and invited her to reclarify her request for access to any other documents.

By processing the request under the FOI Act, the complainant now has the ability to have the decision reviewed. This matter is yet to be finally resolved, with the most recent action being the OPP providing an apology to the complainant, and the complainant yet to pursue her request further.

CASE STUDY 52 – Department of Transport, Port of Hastings documents

In early 2012 I received a complaint from a community group about a request that had been rejected by the Department of Transport. The documents were referred to on the department's website and concerned the Port of Hastings expansion and environmental studies that had been undertaken in its planning.

Despite the reference to these documents on its website the department stated in its decision that 'there are no documents which are relevant to your request'. The decision was also well outside the 45 day time period set under legislation.

I investigated the matter and identified that in handling the application a departmental officer had located documents which she determined should be released. However, following discussions with various parties including staff from the Minister's office, it was decided that the documents fell outside the scope of the request on the grounds that they were developed by the previous government.

I wrote to the Secretary expressing concern that the department's claim that there were 'no documents which are relevant to your request' was misleading considering relevant documents had been found but not released after the department had a briefing with the Minister's office. I also raised my concerns about the department's failure to meet the 45 day target.

I have previously raised concerns about briefings to Ministers' offices in my 2006 report, *Review of the Freedom of Information Act*.[33] I noted instances where ministerial officers had suggested changes to the proposed decisions, even though a brief was only provided to the Minister for noting and comment if desired. I highlighted in my report that I considered this was 'not consistent with the purpose of the noting process and could lend support to the allegation … that the decision-making process is open to manipulation'.

In order to resolve these matters, I proposed that the department:

- reconsider the FOI request within a reasonable timeframe, noting my concerns
- refund any FOI charges paid in relation to this request
- provide reasons for the delay in responding to the FOI request within the statutory timeframe and details of any measures taken to ensure this does not occur in the future.

The Secretary accepted my proposals and DoT subsequently refunded the charges and released some of the documents sought.

It is disappointing that, increasingly, FOI is not complied with by departments and agencies in the spirit of the Attorney-General's guidelines.[34] Departments and agencies seem increasingly to have forgotten that the Freedom of Information Act was intended to be a means of increasing the openness and transparency of government, not a means to justify delay and non-release of information based on technical, tedious and tenuous interpretations of the Act.

This trend may explain the increase in complaints to my office. Many of the matters brought to me involve agencies relying on an excuse not to release a document. However, I have not been able to look into the merits of the decision.

33 Victorian Ombudsman, *Review of the Freedom of Information Act*, June 2006.

34 *Freedom of Information Act 1982, Attorney-General Guidelines on the responsibilities and obligations of officers and agencies*, December 2009.

As I have said in previous reports, the Ombudsman Act vested my office with a limited jurisdiction in relation to FOI matters. It empowers me to look into the administrative aspects of FOI decisions (or failures to reach decisions) within government departments and other bodies within my jurisdiction. However, the substantive merit of such decisions is, for the most part, not within my ambit. Merit is a matter that must be contested before VCAT.

With the creation of the new Freedom of Information Commissioner under the *Freedom of Information Amendment (Freedom of Information Commissioner) Act 2011*, FOI will no longer be within my jurisdiction. The new Act replaces the internal reviews conducted within agencies with external reviews conducted by the Commissioner. This change to the administration of FOI should promote more open, prompt and accurate FOI decision making in agencies. There are, however, limitations in the new framework which may reduce the effectiveness of the changes introduced by the new Act. Those limitations, which include the exclusion of documents claimed to be cabinet documents from the external review process, and the exclusion of Ministerial offices from that process, may need to be reviewed by the government in coming years in order to ensure that the improvements that the new regime could achieve can actually be attained.

16. Implementation of recommendations

There is a risk that, once the immediate publicity around my reports fades, so will the priority given by government agencies to addressing the problems the reports identify.

Section 25(2) of the *Ombudsman Act 1973* allows me to report to Parliament at any time on any matter arising in connection with the performance of my functions. I may also report to Parliament where I consider that appropriate steps have not been taken within a reasonable time in response to a previous report or recommendation. Section 103 of the *Whistleblowers Protection Act 2001* also allows me to report to the Parliament on any matter arising in relation to a public interest disclosure.

That is why in 2010 I began reporting publicly on the implementation of my recommendations. I have tabled two reports on the issue, one in February 2010 and another in October 2010.

I have examined the progress made by government agencies in implementing recommendations I made in a further ten reports:

- *Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre*, December 2009
- *Investigation into the disclosure of information by a councillor of the City of Casey*, March 2010
- *Report on an investigation into Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat*, April 2010
- *Investigation into the probity of the Kew Residential Services and St Kilda Triangle developments*, June 2010
- *Investigation into an allegation of improper conduct within RMIT's School of Engineering (TAFE) – Aerospace*, July 2010
- *Investigation into conditions at the Melbourne Youth Justice Precinct*, October 2010
- *Investigation into the issuing of infringement notices to public transport users and related matters*, December 2010
- *Investigation into allegations of improper conduct by a councillor at the Hume City Council*, February 2011
- *Investigation into the probity of The Hotel Windsor redevelopment*, February 2011
- *The Brotherhood – Risks associated with secretive organisations*, March 2011.

The 10 reports include a total of 145 recommendations. Relevant agencies accepted 131 of the 145 recommendations (90 per cent), either at the time the reports were tabled or subsequently. More recent enquiries made with the agencies identified that they have completed implementation of 108 of the 131 accepted recommendations (82 per cent). In the remaining cases, they are in the process of implementing the outstanding recommendations.

Further information about the recommendations I made in each of the ten reports is set out in Table 8.

In light of this positive response, I have decided not to report separately to the Parliament about the implementation of my recommendations this year. There are three significant matters, however that I wish to draw to the Parliament's attention.

Investigation into the handling of drug exhibits at the Victorian Police Forensic Services Centre – December 2009

There are significant recommendations from my report on the handling of drug exhibits at the Victoria Police Forensic Services Centre that remain unimplemented, even though two and a half years have passed since the report was tabled. The recommendations relate to arrangements for tracking drug exhibits; destroying exhibits when they are no longer required; and random workplace drug testing for staff handling illicit drugs. Victoria Police advises that implementation has been delayed by problems with a new information technology system, consideration of legislative changes by the Government and negotiations with the relevant union. I urge the Government and Victoria Police to give priority to these issues.

Investigation into an allegation about Victoria Police crime statistics – June 2011

I am awaiting the Government's response to my June 2011 report, Investigation into an allegation about Victoria Police crime statistics. Victoria Police expressed support for my recommendation for an independent body to manage, collate and disseminate crime statistics at the time the report was tabled. I had previously recommended the establishment of an independent body for this purpose in 2009.

The Department of Justice recently advised that it has prepared options for an Independent Crime Statistics Agency for the Government's consideration. It has been three years since I first raised the need for such a body. I consider that the establishment of this body is now long overdue.

Child protection reports

Finally, I have asked the Secretary of the Department of Human Services to provide a detailed briefing to me at the end of 2012 regarding progress with the recommendations I made in four reports about Victoria's child protection system.[35] These reports identified significant failures in the child protection system including inadequate resources, poor reporting and major workforce issues, particularly in relation to recruitment and training of child protection workers.

35 Victorian Ombudsman:
Investigation into the Department of Human Services Child Protection Program, November 2009;
Own motion investigation into Child Protection – out of home care, May 2010;
Investigation into the failure of agencies to manage registered sex offenders, February 2011;
Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region), October 2011.

In February 2012, the Protecting Victoria's Vulnerable Children Inquiry, headed by former Supreme Court judge Phillip Cummins, published a significant report on Victoria's approach and performance in relation to protecting vulnerable children and young people. A number of the Inquiry's recommendations cover the same ground as my reports. The Government has now committed to a number of reforms which will take time and resources to implement. I will continue to monitor this important area.

Table 8 – Implementation of recommendations

Report	Total	Accepted	Complete	In progress
Handling of drug exhibits at the Victoria Police Forensic Services Centre	47	47	43	4
Disclosure of information by a councillor of the City of Casey	3	3	3	0
Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat	3	2	1	1
Probity of the Kew Residential Services and St Kilda Triangle developments	18	14	8	6
Allegation of improper conduct within RMIT's School of Engineering (TAFE) – Aerospace	13	13	4	9
Conditions at the Melbourne Youth Justice Precinct	27	27	27	0
Issuing of infringement notices to public transport users	14	12	11	1
Allegations of improper conduct by a councillor at the Hume City Council	1	1	1	0
Probity of The Hotel Windsor redevelopment	17	11	9	2
The Brotherhood – Risks associated with secretive organisations	2	1	1	0

Ombudsman's Reports 2004-12

2012

Whistleblowers Protection Act 2001 Investigation into allegations of detrimental action involving Victoria Police
June 2012

Own motion investigation into Greyhound Racing Victoria
June 2012

The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria
April 2012

Whistleblowers Protection Act 2001 Conflict of interest, poor governance and bullying at the City of Glen Eira Council
March 2012

Investigation into the storage and management of ward records by the Department of Human Services
March 2012

2011

Investigation into the Foodbowl Modernisation Project and related matters
November 2011

Investigation into ICT-enabled projects
November 2011

Investigation into how universities deal with international students
October 2011

Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region)
October 2011

Investigation into the Office of Police Integrity's handling of a complaint
October 2011

SafeStreets Documents - Investigations into Victoria Police's Handling of Freedom of Information request
September 2011

Investigation into prisoner access to health care
August 2011

Investigation into an allegation about Victoria Police crime statistics
June 2011

Corrupt conduct by public officers in procurement
June 2011

Investigation into record keeping failures by WorkSafe agents
May 2011

Whistleblowers Protection Act 2001 Investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee
May 2011

Ombudsman investigation – Assault of a Disability Services client by Department of Human Services staff
March 2011

The Brotherhood – Risks associated with secretive organisations
March 2011

Ombudsman investigation into the probity of The Hotel Windsor redevelopment
February 2011

Whistleblowers Protection Act 2001 Investigation into the failure of agencies to manage registered sex offenders
February 2011

Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a councillor at the Hume City Council
February 2011

2010

Investigation into the issuing of infringement notices to public transport users and related matters
December 2010

Ombudsman's recommendations second report on their implementation
October 2010

Whistleblowers Protection Act 2001 Investigation into conditions at the Melbourne Youth Justice Precinct
October 2010

Whistleblowers Protection Act 2001 Investigation into an allegation of improper conduct within RMIT's School of Engineering (TAFE) – Aerospace
July 2010

Ombudsman investigation into the probity of the Kew Residential Services and St Kilda Triangle developments
June 2010

Own motion investigation into Child Protection – out of home care
May 2010

Report of an investigation into Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat
April 2010

Whistleblowers Protection Act 2001 Investigation into the disclosure of information by a councillor of the City of Casey
March 2010

Ombudsman's recommendations – Report on their implementation
February 2010

2009

Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre
December 2009

Own motion investigation into the Department of Human Services – Child Protection Program
November 2009

Own motion investigation into the tendering and contracting of information and technology services within Victoria Police
November 2009

Brookland Greens Estate – Investigation into methane gas leaks
October 2009

A report of investigations into the City of Port Phillip
August 2009

An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing
July 2009

Whistleblowers Protection Act 2001 Conflict of interest and abuse of power by a building inspector at Brimbank City Council
June 2009

Whistleblowers Protection Act 2001 Investigation into the alleged improper conduct of councillors at Brimbank City Council
May 2009

Investigation into corporate governance at Moorabool Shire Council
April 2009

Crime statistics and police numbers
March 2009

2008

Whistleblowers Protection Act 2001 Report of an investigation into issues at Bayside Health
October 2008

Probity controls in public hospitals for the procurement of non-clinical goods and services
August 2008

Investigation into contraband entering a prison and related issues
June 2008

Conflict of interest in local government
March 2008

Conflict of interest in the public sector
March 2008

2007

Investigation into VicRoads' driver licensing arrangements
December 2007

Investigation into the disclosure of electronic communications addressed to the Member for Evelyn and related matters
November 2007

Investigation into the use of excessive force at the Melbourne Custody Centre
November 2007

Investigation into the Office of Housing's tender process for the cleaning and gardening maintenance contract – CNG 2007
October 2007

Investigation into a disclosure about WorkSafe's and Victoria Police's handling of a bullying and harassment complaint
April 2007

Own motion investigation into the policies and procedures of the planning department at the City of Greater Geelong
February 2007

2006

Conditions for persons in custody
July 2006

Review of the *Freedom of Information Act 1982*
June 2006

Investigation into parking infringement notices issued by Melbourne City Council
April 2006

Improving responses to allegations involving sexual assault
March 2006

2005

Investigation into the handling, storage and transfer of prisoner property in Victorian prisons
December 2005

Whistleblowers Protection Act 2001 Ombudsman's guidelines
October 2005

Own motion investigation into VicRoads registration practices
June 2005

Complaint handling guide for the Victorian Public Sector 2005
May 2005

Review of the *Freedom of Information Act 1982* Discussion paper
May 2005

Review of complaint handling in Victorian universities
May 2005

Investigation into the conduct of council officers in the administration of the Shire of Melton
March 2005

Discussion paper on improving responses to sexual abuse allegations
February 2005

2004

Essendon Rental Housing Co-operative (ERHC)
December 2004

Complaint about the Medical Practitioners Board of Victoria
December 2004

Ceja task force drug related corruption – second interim report of Ombudsman Victoria
June 2004