

Ombudsman Investigation Assault of a Disability Services Client by Department of Human Services Staff

March 2011

Ordered to be printed
Victorian government printer
Session 2010 - II
P.P. No. 16

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament the report of an investigation into the assault of a disability services client by Department of Human Services staff.



G E Brouwer
OMBUDSMAN

2 March 2011

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Executive Summary

Care of People with Disabilities in Victoria

1. The Department of Human Services (the department) is responsible for the administration of disability residential services in Victoria. At the time of my investigation, the department was responsible for 551 residences and 2,641 residents who largely rely on the department and its staff for their day-to-day living requirements. Community Residential Units (CRU) usually house four to six people and are staffed by carers employed by the department to care for residents.
2. The *Disability Act 2006* (the Disability Act) was enacted to promote and protect the rights of people with disabilities and to make disability service providers accountable to the persons accessing their services. It outlines a number of principles to be applied when caring for those with disabilities, including that residents have the same rights as other members of the community to exercise control over their own lives and to live free from abuse, neglect or exploitation.

The Complaint

3. I received a complaint from the Public Advocate, Ms Colleen Pearce on behalf of a CRU client (the resident) who is 39 years old, non-verbal, and suffers from an intellectual disability, epilepsy and spasticity. As he is non-verbal the resident uses gestures and body language to indicate when he is happy, sad, hot or cold. He is unable to advocate for himself, his parents are deceased and at the time of the incident he did not have regular contact with his family.
4. Ms Pearce complained that the department had inadequately responded to an incident where the resident was 'dragged' along the floor of a CRU in Clayton (the unit) by two staff members causing a serious injury which required medical treatment.
5. I decided to conduct an investigation under section 14(1) of the *Ombudsman Act 1973* into the complaint. On 2 September 2010 the Acting Ombudsman advised the former Minister for Community Services and the Secretary, Department of Human Services that I intended to conduct the investigation.
6. This report deals with:
 - the incident in which injury was inflicted on the resident
 - the department's inadequate response to the incident
 - false and misleading evidence provided to my office
 - the misleading information provided to Community Visitors¹ concerned about the treatment given to the resident, and

¹ Independent volunteers who advocate for people with disabilities.

- fabrication of documents by a senior departmental officer.

The Incident

7. My investigation established that on 6 March 2008, two departmental staff members, Ms Patricia Perera and Ms Sylvia Illesca, dragged the resident along a carpeted hallway in the unit, causing him to sustain a serious carpet burn to his back. He was dragged in an effort to force him out of the unit and onto a bus which was to take him to his scheduled day placement.
8. An incident report completed by Ms Perera in relation to the resident's injury did not disclose that she and Ms Illesca dragged him along the carpet. Instead, her report refers to him 'crawling from upper back to wards [sic] kitchen' to imply that his injury was self-inflicted.

Two departmental staff members dragged the resident along a carpeted hallway in the unit, causing him to sustain a serious carpet burn to his back.

9. After being dragged along the floor, Ms Perera took the resident to his day placement² without taking him to receive medical treatment. Ms Perera showed the resident's injury to day placement staff and advised them that she had dragged him along the unit floor.
10. The resident did not receive medical treatment for his injury for over 24 hours after he was injured.
11. As a result of being dragged down the hallway the resident suffered a second degree carpet burn to the upper middle of his back which required ongoing medical treatment. He has a scar from the incident.

After being dragged along the floor, Ms Perera took the resident to his day placement without taking him to receive medical treatment.

The Department's Response to the Incident

12. My investigation established that within four days of the incident a number of incident reports had been received by management within the department and a staff member at the unit had contacted departmental management to express concern about the resident's injury.
13. In response to the incident, the department conducted an 'informal information gathering process' and did not take any disciplinary action in relation to the resident's carers. At interview, the Acting Area Manager who was employed at the time of the 'information gathering process' (officer A)

² A non-government organisation funded by the department to provide day programs for people with an intellectual disability.

informed my officers that the department did not conduct a 'preliminary assessment' to determine if an investigation was required because of concerns involving the department's employee union. She also advised that when she left her role (in May 2008) the department 'had established that he [the resident] was dragged'.

In May 2008 the department had established that the resident was dragged.

14. My investigation concluded that Ms Monica White, then Acting Disability Accommodation Services (DAS) Manager, had the responsibility to respond appropriately to the incident. At interview, Ms White informed my officers that she could not remember details of what had happened at relevant times. After receiving my draft report, she provided additional information not volunteered at interview, including that she instructed officer A to conduct a preliminary assessment.
15. The department's response to the incident was inadequate and shows a disregard for the resident's human rights and the duty of care that the department has a responsibility to exercise. It was also non-compliant with departmental policies and procedures. This is particularly concerning as the resident cannot speak for himself.

The department's response to the incident was inadequate and shows a disregard for the resident's human rights and its duty of care. This is particularly concerning as the resident cannot speak for himself.

16. I consider that the assault on the resident was clearly a category one incident, requiring the police and family of the victim to be notified. However, as it was incorrectly classified, the department failed to notify the Regional Director, police and family and commence an investigation. A number of departmental staff viewed this report without rectifying this error. Every manager interviewed told my investigators that the matter should have been classified as a category one incident and was unable to provide a reason at interview why it was not initially categorised correctly or changed on review.

Misinformation Provided to the Community Visitors

17. Community Visitors are independent volunteers who visit CRUs to report on the quality and standard of care provided to CRU residents. They play a vital role in the provision of disability care within Victoria including advocating for those who cannot speak for themselves.

18. Section 130(3)(b) of the Disability Act states that a member of staff or management of a residential service must give full and true answers (to the best of that person's knowledge) to any questions asked by a Community Visitor.
19. My investigation highlighted that a casual unit staff member told a Community Visitor that the resident's incident was self-inflicted. This was disclosed to Ms White in correspondence from the Community Visitor in 2008 and was not investigated by the department.

Ms White failed on several occasions to provide timely and truthful responses to concerns raised by the Community Visitor.

20. My investigation also found that Ms White failed on several occasions to provide timely and truthful responses to concerns raised by the Community Visitor about the resident's injury. Specifically she:
 - failed to disclose that the department was aware staff had dragged the resident, causing his injury
 - sought to emphasise 'non compliant' behaviours displayed by the resident, implying the injury was self-inflicted
 - stated that the department had investigated the matter when it had not
 - said that she would investigate the false information provided to the Community Visitors by the casual unit staff member when she did not.

Fabrication of Documentation

21. The department provided my office with a preliminary assessment report which was signed by Ms Monica White and supported by a record of telephone discussion purportedly between officer A and Ms Illesca. The preliminary assessment itself included summaries of interviews purportedly undertaken by officer A to determine if further investigation was warranted; it recommended that no further action be taken.
22. Officer A denies undertaking this preliminary assessment and it is dated as being prepared by her before she commenced in the relevant position at the department. In addition, her first name is spelt incorrectly throughout the report and she and the interviewees deny that the interview or telephone discussion occurred.
23. The available evidence leads me to conclude that Ms White fabricated the preliminary assessment report. She admitted signing and backdating the report and while it is one thing to make an error in record keeping, it is far worse to falsify records.

Recommendations

24. As a result of my investigation, I have recommended that the department:
- consider taking disciplinary action against the staff involved in the assault on the resident and the managers who failed to ensure the incident was appropriately responded to
 - reinforce with all staff and community service organisations their obligations under the *Charter of Human Rights and Responsibilities Act 2001* and the department's incident reporting procedures and investigation guidelines
 - review the current incident reporting forms to ensure they are clear
 - consider implementing a web-based reporting system for incident reporting to provide a more efficient and immediate reporting process
 - reinforce with staff the importance of the role Community Visitors play in the disability system and that staff are required to assist them.
 - consider taking disciplinary action in relation to the failure of the casual unit staff member and Ms White to provide truthful answers to the Community Visitors as required by section 130(3)(b) of the Disability Act
 - review the suitability of Ms White's employment in light of the conclusions in this report.
25. The department has advised that it supports all of my recommendations.

Background

The Complaint

26. I received a complaint from the Public Advocate, Ms Colleen Pearce on behalf of a CRU resident who is 39 years old; non-verbal; and suffers from an intellectual disability, epilepsy and spasticity (the resident).
27. Ms Pearce complained that the department had inadequately responded to an incident where the resident suffered a 'serious physical assault' by two departmental staff members. Ms Pearce said that on 6 March 2008 the resident was 'dragged' by two staff members along the floor of his unit, causing an injury which required medical treatment.
28. Ms Pearce complained that the department had failed to:
 - conduct an adequate and timely investigation of the incident
 - appropriately reprimand staff involved in the assault
 - categorise the incident correctly and follow departmental notification requirements
 - ensure accurate and timely provision of information to a Community Visitor.
29. On 6 September 2010 the Acting Ombudsman notified the Secretary of the department and the then Minister for Community Services of my intention to investigate the department's response to the alleged assault on the resident.
30. While investigating this matter a number of further issues were brought to my attention. Consequently, my investigation also examined whether:
 - the department adequately responded to the incident
 - departmental documentation was fabricated to give the appearance that the department had adequately responded to the incident
 - departmental staff provided false or misleading information to a Community Visitor and under oath to my officers.

Disability Care Within Victoria

31. The Disability Act was enacted to promote and protect the rights of persons accessing disability services and to make disability service providers accountable to their residents.³
32. The Disability Act outlines a number of principles to be applied in the care of people with disabilities. It says that people with disabilities have the same right as other members of the community to exercise control over their own lives and to live free from abuse, neglect or exploitation. It states that disability services should:

³ Disability Act 2006 sections (4)(d) and (f).

- be flexible and responsive to individual needs
- maximise the choice and independence of people
- be provided in a manner that respects the dignity of those accessing the service.

Human Rights

33. The Charter of *Human Rights and Responsibilities Act 2006* (Charter) outlines minimum standards of human rights enjoyed by members of the Victorian community. The Charter outlines 20 civil and political rights including the right to life, to be free from forced work and the right to protection from torture and cruel, inhuman or degrading treatment.⁴ The Charter requires public authorities to act in a way that is compatible with the rights outlined in the Charter.

The Department of Human Services

34. The Department of Human Services (the department) is responsible for the administration of disability residential services in Victoria. Community Residential Units (CRU) are residential units staffed by carers employed by the department to care for residents and usually house four to six people.
35. The department has a duty of care⁵ to ensure that it takes reasonable steps to minimise harm to anyone in a CRU and that staff act on and report any issue of concern, including any incidents that may cause harm to others.

Community Visitors

36. Community Visitors are independent volunteers who visit CRUs and report on the quality and standard of care provided to residents. They play a vital role in the provision of disability care within Victoria including advocating for those who cannot speak for themselves.
37. Community Visitors are appointed by the Governor in Council on the recommendation of the Public Advocate⁶ and can visit any residential service provided by the department (either with or without notice) at any time they consider appropriate. They are statutorily empowered to inspect any part of a CRU premises, see any resident, make enquiries relating to the provision of services to residents and inspect any document relating to a resident which is not a medical record.⁷
38. Community Visitors regularly visit each residential unit in Victoria and can report any concerns they have, either to the Public Advocate or directly to the department. One function of the Community Visitors is to inquire into any case of suspected abuse or neglect of a resident.⁸

4 Charter of Human Rights and Responsibilities Act 2006 sections 9, 10 and 11.

5 Residential Services Practice Manual, Second edition 2009, Department of Human Services.

6 Disability Act 2006 section 28(1).

7 Disability Act 2006 section 130(3)(b).

8 Disability Act 2006 section 30(e).

The Investigation

39. To investigate this matter, my officers:
- interviewed departmental staff
 - examined departmental files
 - conducted site visits at the unit
 - interviewed a private medical practitioner
 - reviewed the resident's departmental files
 - interviewed Community Visitors.
40. In the course of this investigation, 18 witnesses were interviewed under oath or affirmation. Every witness attended at interview on a voluntary basis. One person requested and obtained legal representation, another requested and obtained the presence of a support person. A number of witnesses were given the opportunity to comment on the evidence and my preliminary conclusions. The responses of those who chose to comment are fairly set forth in this report.

The Resident

41. The resident is 39 years old. He first entered the department's care in Kew Residential Services on 24 November 1980 and was moved to the Clayton CRU unit on 31 May 2005.
42. The resident suffers from an intellectual disability, epilepsy and spasticity. As he is non-verbal, he uses gestures and body language to indicate when he is happy, sad, hot or cold. The resident is unable to advocate for himself, his parents are deceased and at the time of the incident he did not have regular contact with his family.

The Assault

43. On 6 March 2008 the resident was at home in the unit under the care of Ms Patricia Perera, a permanent departmental staff member and Ms Sylvia Illesca, a casual staff member.
44. At interview on 1 October 2010, Ms Illesca said that the resident was scheduled to attend his day placement on 6 March 2008, however indicated to Ms Perera and herself that he did not wish to leave the unit. She said that he did this by yelling, sitting on the floor and refusing to get ready. Ms Illesca described the resident as 'very upset' on the day of the incident and said that she followed Ms Perera's instruction to get his radio in an attempt to entice him to attend placement.

45. Ms Illesca said that when he ‘refused to cooperate,’ Ms Perera asked Ms Illesca to help her carry the resident down the hallway of the unit to the front door where a bus was waiting to take him to placement. Ms Illesca said:

There was a moment when I said to Patricia [Perera], ‘Patricia, don’t try. Your back is very important. Leave him. I am not – I am not with you because I have to look after myself. My person is more important than him. If I want to work – continue working I am not doing that.’

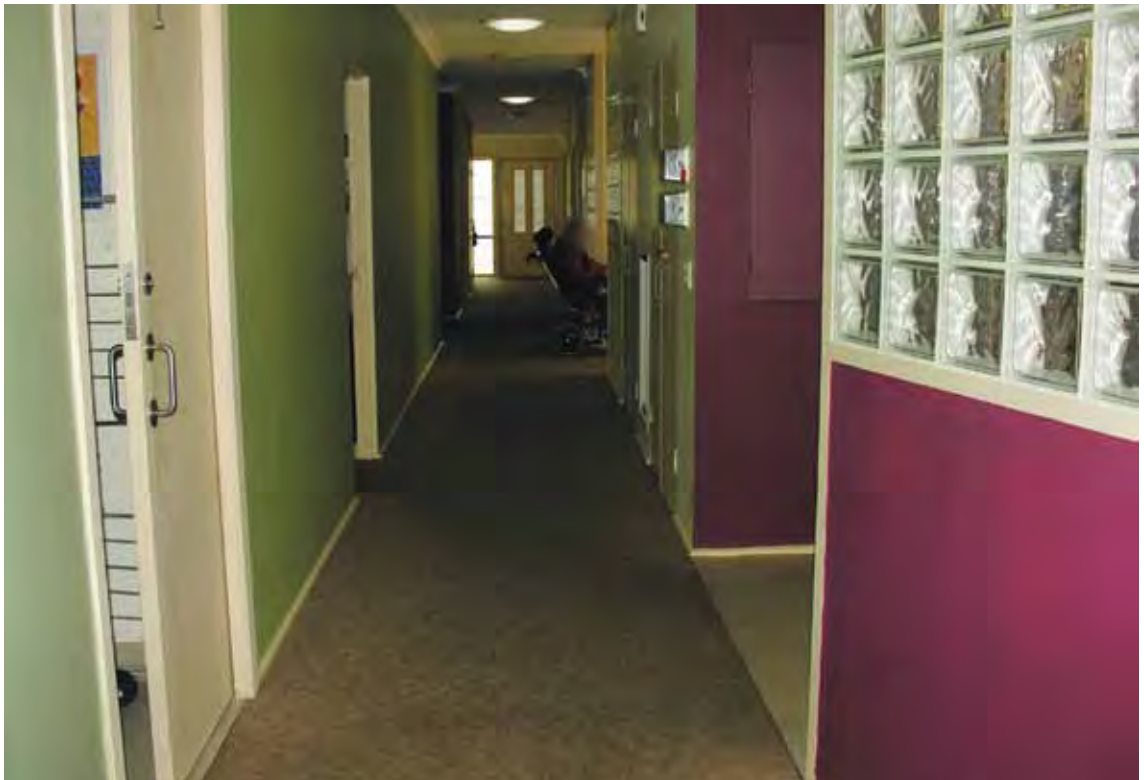
46. In response to my draft report, Ms Illesca said:

... what I said to Mrs Perera [as quoted above] was because I was concerned not to injure my back by lifting the resident rather than lack of concern for him. I wish to note that English is my second language and certain statements said by me may not be clear.

47. At interview, Ms Illesca told my officers that although she had concerns for her physical safety she agreed to follow Ms Perera’s instruction in carrying the resident out of the house.

First we tried to help – help bring him walking. He refused ... And there was a moment there when we carry him to the door.

48. Ms Illesca said that while the resident was being carried by her and Ms Perera ‘he was on the ground’. When my officers asked if he was dragged along the floor she said ‘yes’, and told them he was dragged for approximately half the length of the unit’s hallway. The following is a photograph of the unit’s 16.8 metre carpeted corridor.



Photograph I. The hallway along which the resident was dragged.

49. As a result of being dragged down the hallway the resident suffered a second degree carpet burn to the upper middle of his back which required ongoing medical treatment. He has a scar from the incident.
50. Ms Illesca told my officers that when she, Ms Perera and the resident got outside the unit she noticed that the resident's back was 'a little bit red' and drew this to Ms Perera's attention. She said that Ms Perera looked 'in shock a little bit' and then drove the resident to the day placement. Ms Illesca did not complete an incident report in relation to this incident.
51. In response to my draft report, Ms Illesca said:
- Normally an Incident Report could be completed by the permanent staff member if there is a permanent staff member working at the time. I expected Ms Perera as the permanent staff [member] to complete an Incident Report, and as a casual staff member this is why I did not complete one.
52. Ms Perera completed an incident report, dated 7 March 2008, which states:
- Staff informed [the resident] it was time to go to placement (another staff member was already on the bus). [The resident] then began shouting, hitting his thigh and pacing quickly... [The resident] then dropped to the ground crawling from upper back to wards [sic] kitchen ... Sylvia and myself attempted to lift [the resident] from the armpit but failed ... When we went to the front door he stand [sic] up, [and] got into the bus.
53. At interview, Ms Perera said that she could not recall the incident or whether she was working on the day it occurred. When my officers showed her the incident report she confirmed it was her document and said:
- ... [The resident] get redness in him [from] ... when we take him from the ground ... we pull, we take him from the armpit and after that he stand up and he go to the bus.
54. Ms Perera told my officers that the resident's 'back was on the ground' for about two metres while he was being pulled by her and Ms Illesca. Her incident report does not include this information but notes that he 'dropped to ground crawling from upper back to wards [sic] kitchen.' Ms Perera said that after the incident the resident was taken to his placement but that she could not recall who took him there.
55. My officers obtained an incident report which was created in response to the resident's injury by the day placement Manager, it states:
- Patricia [Perera] explained to [the day placement carer] that [the resident] had an injury on his back – then showing [sic] [the day placement carer] the large red raw carpet burn on [the resident's] back. Patricia stated that [the resident] would not get up from the floor and staff had to drag him.
56. The day placement manager's report says that, after she was informed of the injury by the day placement carer, she telephoned the unit and spoke to Ms Perera who advised her that she (Ms Perera) and Ms Illesca had used dettol cream to cover the resident's wound. At interview, the day placement manager said that she told Ms Perera the day placement had to remove the resident's

shirt because the wound was 'weeping and sticking to his shirt'. Her incident report confirms this and also notes that when she said this to Ms Perera, Ms Perera responded by saying 'that's ok'.

57. Staff at the day placement did not take the resident to receive medical treatment. At interview, the day placement manager said in hindsight she should have taken him for medical treatment. Specifically, she said:

I thought I was keeping him at day placement and ensuring that he was supervised, um ... look, I could have made the call to get medical advice. But I didn't - obviously.

Untimely Provision of Medical Treatment

58. The following photograph was taken of the resident's injury approximately one week after the incident. It was taken by a permanent unit carer who was not rostered to work on the day of the incident. Ms Illesca viewed this photograph at interview and said that the photograph looked 'better' than the resident's back looked immediately after the incident.



Photograph 2. The resident's injury, one week after he was dragged.

59. Ms Illesca said that in her view, the resident's injury required medical treatment. She was not able to explain why she did not seek medical treatment for the resident.

60. At interview on 4 October 2010 Ms Perera said that she did not seek medical treatment for the resident because she did not know he was injured until he returned home from placement that evening. Her incident report states that 'on return from the day placement staff noted a redness to [the resident's] back'.
61. The resident did not receive medical treatment until approximately midday on 7 March 2008, over 24 hours after the incident. He was taken for medical treatment by the permanent unit carer. At interview on 6 September 2010, the permanent unit carer said that when he began work on 7 March 2008 Ms Perera told him that the resident had a 'little mark' on his back. He said that when he looked at the injury he:
- went pale and said, 'has he seen a doctor?' She [Ms Perera] said 'no' and I said, 'well he needs to go to a doctor'.
62. The permanent unit carer said that he took the resident to the doctor and when they arrived, the resident's shirt had stuck to his wound and the wound and material had to be separated with water.
63. At interview, the doctor who treated the resident on 7 March 2008 said that the resident had a 'partial thickness⁹ burn to his back' which required ongoing medical treatment for dressings and observation. He said that the wound later became infected.

Conclusions

The Assault and Provision of Medical Treatment

64. My investigation established that on 6 March 2008 the resident was dragged by two departmental staff members, Ms Patricia Perera and Ms Sylvia Illesca, along a carpeted hallway in the unit, causing him to sustain a second degree burn to his back.
65. It is clear from the photographs provided to my office and the doctor's evidence that the resident was seriously injured. He did not receive medical treatment until over 24 hours after the incident, despite a number of departmental staff and contractors being aware of his injury.
66. Departmental staff members and disability service providers have a duty of care to ensure that the resident receives medical assistance for any injuries he suffers. The day placement staff acknowledged to my officers that they failed to uphold this duty for the resident. At interview, the day placement manager said that she 'should have gotten them [the unit staff] to pick him up immediately [from the day placement]' and the day placement carer said that, in hindsight, 'a doctor should have been rung on our part'.

⁹ A partial thickness burn is a second degree burn.

67. Ms Perera gave evidence to my officers under affirmation that she did not know the resident was injured until he returned to the unit at the end of the day. This evidence is inconsistent with:
- Ms Illesca's evidence that she showed the resident's injury to Ms Perera outside the unit prior to him leaving for day placement
 - the day placement's incident report which states that Ms Perera showed the resident's injury to a day placement staff member on arrival at the day placement
 - the day placement manager's evidence that she telephoned Ms Perera during the day on 6 March 2008 to discuss the injury.
68. At interview Ms Perera first told my officers she did not know if she was working on the day the resident was injured. She said that she could not remember much about the incident, however remembered some relatively specific details (including the distance the resident's back was in contact with the floor). I consider that her answers to my officers' questions were vague and evasive. I have concerns that Ms Perera provided false and misleading information to my investigators while being interviewed under oath.
69. Ms Perera's incident report does not disclose that she and Ms Illesca dragged the resident down the hallway of the unit and that this caused his injury. Instead, the report states that the resident crawled from his upper back towards the kitchen, implying the injury was self-inflicted. I consider that her incident report to the department was misleading.
70. During my investigation, both Ms Perera and Ms Illesca admitted that they had forced the resident along the floor of the unit and that this had injured him. Departmental guidelines define assault as 'any non-accidental form of injury caused by the direct (or indirect) application of force'. I am satisfied that Ms Perera and Ms Illesca assaulted the resident. I also consider that the injury to the resident may amount to a criminal assault.
71. I am satisfied that the assault on the resident warrants the department instigating disciplinary action against Ms Perera and Ms Illesca. I note that both staff are still employed by the department to care for people with disabilities.
72. I also note that Ms Perera still works directly with the resident. This is particularly concerning as Ms Perera was recently investigated in relation to further allegations that she:
- physically assaulted the resident on 26 July 2010 causing him to suffer carpet burn
 - verbally abused the resident on 9 August 2010.
73. The department's investigation report regarding these incidents states that the allegation of physical assault was unable to be substantiated; however the allegation of verbal abuse was substantiated.

Breach of Human Rights

74. The actions of Ms Perera and Ms Illesca in physically forcing the resident to attend day placement constituted a clear failure to treat him with dignity and respect. The treatment of the resident was also humiliating and caused him to suffer a serious physical injury. As such, I consider Ms Perera and Ms Illesca have breached his human right to protection against cruel, inhuman or degrading treatment.

Inadequate Action Taken by the Department

75. My investigation established that at the time of the incident and subsequently the department failed to:
- investigate the incident
 - correctly categorise the incident
 - notify relevant parties
 - take appropriate action against the staff members responsible for the resident's injury.

Staff Within the Community Residential Unit

76. At interview, the permanent unit carer said that on 7 March 2008, after taking the resident for medical treatment, he telephoned a departmental team manager to report his concern about the cause of the injury and he then filed an incident report.
77. The unit's house supervisor was on leave on the day of the incident. She said that when she returned to work on the 8 March 2008 Ms Perera initially denied to her that she had caused the resident's injury but upon further questioning, admitted dragging the resident. The house supervisor and permanent unit carer both noted that Ms Perera expressed concern that she had hurt her own shoulder while dragging the resident.
78. The house supervisor said that after submitting Ms Perera's incident report on 10 March 2008, she attempted to contact the regional office a number of times and was advised that departmental management were 'looking at it'. The house supervisor said that on 12 April 2008 she had not heard from the management, she decided to hold a 'supervision' with Ms Perera. The record of this supervision includes the following:
- [Ms Perera] realises that she has made a mistake ... and in the coming weeks [they would] go through the legislation together.
79. The house supervisor said that she contacted Ms Illesca to advise her that due to the incident Ms Illesca would not be working at the unit in future. She said that she did not have authority to do this with Ms Perera due to Ms Perera's contract with the department. While Ms Illesca has not returned to the unit, she remains registered on the casual staff list and still works as a carer for the department at other CRUs.

Department of Human Services Management

80. In 2008, the Regional Director of the department managed Disability Accommodation Services. The Regional Director was supported by the following positions:

- Disability Manager (most senior)
- DAS Manager
- Area Manager and
- Team Leader (least senior).

Receipt of Incident Reports

81. On 6 March 2008 (the date of the incident), the Area Manager was Ms Monica White and the DAS Manager was officer B.
82. At interview, Ms White said that she was 'pretty sure' she had seen an incident report in relation to the incident but was unable to remember which incident report she saw or what she did after reading it. She said that she remembered talking with officer B about the matter and in response to my draft report, also advised that she discussed the incident with officer B's superior, the Disability Manager.
83. In response to my draft report, officer B said:
- My recollection I believe in [sic] that I sighted an incident report document prior [sic] my leave which was poorly written and unclear, and so it was sent back to the house for further information and advice on the incident to inform the subsequent required actions.
84. Approximately three weeks after the incident, officer B went on leave and Ms White assumed the role of Acting DAS Manager, officer A commenced as Acting Area Manager and a new team manager was hired.
85. Officer A told my officers at interview that when she commenced her role, Ms White drew the incident reports to her attention for action.
86. Officer B said that when she returned from leave (in May 2008) the department's response to the incident investigation was 'mostly finalised'.

Response to Incident Reports

87. When faced with potential staff disciplinary issues, the department is required to undertake a preliminary assessment to determine whether the matter should be investigated.¹⁰ A preliminary assessment report is produced by the assessing officer after completing a number of enquiries such as interviewing staff and reviewing relevant documents.
88. The Disability Services Agreement between the department and the Health and Community Services Union (the union) states that a preliminary assessment must be concluded within 10 business days of the department being made aware of the allegation. Officer A said that she 'would have' instigated a preliminary assessment however was unable to do so because the 10 day time limit had lapsed.

¹⁰ Managing discipline policy (VPS) Unsatisfactory work performance and misconduct – Procedure A.

89. Officer A told my officers that she was concerned a preliminary assessment undertaken after the 10 day time period could be rebutted by the union. She said:
- I remember having a conversation with my Manager [Ms White] and saying that the time has lapsed, and the union, you know we had a fairly strong union body and if the union represented the staff that we were interviewing, ... they could say ... 'what are you doing, a prelim that's past [the cut off date]' ... you know that was my concern.
90. In response to my draft report, Ms White said:
- I strongly deny that this conversation occurred. I am not intimidated by the union, and would never be concerned about time lines because of the union body, and am appalled by the implication that I am. I have previously processed Preliminary Assessments that have not met timelines without hesitation.
91. At interview, officer A said that Ms White advised her to undertake an informal process 'chatting to staff around the incident'. In relation to her direction from Ms White, officer A said, 'I am certain she said "don't do a prelim [preliminary assessment]"'.
92. In response to my draft report, Ms White also provided additional information that she did not volunteer to my officers at interview. She said:
- I recall requesting [officer A] to prepare a Preliminary Assessment Report. I have not changed my account or recollection of the events surrounding the incident.
93. At interview the new team manager said that under instruction from officer A she had a brief conversation with the house supervisor and asked her to collect information in regards to the incident. She also said she collected the incident reports, supervision notes and photos and 'handed them all to [officer A], who I left to do further investigation'.
94. Officer A informed my officers that the department 'established that he [the resident] was dragged', and both she and the team manager stated that this information was forwarded to Ms White.
95. In response to my draft report, Ms White said:
- I was not made aware of the new information that established that the resident's carers had dragged the resident. It was not appropriate that this information be forwarded to me as I was no longer involved in the Outer program, and was no longer privy to information in relation to this incident.
96. It is unclear what new information Ms White is referring to. I note that officer A left her role as Acting Area Manager prior to Ms White ceasing her role in May 2008.
97. Mr Todd Keating took over from officer A as Acting Area Manager on 12 May 2008. He said he was made aware of the incident by officer A as part of his handover process.
98. Mr Keating signed both incident reports on 20 May 2008 and forwarded them to his Manager, officer B who signed the incident reports.

99. At interview, Mr Keating said that he did not consider the nature of the matter and the department's response prior to signing off the incident reports. When asked why he signed off the incident reports without considering these details, Mr Keating said that he assumed officer A had done this. No further action was taken by the department in response to the incident.

100. In response to concerns raised in my draft report Mr Keating provided further information that he did not volunteer at interview. Specifically he said:

I was informed by [officer A] that it had been discussed with the then Acting Outer East DAS Manager, Ms White, and was waiting the supervision notes of the [house supervisor] and staff member, Ms Perera. Once the supervision notes were received the report would then be ready to go to the Outer East DAS Manager. I asked the [team manager], to followup with the [house supervisor] as a matter of priority. A short time later I received the supervision notes. I attached the supervision notes to the report and signed as "supervision notes attached." [his emphasis] The supervision notes show that the [house supervisor] had discussed the incident with Ms Perea [sic], her response, actions and behaviour towards the resident, and the expected behaviour, support and response that must occur.

...I did not 'sign off' both incidents reports [sic] on 20 May 2008. I signed one as 'supervision notes attached' [his emphasis] and signed the other confirming particular actions had been taken such as medical treatment with a doctor.

These reports then went to my manager,[officer B]. The reports were subsequently signed by [officer B]. I recall that I personally gave these reports to [officer B] and, based on our usual practice, there was likely some discussion around the incident, actions taken and followup [sic].

...

I did consider the nature of the incident and action taken, however, because 8 weeks had passed and considering that the DAS Manager [had] been briefed and involved in the response and assessment of the incident I did not commence a reassessment of the incident.

...

My assumption that [officer A] considered the details and nature of the incident is based on a conversation with her at handover and my understanding of the responsibility and accountability of the Area Manager position and that of a DAS Manager, and that the DAS Manager had been involved/consulted/briefed at the time of the incident. I also believe it is reasonable to assume that the DAS Manager had a discussion with the Manager Disability Services and I believe that this happened.

101. When responding to my draft report, Mr Keating also said that he undertook further action including:

- notifying the resident's family of the incident
- obtaining an advocate for the resident
- drafting guidelines for staff in the event that the resident did not want to attend his day program
- exploring day program options that may have better suited the resident's personal preference

- engaging the department's 'practice leader of positive support' to meet with the staff and work through best practice in supporting residents in the least restrictive way and respecting and maintaining human rights.

Categorisation of the Incident and Notification Requirements

- I02. The department's Incident Reporting Instruction states that when incidents occur, they must be reported to the department's regional management and categorised as an incident one, two or three, according to severity.¹¹
- I03. The most serious incidents are classified as category one incidents. Allegations of (or actual) physical assault of a resident by a staff member or volunteer are category one incidents, regardless of the need for medical attention.
- I04. For allegations of assault, the police and family of the victim must be notified and the incident report must be forwarded to a regional director within one day of an incident occurring. Neither of these steps were taken in response to the resident's assault.
- I05. The incident reports completed by the permanent unit carer, Ms Perera and the day placement manager are all classified as category two. These reports were viewed by the team manager, officer A, officer B, Mr Keating and Ms White, then Acting DAS Manager. None of these people changed the incident report to a category one incident or challenged the assessment. No person interviewed by my office (including Ms White) was able to provide a reason for this at interview.
- I06. In response to my draft report, Ms White said:
- I did not change the categorisation as I believed on the facts provided by the Housing Staff, it was the correct categorisation.
- I07. In response to my concerns, Mr Keating said:
- Since the time of the incident occurring, the Department has implemented procedures such that I believe that if reported today it would be reported as a category 1. There is now a much clearer managing performance and discipline procedure, with an assessment tool to assist managers. There is also greater support from the Human Relations Department both at the region and DHS Central office.

Incident Report Format

- I08. The incident reports reviewed by my officers are all of a differing format. There appears to be no standardised form and the pertinent information is not readily seen on the front page. The time, date and place of the incident are recorded on different pages in different versions and the incident reports do not contain the time and date they are received by the department. I note that the manager signs the report on the last page to finalise the matter and no outcome is recorded.

¹¹ Department of Human Services Incident reporting instruction, Instruction 4.3, March 2008.

Conclusions

109. My investigation established that within four days of the incident the permanent unit carer's and Ms Perera's incident reports had been received by the regional office.
110. This information was sufficient in my view to commence a preliminary assessment. It is unclear why the department failed to act on this information within a reasonable period of time.
111. At interview, Ms White advised that she had seen an incident report but was unable to recall when she had seen it or what she did in response. It was only after receiving my draft report and its conclusions that she advised my office that she had requested officer A to conduct a preliminary assessment.
112. At interview, officer A said she could not conduct a preliminary assessment because she was concerned the union would take action for the expiration of the due date. In my view, a union's involvement should not be a consideration in the department's ability to pursue an allegation of assault on a resident by a staff member.
113. Officer A said that a more 'informal' process was undertaken, to 'establish what had happened'. This 'informal process' consisted of the team manager collecting the incident reports, photographic record of the resident's injury and the supervision notes and forwarding these to management. At this time, the department was also in receipt of the day placement's incident report which referred to Ms Perera 'dragging' the resident and causing his injury.
114. There is no evidence that management spoke with (or interviewed) any staff member in relation to this matter other than a brief conversation with the house supervisor. In my view, this is an inadequate response to a serious allegation of assault on a resident by departmental staff resulting in an injury.
115. In consequence of dragging the resident, Ms Illesca was advised she could no longer work at the unit (but remains on the casual staff call list) and Ms Perera received 'supervision'.
116. Mr Keating replaced officer A (who has now ceased working with the department) and at interview told my officers he 'signed off the incident report' without reviewing the merit of the matter. He said that he had assumed officer A would have adequately assessed the matter.
117. In response to my preliminary conclusions, he has advised that he did not sign off the matter. I do not accept Mr Keating's evidence that he did not need to review the substantive content of the matter. From the incident reports and information in possession of the department, it was clear that a serious assault had occurred. I consider that a manager should not forward an incident report to his superior unless the content of it has been considered and they are satisfied the matter has been appropriately handled. In my view he abrogated his responsibility as an Acting Area Manager and failed in the duty of care he owed to the resident.

118. I consider that the assault on the resident was clearly a category one incident. However, as it was incorrectly classified, the department failed to notify the Regional Director, police and family and commence an investigation. A number of departmental staff viewed this report without rectifying this error. Every manager interviewed told my investigators that the matter should have been classified as a category one incident and was unable to provide a reason at interview why it was not initially categorised correctly or changed on review.
119. Officer B, officer A, the team manager and the house supervisor said that the responsibility to take action rested with the DAS Manager. At the time of the incident, officer B held the position of DAS Manager and Ms White assumed the position of Acting DAS Manager in late March 2008.
120. In response to my preliminary conclusions, officer B said:
- I did sight the incident report prior my leave but with inadequate information on the report to determine the subsequent actions required, I referred this back via line management (either Team Manager or Area Manager although cannot recollect who) to follow up with the house supervisor and staff for further information. Various responsibilities and related actions are required in the process by levels of line management. I believe (and I answered at interview) that the responsibility relating to actioning serious incidents does primarily sit with the DAS Manager and delegated responsibilities sitting with all levels of line management. This includes the Manager Disability Services who decides whether an external investigation is warranted.
121. I note that at the time of officer A's 'informal' process, Ms White was in the position of Acting DAS Manager and I am of the view that she had the responsibility to respond to the incident and ensure staff were appropriately dealt with. She did not. I consider that she failed in her duty of care for the resident.
122. In response to my draft report, Ms White said:
- I disagree with this paragraph. As DAS Manager Outer, [officer B] had the ultimate responsibility for the incident prior to going on leave, and upon returning from leave. As the Area Manager Outer at the time of the incident, and then for the five week period that I was the Acting DAS Manager, I also had responsibility for the incident, and believe that I responded to the incident appropriately, and did not fail in my duty of care for the resident.

Misinformation Provided to the Community Visitors

123. My investigation established that at the time of the incident and subsequently staff and the department failed to provide Community Visitors with:
- truthful answers
 - timely and accurate responses.
124. Community Visitors are appointed by the Governor in Council to inspect residential services and report on the quality of care provided to residents. Section 33(d) of the Disability Act permits Community Visitors to refer matters to my office.
125. Section 130(3)(b) of the Disability Act states that staff and management within residential services (such as the department) must give truthful answers to the best of that person's knowledge to any questions asked by a Community Visitor. It is a criminal offence to fail to do so.
126. On 13 March 2008 a Community Visitor attended the residential unit. She noted that the unit's communications book contained an entry about the resident receiving medical treatment and asked a casual unit staff member how the injury occurred. At interview, the Community Visitor told my officers that the casual unit staff member advised her that the injury was self-inflicted by the resident rubbing his back on the carpet in his bedroom.
127. The casual unit staff member admitted at interview that he told the Community Visitor that the resident's injury was self-inflicted; however he also said that at the time he spoke with her, he did not know how the injury was caused. The casual unit staff member said:
- On talking with the um Community Visitors, you can't really um say things like 'I think this and that', so the only when I spoke to the Community um Visitors I could only surmise that it may have been self-inflicted...you do see them [residents] fall over, you do see them self injurous [sic] so of any injuries first hand you actually look at, um [if] it may have been self-inflicted.
128. In response to my draft report, the casual unit staff member said that he told the Community Visitor that the resident's injury 'MAY [his emphasis] have been self-inflicted'. He also said:
- ... to the best of my knowledge at the time that the question was put to me, [by the Community Visitor was that [sic] I believed the resident's injury was self-inflicted and that I did not know how the injury was caused.
- ...
- I am at pains whether I theorised that the resident rubbed himself on the carpet or if it was what I had heard of from another staff member.

129. The Community Visitor provided my office with an email she sent to Ms White at 3:54 pm on 27 March 2008, when Ms White was in the position of Area Manager. In this email, the Community Visitor advised Ms White that although she had initially accepted the casual unit staff member's explanation, she remained 'troubled' because of 'practical difficulty for self injury on that part of the body'. She asked Ms White to explain how the injury was inflicted and the extent that the matter was being investigated.

130. Ms White failed to respond. At the next regular inspection of the unit on 18 June 2008 the Community Visitor accessed the incident reports concerning the resident's injury. She again wrote to Ms White on 20 June 2008, asking for a response to her correspondence of 27 March 2008. She then forwarded the email to Mr Keating later that afternoon. The Community Visitor attached a Disability Services Issues Report to her correspondence to Ms White and Mr Keating. This report stated:

It is inferred that this [the incident] was carried out in a humiliating way by a regular staff member and a casual staff member with the co-opted assistance of another resident. In the circumstances as CV's [Community Visitors] understand them, it appears that the resident would reasonably be entitled to think he had been subjected to an assault in his own home by the very people entrusted to care for him.

131. In response to my draft report, Ms White said:

I recall receiving a number of emails and issue reports from the community visitor but I have no record of a letter dated 27 March 2008, nor can I recall receiving the letter.

I did not fail to respond ...

In June 2008 I was in the position of Manager of Quality, and I recall receiving an email from the Community Visitor dated 20 June 2008 with the Disability Services Issue Report attached, which I discussed with [officer B]. I recall [officer B] instructing me that I forward this email to Mr Keating as he was the Area Manager Outer, and was familiar with the incident. I forwarded the email to Mr Keating, and the community visitor also forwarded this email to Mr Keating on 20 June 2008. Mr Keating responded to the community visitor that he would discuss the background to the incident with me, and that he would provide a response.

132. On 29 June 2008 Ms White responded to the Community Visitor and said:

I too am alarmed about the difference in the account of the event and I will investigate that immediately with Mr Keating and get back to you as soon as possible.

133. My investigation established that no such investigation occurred. In response to my draft report, Ms White said:

... my letter of 29 June 2008 specifically refers to investigating the contents of the Report with Mr Keating as I was no longer involved in the management of the incident, and had no knowledge of the further information obtained which gave rise to the concerns raised in the Report.

- I 34. Ms White did not provide a substantive response to the Community Visitor until 25 September 2008; six months after the Community Visitor initially contacted her. Ms White's letter:
- noted there was a recorded incident of the resident 'being very non-compliant and lying on the floor and rubbing his back along the carpet which would explain to some degree the injury he endured'
 - acknowledged the untimely medical treatment and the failure of staff to respect the resident's desire to remain home
 - stated that 'from the investigation there was clearly no evidence of intentional abuse or assault of the resident'
 - indicated there had been no decision concerning Ms Illesca's employment at the unit.
- I 35. In response to my draft report, Ms White said:
- I understood and expected that [officer B] and Mr Keating were managing the incident, as they were responsible for it, and that they were responding to the Community Visitor. However, I was asked by [officer B] to draft a response in September 2008, as Mr Keating had not provided one, and [officer B] said that Mr Keating did not have adequate writing skills to do so. I cannot recall when this was requested but believe it would have been in mid September. I forwarded my draft response to Mr Keating on 25 September 2008 and this draft response was based upon my knowledge of the incident, which was limited to my knowledge from when I left my role in management of the Outer Area in May 2008.
- Mr Keating did not amend or correct my draft response, and I now realise that my knowledge of the incident in September 2008 was incomplete.
- I 36. The Community Visitor said she was dissatisfied with Ms White's response. She provided my officers with a copy of an email sent to Ms White on 13 October 2008 in which she sought to meet with Ms White, Mr Keating, the team manager and the house supervisor to discuss her concerns. The Community Visitor was provided a list of dates by Mr Keating on 30 October 2008 by email and a meeting was scheduled for 17 November 2008. Present at that meeting was the house supervisor, the Community Visitor, Mr Keating and the team manager; Ms White did not attend.
- I 37. In response to my draft report, Ms White said:
- I cannot recall receiving the letter dated 13 October 2008, and presume that it was addressed to me in the position of Area Manager Outer, and therefore opened and handled by Mr Keating. I was not made aware of the meeting on 17 November 2008, and this is why I did not attend. I also believe that it was appropriate that Mr Keating attended, as he was the Area Manager and has been involved and responsible for managing the incident since May 2008.
- I 38. The meeting minutes, which were collated by the Community Visitor and confirmed as accurate by Mr Keating state that:
- two staff members dragged the resident along the hallway of the unit

- medical treatment was not sought until the next day, although departmental staff had noticed the resident's back was 'oozing'
- Ms White made 'an assessment of the incident report (together with [officer A])'
- Ms White assisted the house supervisor to revise the resident's behaviour support plan to include a record of behaviour that did not occur¹²
- Ms Illesca had been told not to work at the residential unit again.

I 39. In response to my draft report, Mr Keating said that the minutes as presented above were an 'incomplete paraphrase of the actual meeting minutes'. He also said:

After I received these minutes in late 2008 from the Community Visitors I reviewed and made some corrections. I confirmed these minutes by email with the Community Visitors as a record of what was discussed, and of documents that were read and discussed at the meeting. The [house supervisor] was the only person present at this meeting who was able to talk personally about events and actions at the time of the incident.

I 40. In response to my draft report, Ms White said:

I was not aware when I left the position of Area Manager in May 2008 that two staff members had dragged the resident along the hallway.

...

I made an assessment of the incident on the facts provided with [officer A], and asked [officer A] to prepare a Preliminary Assessment Report and investigate the relevant behaviour management strategies. I deny that I assisted [the house supervisor] to revise the resident's behaviour support plan.

...

I had no contact with the house supervisor, and I had no involvement in revising residents' behaviour support plans.

I 41. On 27 February 2009 the Community Visitor again wrote to Ms White seeking a meeting. Ms White responded on 1 April 2009 to suggest a meeting time and stating if the one time she suggested was inconvenient, she could not meet with the Community Visitors until after 11 May 2009.

I 42. The Community Visitor wrote to Ms White on 2 April 2009 and asked her to respond to their concerns in writing. Ms White provided a response on 16 April 2009 further emphasising the resident's 'non compliant behaviour' and that:

When this incident occurred it was investigated and every avenue to ensure the safety and well being of the resident is [sic] monitored and that the actions of the staff are not repeated. Very clearly from the investigation there appears to be no intent to causing [sic] harm to the resident.

I 43. In response to my draft report, Ms White said:

[Officer B] requested me to respond to the letter however I was uncomfortable as I believed it should have been Mr Keating who made the response.

...

¹² A behaviour support plan is a document used by departmental staff to record challenging behaviours exhibited by residents and strategies for dealing with those behaviours.

I drafted the response and forwarded it to Mr Keating, to finalise and add any additional information, prior to it being sent to a Community Visitor. I do not believe that Mr Keating made any amendments. I believe that Mr Keating as the Area Manager should have responded to these requests and concerns, and that I should not have been asked to do so, particularly as it is apparent that further relevant information had been obtained since I left the position, and which I had not been made aware of.

- I 44. On 29 June 2009 the Community Visitors wrote to the Regional Director requesting a meeting between the Community Visitors and the department. The regional director responded on 7 August 2009 when he declined the Community Visitor's request and referred them to meet with the Disability Manager.
- I 45. Officer B returned to her substantive role as DAS Manager on 17 April 2009. She wrote to the Community Visitor on 14 July 2009 and:
- apologised for the timing of communication to the Community Visitor
 - noted that 'management had conducted a formal assessment of the situation,' and had deemed it not appropriate to seek an external investigation because 'there was inadequate information to suggest that it was directly staff or [the resident's] actions that had resulted in his injury'
 - advised that the department had implemented a new preliminary investigation process however she was 'not sure that under these new guidelines that the outcomes would have been different'.

Conclusions

- I 46. Community Visitors are independent volunteers who advocate for some of the most vulnerable members of our community. The resident is non-verbal and unable to represent himself; he does not have an advocate; and when he was injured he was not in contact with his family. At the time of the incident the resident did not have anyone else to speak on his behalf.
- I 47. From a review of the correspondence between the department and Community Visitors, it is clear that the department failed to provide timely and frank responses to legitimate concerns raised by the Community Visitor in relation to the resident's injury.
- I 48. I consider that Ms White was not truthful in her responses to the Community Visitor.
- I 49. In response to my draft conclusions, Ms White said:
- I deny that I was not honest and truthful in my responses to the Community Visitors. My responses were based upon the knowledge I had of the incident.
- I deny that I placed intentional emphasis on [the resident's] non compliant behaviours, and deny that I was deliberately making any negative implications.

Fabrication of Information by Department of Human Services Staff

150. While investigating this matter, my officers identified that two documents allegedly created in response to the incident were fabricated by a staff member to give the false impression that the department had investigated the matter. These documents were:
- a preliminary assessment report recording a preliminary assessment which was purportedly undertaken in response to the incident, and
 - a record of telephone discussion purportedly had between Ms Illesca and officer A.

Preliminary Assessment Report

151. In response to my initial enquiries, the department provided my office with a preliminary assessment report (the report) created in response to the resident's assault. The report records a number of interviews which were stated as being completed by officer A with departmental staff on 10 and 12 March 2008; it is signed by Ms Monica White and concludes that no further action be taken.
152. The report states that it was commenced by officer A on 10 March 2008 and completed on 20 May 2008. At interview, officer A stated she had not undertaken a preliminary assessment and did not conduct any of the interviews recorded in the report, she said 'no it's not my document, I didn't write this'. The team leader, Mr Keating and the carers working within the unit said they had not seen the report and did not know who prepared it.
153. My investigation identified the following discrepancies with the information contained in the report:
- Officer A's first name is spelt incorrectly throughout the report.
 - The report states that Ms Perera, Ms Illesca, the permanent unit carer and the house supervisor were interviewed by officer A. However at interview, these people all denied being interviewed.
 - Officer A did not commence working in her role until 31 March 2008 and therefore was not in a position to conduct the interviews which purportedly occurred on 10 and 12 March 2008.
 - The report states that the house supervisor discussed the incident with the team manager at a date prior to her commencing with the department.
 - The report is signed and dated by Ms Monica White, purportedly on 20 May 2008 however Ms White is recorded as being on leave from the department on this date.

154. At interview, Ms White confirmed that it was her signature on the preliminary assessment report. When asked if this indicated she had seen the document she said:

Yes, on the 20th of May.

155. In relation to the creation of the preliminary assessment report Ms White said:

I've obviously signed the document, but I certainly haven't produced this document.

156. In response to my draft report, while denying that she fabricated the report, she admitted signing and backdating it. Specifically, she said:

It is my signature on the Report, however, I did not sign it on 20 May 2008. The first time that I saw the Preliminary Assessment Report was in April 2010, when [officer B] showed me a copy of it in her office ... When [officer B] showed me the document, it was unsigned, and dated as having been lodged on 20 May 2008. I assumed that it was the final draft of the Report by [officer A] and that it should have been signed by me. I therefore signed the Report in [officer B's] office, and backdated it to 20 May 2008 ...

I immensely regret signing and backdating the Preliminary Assessment Report, as it is now apparent that it was not the final document, and was not prepared by [officer A] as I had believed.

Purported Previous Behaviour of the Resident

157. In relation to the cause of injury, the report:

- states that on 6 March 2008 the resident 'threw himself onto the floor on his back and was pushing himself backwards using his feet'
- incorrectly states that Ms Perera's incident report records that the resident 'propelled himself backward towards the kitchen' (when Ms Perera's incident report states he 'started crawling from upper back to wards kitchen')
- refers to a previous behaviour purported to have been undertaken by the resident when he lived at 'Unit 15' in Kew Residential Services. It states that the resident was
- known to throw tantrums by throwing himself on the floor and *propelling* [emphasis added] himself backwards while screaming ...

158. Prior to being shown this preliminary assessment report at interview Ms White advised my officers that:

He [the resident] would throw himself down on the floor and what he would do is he would kick with his legs; kick backwards and he would *propel* [emphasis added] himself along.

159. When discussing her communications with the Community Visitors she said:

I may have used the word 'propel' to a community visitor because that's what it would have looked like ...

160. Ms White stated that she had seen the resident exhibit this behaviour while she was working at Kew Residential Services in the 1980's as a student nurse. She said that there was no record of him sustaining an injury from this behaviour before because the floor at Kew was 'glossy' and would not have caused him an injury.

161. My investigation ascertained that the resident did not reside at Unit 15 (as recorded in the report) but lived in Unit 16. Ms White worked at Unit 15 and when asked at interview how much her previous knowledge of the resident's behaviour affected her decision, Ms White said:

I believe probably a large part of it. Because certainly the behaviour that had been explained to me at the time of the incident certainly, I could actually visualise it with [the resident] from my previous knowledge and awareness of his behaviour.

162. In response to my draft report, Ms White said:

In the late 1990's and early 2000's I worked at Unit 15, and the resident lived in Unit 16. Unit 16 then became Unit 15B, and therefore became part of the Unit that I worked at. Both of the Units were collectively referred to as Unit 15. This is why I referred at the interview to the resident living at Unit 15.

At interview I do not recall saying that my recollection of the resident's behaviour in the 1990's largely influenced the way in which I responded to the incident. I also disagree that in responding to the incident I was influenced by my previous experience with the resident. My management of the incident was based on the information that was provided to me by management at the time of the incident.

163. Staff working with the resident at his day placement and in the unit all said that they had seen the resident 'drop to the floor' but not 'throw himself on the floor'. The permanent unit carer said:

[The resident] doesn't throw himself to the ground because [the resident] doesn't want to get hurt. [The resident] will sit himself down. He will kick a door, if you come close enough he will kick you. He will not lay on his back and drag. Because with his scoliosis, if he lays on his back, he has an arch he will either flop to one side. He can't lay straight on his side.

164. Officer A said that she knew the resident 'quite well' at Kew Residential Services and had also cared for him as a day placement carer. She said that she was '100 per cent certain' that she had never seen the resident engage in that behaviour and that he 'wouldn't be able to do that'.

Evidence of telephone discussion

165. The department provided my office with a document apparently recording a phone discussion between Ms Sylvia Illesca and [officer A]. This document contains a list of questions purportedly asked by officer A and a summary of the answers given by Ms Illesca.

166. At interview, both officer A and Ms Illesca denied they had had a telephone discussion over this matter. Officer A said that she did not write the record of conversation and said that she did not think it would have been appropriate to conduct a discussion of this nature over the telephone.
167. Consistent with the preliminary assessment report, this document incorrectly spells officer A's first name. It dates the telephone conversation as Monday 19 May 2008, one day before the assessment report was purportedly signed by Ms White.
168. In response to my draft report, Ms White said:
- I have no knowledge of the telephone discussion, who it was between, whether it occurred, or who produced the record of the telephone discussion. I deny any involvement in the record of the telephone discussion.

Conclusions

169. I consider that the preliminary assessment report has been fabricated. Officer A denies preparing the report and the persons named in the report as being interviewed by officer A deny on oath that such an interview took place. The purported author's name is spelt incorrectly throughout the document and it is signed by Ms White on a date she now admits is false.
170. I consider that Ms White also fabricated information about the purported behaviour of the resident and the record of phone discussion with Ms Illesca. This is supported by the following:
- Ms White acknowledges signing and backdating the report. She confirmed her signature at interview and subsequently advised that she had provided false information to my investigators at interview concerning the date she signed the report.
 - The report describes a behaviour exhibited by the resident 'throwing himself on the floor and propelling himself backwards'. This is a behaviour denied by every other person interviewed in this investigation, except Ms White.
 - At interview, prior to viewing the report, Ms White said that the resident had a history of 'propelling' himself along the floor while he was at Kew Residential Services. She said that she viewed this behaviour when she worked at Unit 15 and that this influenced her response to the incident.
 - The term 'propel' is an expression used twice in the report and not expressed by any other person interviewed in this investigation.
 - Officer A is purported to be the author of the preliminary assessment report. Officer A was the unit manager at Unit 16.
 - Officer A only referred to the resident living in Unit 16. Officer A said that she knew the resident 'quite well' and at interview described Unit 16 where the resident was living. She was aware that the unit later became part of Unit 15.

- The report describes the resident's behaviour occurring in Unit 15, however the resident lived in Unit 16 and Ms White worked in Unit 15.
- In correspondence to the Community Visitors dated 16 April 2009, Ms White said:

I had completed the initial report and certainly I ensured that the incident was investigated following the initial report.
- The record of meeting between the Community Visitors and the department states that:

Monica White, the usual Area Manager is said to have *made an assessment* [emphasis included] of the Incident Report (together with [officer A]) and also appears to have assisted the house supervisor write the revised behaviour support plan dated 13 September 2008.
- Ms White had an interest in fabricating the preliminary assessment report as responsibility for the department's response to the incident rested with her as Area Manager.

171. The evidence leads me to conclude that these documents were fabricated by Ms White to conceal the fact that the department failed to respond to a serious allegation of assault by staff on a vulnerable resident.

172. In response to my draft report, Ms White said:

I deny each and every allegation ... In particular, I deny that I had any interest in or motivation for fabricating the Preliminary Assessment Report. I responded to the incident appropriately by taking the steps referred to above to investigate the incident, and my superior [officer B], was aware of the incident. Reference to an 'initial report' are references to the Incident Report received from the Housing Staff. The investigation that followed was the preparation of the Preliminary Assessment Report. [Officer A] was aware of the Preliminary Assessment Report as I had asked her to prepare it, and Mr Keating and [officer B] were aware of it as it was part of my handover to them in May 2008.

Recommendations

I recommend that the department:

Recommendation 1

Consider taking disciplinary action against both Ms Perera and Ms Illesca in relation to the incident.

The department's response:

Recommendation supported.

The Department [will] ... immediately initiate an investigation under the *Managing Performance and conduct in Disability Services policy*, [its emphasis] consistent with Schedule C in the HACSU *Department of Human Services Disability Services Enterprise Agreement 2008-2012*.

Recommendation 2

Review the suitability of both Ms Perera and Ms Illesca to care for vulnerable people with disabilities, in light of my conclusions.

The department's response:

Recommendation supported. (Refer to response to Recommendation 1).

Recommendation 3

Reinforce with all staff and day placement Community Service Organisations their obligations under the *Charter of Human Rights and Responsibilities Act 2006*.

The department's response:

Recommendation supported.

The department will include information in the Practice Alert/Disability Accommodation Services Practice news and reinforced all staff's obligations under the *Charter of Human Rights and Responsibilities Act*. [Its emphasis.]

In relation to reinforcing the obligations of day placement organisations, the department commenced a tender process in December 2010 to engage a provider to conduct forums for community service organisations and department managed services that deliver services and supports to people with a disability to make service providers aware of the policies, templates and tools that are available to assist with their compliance with the Disability Act.

Recommendation 4

Reinforce incident reporting and investigation guidelines to ensure that all staff are aware of:

- incident reporting requirements
- category definitions
- the requirement to meet reporting time frames
- process and procedures when reporting time frames are not met
- report notification requirements
- the requirement for recording accurate information.

The department's response:

Support. The department will:

- Reinforce to regional and central office executive groups the importance of all staff adhering to incident reporting and investigation guidelines.
- Continue to undertake activities to raise awareness of all staff about the department's incident reporting instruction and associated requirements.

Recommendation 5

Consider implementing a web-based reporting system for incident reporting to provide a more efficient and immediate reporting process that includes an electronic audit trail or log of events.

The department's response:

Support in principle.

The implementation of a web-based reporting system would be complex and would take some time to achieve. The department is currently considering other options to improve the incident reporting process including:

- The development of standard automated data reports. The first set of these new management reports was completed in December 2010, and they are now available to central office and regions. The full set of automated data reports will be finalised by April 2011.
- A review of the current management of Category Three incident reports and their role in the DHS Incident Reporting System. This policy review and any proposals for change will be completed by April 2011.

- Possible further changes to incident reporting policy, systems, and processes as part of an overall continuous improvement approach to incident reporting.

Recommendation 6

Review the current incident report forms to provide clearer information on the front page including:

- time, date and place of the incident
- category and authorisation / approval of that category
- person reporting the incident
- supervisor notified of the incident
- manager receiving the incident
- manager finalising the report, time and date
- recommendations / outcomes.

The department's response:

Support in principle. The department will review information on the front page of incident reports forms. Of note: the current form includes on the front page time, date and category of incident.

Recommendation 7

Consider taking disciplinary action against Ms White and Mr Keating, in view of their failure to exercise a duty of care to the resident and adequately investigate the incident.

The department's response:

The department will use information in the Ombudsman's final report...to immediately initiate an investigation under the *Managing Performance and conduct in Disability Services Policy*, consistent with Schedule C in the *HACSU Department of Human Services Disability Services Enterprise Agreement 2008-2012* for Mr Keating and under the *Managing discipline policy (Victorian Public Service Agreement) transitional* for Ms White.

Recommendation 8

The department reinforce with staff the importance of the role Community Visitors play in the disability system and the requirement of staff to assist them.

Department's response:

Supported. The Department will:

- Revise the existing Protocol between NDSV, Community Visitors Program and Disability Services Division in 2011 ...
- In 2010-11, additional funding will be provided to the Community Visitors program to support activities such as training for Community Visitors.
- Continue its quarterly meeting with the Community Visitors Program Representatives.

Recommendation 9

The department consider taking discipline action in relation to the failure of the casual unit staff member and Ms White to provide truthful answers to the Community Visitors as required by Section 130(3)(b) of the *Disability Act 2006*.

Department's response:

The department will use information in the Ombudsman's final report... to immediately initiate an investigation under the *Managing Performance and conduct in Disability Services Policy*, consistent with Schedule C in the HACSU *Department of Human Services Disability Services Enterprise Agreement 2008-2012* for [the casual unit staff member] and under the *Managing discipline policy (Victorian Public Service Agreement) transitional* for Ms White.

Recommendation 10

I recommend that the department review the suitability of Ms White's employment in light of the conclusions in this report.

Department's response:

Supported. This recommendation will be addressed as an outcome of an investigation under the *Managing discipline policy (Victorian Public Service Agreement) transitional* for Ms White.

Ombudsman's Reports 2004-11

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

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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

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June 2009

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April 2009

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March 2009

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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