

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

September 2017

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

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my *Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus*.

A handwritten signature in black ink, appearing to read 'Deborah Glass', with a stylized flourish at the end.

Deborah Glass OBE

Ombudsman

25 September 2017

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Foreword

'As [Robert's] parents we continue to be horrified at the sexual attacks on him... I can't think of any other situation where a repeat sexual offender would be allowed to stay in close proximity to his victim...the rights of disabled people need to be protected.'

Complaint to DHHS from
Robert's father in December 2014

This investigation concerns matters that are deeply disturbing: a series of reported sexual assaults by one resident on another in a group home for people with a disability run by for-profit provider, Autism Plus; and the response by both Autism Plus and the Department of Health and Human Services to those assaults.

At the centre of the investigation is a young man with multiple disabilities and a history of assaultive behaviour, whom we call Edward (not his real name). Edward, who has been in the care of the state since he was 13 years old, reportedly perpetrated a series of sexual assaults against another young man, whom we call Robert. Robert has autism and is non-verbal. After the first reported assaults in late 2014, the risk of Edward remaining in the home was the subject of regular discussion between Autism Plus, which received over \$260,000 in funding that year for his care, and various department officials. Concerns were expressed by Robert's family and by Community Visitors.

Yet Edward remained, ostensibly under constant watch, until after the alleged rape of Robert by Edward. Edward had also disclosed that he had sexually assaulted at least five other co-residents. It is particularly troubling that it was only following the intervention of my office that the families of other people reportedly subjected to sexual assaults by Edward, were informed of these allegations.

This has been a lengthy investigation – extended by police enquiries, which ultimately resulted in no charges – and complicated by the number of parties involved and by legal questions. Although the original incidents occurred over two years ago, I am tabling this report to draw attention to the issues arising from this case that, sadly, are still current.

The investigation raises serious questions about the suitability of a service provider that receives significant public funds. It also raises questions about action and inaction by officials in the Department of Health and Human Services, in particular the role of Child Protection, and poor co-ordination between Child Protection and Disability Services. Lines of responsibility were unclear – a point underlined by many of those subject to this investigation, who were eager to deny responsibility or blame someone else for the failings identified.

Both Robert and Edward have been failed in this case, by people and systems.

All too often cases like this come to public notice. This case is especially shocking – not only because of the enduring impact of the trauma associated with sexual assault, or the acute vulnerability of those involved, but that this could still happen today despite the supports available to people with a disability.

I have in previous reports expressed concerns about the safeguards available to people with disability, and that the extreme vulnerability of some people will not lessen with the introduction of the National Disability Insurance Scheme. Oversight is needed for all facilities, not least when the provider has a profit motive. Over 5,000 people with disability live in supported accommodation in Victoria; the department owes it to them, indeed to our need to be a humane society, to do better.

Deborah Glass
Ombudsman

Executive summary

1. This report details what has been a long and complex investigation. It commenced on 17 June 2015 when the Independent Broad-based Anti-corruption Commission (IBAC) referred a matter to the Ombudsman pursuant to section 73 of the *Independent Broad-based Anti-corruption Commission Act 2011*. IBAC had determined the matter to be a 'protected disclosure complaint' under the *Protected Disclosure Act 2012*.
2. The complaint alleged that Autism Plus failed to appropriately manage the behaviour of Edward,¹ a young man in a group home for persons with a disability (Smith Street), resulting in his sexually assaulting another resident, Robert, in April 2015. In the six months preceding the alleged rape, Edward reportedly perpetrated a series of other sexual assaults against Robert and made threats of serious violence towards Robert and his family. This period of time was the focus of the investigation.
3. At the relevant time, Autism Plus was operating under a service agreement with the Department of Health and Human Services (DHHS). Autism Plus is a for-profit provider of accommodation and day program services on a 'fee for service basis' for DHHS clients. During the investigation Autism Plus was the subject of media attention, including a Four Corners report into disability care.
4. Autism Plus is regulated and funded by DHHS. In 2014-15 Autism Plus received \$5,332,196 from DHHS to deliver Community-based Respite, Futures for Young Adults, Individual Support Packages, Residential Care and Flexible Support Packages. As part of that year's funding, Autism Plus received \$266,923.58 to care for Edward.
5. For this reason, the investigation also considered whether:
 - as regulator and funder, DHHS adequately monitored Autism Plus at the relevant time; and
 - Disability Client Services (Disability Services) and the Victorian Child Protection Services (Child Protection), DHHS, provided adequate care, management and protection of Edward, to prevent harm to Edward and other residents.
6. As young people with complex disabilities, Edward and Robert moved into the Autism Plus group home in 2014 because they were unable to reside independently and they required supportive, high quality, specialised care.
7. Edward, who had displayed an escalating pattern of assaultive behaviour in the years preceding the alleged assaults, was diagnosed with multiple disabilities during childhood including a moderate intellectual disability (IQ of 42) and multiple behavioural disorders. Edward's psychologist described him as a 'low relative functioning individual who presents as significantly higher functioning than he is' who is 'opportunistic...very compulsive and impulsive' and presents with a 'high level sex drive'. Edward had been unable to live with his parents from the age of 13 and had since been in the care and legal custody of Child Protection.
8. Robert has Autism, cognitive deficits and is non-verbal.

¹ The names of the residents and the group home have been anonymised to protect the privacy of individuals.

What happened

9. On 31 October 2014, Edward, who was funded for one-on-one staff to client care, was left unsupervised. He was found by a staff member in Robert's room allegedly sexually assaulting him. The alleged assault involved Edward gyrating himself or 'humping' Robert while they were both fully clothed. This incident was initially incorrectly classified as a Category Three 'non-sexual assault incident' by Autism Plus and was not reported to DHHS within 24 hours as required.
10. It was not until Edward disclosed details of the incident, and at least one prior alleged sexual assault of Robert, to his psychologist on 11 November 2014, that Autism Plus submitted a Category One incident report to DHHS. This incident report was also not categorised as a sexual assault.
11. On 9 December 2014 Edward again allegedly attempted to sexually assault Robert and was restrained by two Autism Plus staff members. As a result, Robert's parents, concerned that their son was not safe at Smith Street, complained to Autism Plus and DHHS. Autism Plus responded by advising DHHS that Edward would be removed from Smith Street on 10 December 2014.
12. Autism Plus contacted Disability Services advising that it did not believe it could safely accommodate Edward at Smith Street and offered to support him at another Autism Plus residence where he would be the only resident.
13. On 12 December 2014 senior managers from Autism Plus, Disability Services and Child Protection met to discuss Edward's placement. What occurred at this meeting is disputed by Autism Plus and Disability Services; however, it is clear that DHHS did not respond to the concerns raised by Robert's family by providing any alternative placement options for either young person. Autism Plus told the investigation that it was instructed by DHHS that it had no authority to move Edward and he was to remain at Smith Street.
14. Disability Services stated that there was no direction issued, rather an agreement was reached with Autism Plus for Edward to stay. Such disputes and differing accounts about who made key decisions regarding Edward's care were common during the investigation; striking for the fact that no one agency was prepared to take responsibility, nor were records kept of key decisions and the authority relied upon for making them.
15. The end result was that Edward stayed at Smith Street without any significant changes made to manage his behaviour, ameliorate the risks and protect Robert.
16. From late 2014 to early 2015 there were several other incidents involving Edward including occasions where he threatened to stab Robert and his parents and tried to punch Robert.

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17. The management of Edward's behaviour did not significantly change during this time despite the ongoing threats to Robert; the concerns of Robert's parents and Autism Plus and concerns about the suitability of Edward's continued placement at Smith Street raised by Community Visitors, the Disability Services Commissioner and Victoria Police. Concurrently, DHHS staff raised their own concerns about the quality of care and supervision of its clients at Smith Street.
 18. This situation remained until 12 April 2015 when Autism Plus reduced the number of staff present at Smith Street at night from two staff members to one. Under Edward's Residential Statement (his contract of care to be provided), Autism Plus was required to provide a sleepover and active staff member at night. This was essential as there was an obvious need to ensure that two staff were present to respond in the event of another sexual or violent assault by Edward.
 19. When interviewed during the investigation about why the staffing levels were suddenly reduced, one of the Directors of Autism Plus, who had stated the risk posed by Edward in December 2014 'was still too great', told the investigation 'basically it was a financial decision'. Autism Plus did not consult DHHS or even inform it of this significant change.
 20. On 13, 14, 16 and 17 April 2014 Edward instigated serious incidents, three of which necessitated police attendance. This included an instance where Edward allegedly threatened the lone staff member present with a knife and another during which he attacked Robert and ripped his clothes. None of these incidents led Autism Plus to reconsider its decision.
 21. On 18 April, just six days after the night-time staffing number was reduced to one, Edward allegedly sexually assaulted Robert during the night. The alleged assault was even more serious than that which had occurred over six months earlier in October 2014. Edward detailed the incident in subsequent discussions with Autism Plus staff and his psychologist (a few days later). He stated that after attacking and threatening to kill the lone staff member, he had anally penetrated Robert who had been trying to use the bathroom. He then threatened to kill Robert.
 22. During the investigation, it was revealed that during his disclosure of the alleged rape, Edward also detailed that he had possibly sexually assaulted at least five other clients in Autism Plus group homes and day programs in the preceding years. These other disclosures included sexual penetration of at least two other clients on multiple occasions.
 23. Autism Plus concluded that the disclosures were unsubstantiated given the absence of reported changes in the health or behaviour of the identified clients and the perceived 'low possibility' of Edward being unsupervised. This conclusion is not consistent with the evidence obtained by the investigation, which revealed Edward had the opportunity to take advantage of the vulnerability of his peers owing to significant deficiencies in his supervision and Autism Plus's understanding of sexually assaultive behaviours. It was only after the intervention of this office that the families of those affected were informed of the allegations.

Key failings by the agencies involved

24. There were numerous failings in the management of Edward by the agencies involved. Some of the most concerning are summarised here.

Autism Plus

25. The evidence shows that Autism Plus had concerns about its ability to manage Edward. Yet in December 2014, DHHS in effect instructed the agency to keep Edward at Smith Street. Autism Plus reluctantly agreed, at least in part, for fear of losing government funding.

26. In April 2015, one of the two Directors and owners of Autism Plus cut staff supervision of Edward at night from two staff members to one, in contravention of Edward's 'guaranteed supports' in his Residential Statement provided under the *Disability Act 2006*. This decision was made despite objections from staff and meant that the two-person restraint, identified by Autism Plus as a necessary response to assaults by Edward, could not be implemented if required at night.

The Department of Health and Human Services

27. Edward was a dual client of DHHS with his care having involvement of both Child Protection and Disability Services.

28. Neither Child Protection nor Disability Services obtained the specialist risk assessment DHHS had deemed necessary, following the alleged sexual assault of Robert on 31 October 2014. Disability Services also failed to ensure that Autism Plus completed tasks assigned following meetings with the agency and those recommended by the Senior Practitioner - Disability Team, such as training Edward's carers to understand or respond appropriately to sexual assaults and implement a psychological tool (the DRAMS) designed for non-clinical carers to predict Edward's assaultive behaviour.

29. Similarly, Disability Services took insufficient action to ensure that Edward's Behaviour Support Plan was updated by Autism Plus or that medical reviews for the prescription of psychiatric drugs were completed while he was at Smith Street - tasks which were barriers to Edward being able to move to any new placement.

30. In the absence of any assessment to determine the treatment needs and suitability of alternative placement options for Edward in accordance with the *Children, Youth and Families Act 2005* (CYFA), Child Protection made the decision to allow Edward's Protection Order to lapse on 18 November 2014. This occurred one day after purportedly telling Disability Services and Autism Plus that the order had already lapsed because there was 'no role' for Child Protection.

31. Of further concern is the fact that although Edward was a Child Protection client for many years until his order was allowed to lapse in November 2014, no Child Protection Officer had visited Edward in any of his residential placements since October 2011, a period of over three years. This was despite Edward being involved in around 30 incidents of alleged physical assaults, sexual assaults and behaviour, and property damage.

Conclusions

32. Children who have been removed from their parents have a right to the highest standard of care and to protection of their best interests and rights by DHHS and its service providers. They have a right to be free from violence in the care of the state. Both Robert and Edward are highly vulnerable people who have been let down by the disability and child protection sectors in Victoria.
33. The Ombudsman commented in the 2009 *Investigation into the Department of Human Services Child Protection program*, that the majority of child protection staff are highly committed to achieving positive outcomes for children. Equally dedicated are most of the workers in the disability sector who passionately support and advocate for the rights of people with a disability. The failures identified in this report should not be seen to reflect on the dedicated staff working in such challenging circumstances.
34. The evidence in the investigation has shown that there were serious deficiencies in Edward's supervision and care at Smith Street. Repeated failures by Autism Plus and DHHS, both by individuals and systemically, contributed to an unacceptable risk of significant harm to other clients, staff and Edward. According to Edward's disclosures to his psychologist, for at least three residents, including Robert, the consequences of these failures were of the severest kind. This is not acceptable.
35. Edward had been a DHHS Child Protection client for nearly five years before he turned 18 and it was obvious that he would need continued support as a Disability Services client. However, there is no evidence that his long-term care was adequately planned for or effectively managed by either Child Protection or Disability Services, with both services advising the investigation they lacked placements for children with disabilities.
36. The actions and decisions which underpinned the failures identified in Edward's care and management by DHHS and Autism Plus were not consistent with rights afforded to children and persons with a disability. Residents at Smith Street were not protected from harm; and Edward, a vulnerable child with complex needs, was not provided with alternative accommodation or intervention services when he needed them to ensure his best interests were protected.
37. The government has recently called for expressions of interest from private and non-government organisations to take over residences operated by DHHS as part of the national transition towards the NDIS.
38. This report highlights the need for any such changes to be supported by a rigorous accountability and oversight system that will hold organisations to account and adequately protect people with disabilities.

Background

39. On 17 June 2015 the Independent Broad-based Anti-corruption Commission (IBAC) referred a matter to the Ombudsman to be investigated or otherwise dealt with as is considered appropriate pursuant to section 73 of the IBAC Act. IBAC had determined the matter to be a 'protected disclosure complaint' under the Protected Disclosure Act.
40. The complaint alleged that Autism Plus, a disability services provider funded by DHHS,² failed to appropriately manage the behaviour of 'Edward'³ in a residential facility (group home) for persons with a disability at Smith Street,⁴ resulting in his sexually assaulting another resident, 'Robert'.⁵
41. The Ombudsman's jurisdiction to investigate protected disclosure complaints is derived from section 13AAA of the *Ombudsman Act 1973*. This provides that the Ombudsman has the function to investigate protected disclosure complaints about conduct by or in an authority or protected disclosure entity. The definition of 'an authority' under section 2(1) of the Ombudsman Act includes a department such as DHHS. However, Autism Plus is not an authority, nor is it a protected disclosure entity.
42. Section 13(1) of the Ombudsman Act gives the Ombudsman jurisdiction to investigate the administrative actions of authorities, such as DHHS. Section 13(4) in effect deems the actions of certain persons or bodies acting under the 'powers or functions conferred on or instructions given by an authority', to be the actions of the authority.
43. The *Disability Act 2006* defines the role of the Secretary of DHHS as including 'to plan, develop, provide and fund or purchase comprehensive services, programs and initiatives for persons with a disability'.⁶ Functions of the Secretary include 'to develop policies for disability services';⁷ 'to monitor, evaluate and review disability services';⁸ 'to promote the quality of disability services';⁹ and 'to foster collaboration, coordination and integration in the provision to persons with a disability of disability services with other local services'.¹⁰ The Secretary may enter into contracts with a person or non-government organisation and allocate funds for the provision of disability services.¹¹

2 The Department of Human Services (DHS) merged with the Department of Health (DoH) on 1 January 2015 and the currently accepted acronym is DHHS. Where direct quotes have been used by authors using the acronym DHS, these have been maintained, otherwise DHHS has been used when referring to the department in this report.

3 Not his real name. Names in this report have been anonymised where appropriate to protect the privacy of the clients and individuals involved.

4 Not the real location.

5 A second allegation regarding Autism Plus was made. However, this matter has been reported to the relevant Minister and Secretary separately to this report.

6 Disability Act section 8(1)(a).

7 Disability Act section 8(2)(c).

8 Disability Act section 8(2)(f).

9 Disability Act section 8(2)(g).

10 Disability Act section 8(2)(i).

11 Disability Act sections 9 and 10.

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44. At the relevant time, Autism Plus was operating under a service agreement with DHHS.¹² Autism Plus is a for-profit provider of accommodation and day program services on a 'fee for service' basis for DHHS clients. The service agreement at the time contained a list of DHHS policies and procedures with which Autism Plus was mandated to comply as a funded agency. This agreement also detailed performance measures and their corresponding monetary value for 'activities' Autism Plus was funded by DHHS to perform, including residential care for Child Protection and Disability Services clients.
45. In view of section 13(4) of the Ombudsman Act and the functions conferred on Autism Plus by DHHS, the Ombudsman decided to investigate the administrative actions of DHHS and Autism Plus that formed part of the matters referred to the Ombudsman by IBAC.
46. Additionally, the Ombudsman also considered whether:
- as regulator and funder, DHHS adequately monitored Autism Plus at the relevant time
 - Disability Services and Child Protection provided adequate care, management and protection of Edward, to prevent harm to Edward and other residents.
47. Notwithstanding this, as IBAC determined the initial complaint to be a 'protected disclosure complaint', the confidentiality provisions and protections as outlined in the Protected Disclosure Act and IBAC Act apply.
48. On 9 December 2015 the Ombudsman notified the Hon Martin Foley MP, Minister for Housing, Disability and Ageing; Ms Kym Peake, Secretary of DHHS; and Director 1, Autism Plus of the Ombudsman's intention to conduct an investigation into this matter. During the course of the investigation, the office received information about Child Protection's involvement with Edward. Accordingly, on 22 February 2017 the Ombudsman notified the Hon Jenny Mikakos MP, Minister for Families and Children of the investigation.
49. In reaching the conclusions in this report, the standard of proof applied is the balance of probabilities. In determining whether that standard has been met, the High Court decision of *Briginshaw v Briginshaw*¹³ is relevant. Specifically, the Ombudsman has considered the seriousness of the allegation made and the gravity of the consequences that may flow from any adverse finding.
50. There were some delays in finalising the investigation. This was due in part to the complexity of the jurisdictional issues associated with protected disclosure complaints about private organisations, such as Autism Plus, providing disability services under contract with DHHS. Additionally, multiple consultations were conducted with Victoria Police to ensure that the investigation did not prejudice any criminal proceedings.¹⁴ The relationships between the key agencies involved are also complex and the identification of Child Protection's integral role in Edward's care expanded the scope and length of the investigation.

12 Service agreement: aligned to the whole of Victorian Government common funding agreement 1 July 2012 to 30 June 2015, variation to service agreement between DHHS and Autism Plus no. 24503-12 version #50, 15 April 2015 (Autism Plus Service Agreement).

13 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

14 Ombudsman Act section 13AB.

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51. A large volume of documentary evidence was obtained by the investigation, including a significant number of additional documents provided by Autism Plus and individuals in response to the Ombudsman's draft report. This report is not a brief of all of this evidence; rather it contains key documentary and witness evidence, which highlights Edward's care and management from a placement, case management and statutory case planning perspective and provides facts to support the Ombudsman's conclusions and opinions.
52. This report includes adverse comments about:
- Autism Plus
 - DHHS
 - Child Protection
 - Disability Services
 - Senior Practitioner – Disability Team (SPDT)
 - Area Manager Child Protection
 - Team Manager Child Protection
 - Individual and Family Support (IFS) Manager DHHS (includes responsibility for case management teams in Disability Services)
 - Director 1 Autism Plus
 - Senior Manager Autism Plus
 - House Manager Smith Street, Autism Plus
 - Regional Manager Autism Plus.
53. In accordance with section 25A(3) of the Ombudsman Act, any other persons who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion; and:
- the Ombudsman is satisfied that it is necessary or desirable in the public interest that the information identifies or may identify those persons included in this report; and
 - the Ombudsman is satisfied that this will not cause unreasonable damage to those persons' reputation, safety or wellbeing.
54. In accordance with sections 17(4) and 25A(2) of the Ombudsman Act, the Secretary of DHHS, Autism Plus, the Chief Commissioner of Victoria Police and relevant individuals were provided with a reasonable opportunity to respond to the material in the Ombudsman's draft report.
55. Names in this report have been anonymised where appropriate to protect the privacy of the individuals involved.

Key agencies and staff

Autism Plus

56. Autism Plus is a privately owned and operated for-profit disability services provider with a focus on providing support to people with an Autism Spectrum Disorder and other disabilities. It is regulated and funded by DHHS to provide accommodation and support services, such as day programs and residential care.¹⁵ In 2014–15 Autism Plus received \$5,332,196 from DHHS to deliver Community-based Respite, Futures for Young Adults, Individual Support Packages, Residential Care and Flexible Support Packages.¹⁶
57. Smith Street (as noted, not its real name) is an Autism Plus operated group home offering accommodation and day program services on a 'fee for service basis' for DHHS clients.

DHHS

58. DHHS regulates funded agencies, such as Autism Plus, to ensure that all 'providers registered by the department meet the Human Services Standards'. For agencies providing disability residential care, DHHS 'monitor and oversee their compliance with the service agreement... including conducting...reviews and other interventions, if required'.¹⁷

Disability Client Services

59. Disability Services, within DHHS, provide financial assistance, accommodation options, community involvement and other supports and services for people with a disability, their families and carers.¹⁸
60. Edward has been a Disability Services client since 2010. He received funding for accommodation and support services including case management in accordance with an Individual Support Package (ISP). On 23 December 2016, the National Disability Insurance Scheme (NDIS) approved a plan and funding for Edward to receive accommodation and personal support and Edward engaged a community service to provide and coordinate his new services.
61. Despite Edward's transition to the NDIS, Disability Services case management remained active to support Edward with his involvement in the criminal justice system. In 2017, after completing the Melbourne Magistrates' Assessment and Referral Court (ARC) program, the court:

discharged all charges (over 100 including client to staff assault and property damage) due to concerns about [Edward's] culpability, his participation in the ARC list and improvements in behaviours (no assaults to staff or property damage in over 4 weeks).

Edward's Disability Services case management intends to submit a public housing application for Edward and then cease its involvement; he is no longer in receipt of any other funded services from DHHS.¹⁹

¹⁵ <<http://www.autismplus.com.au/index.html>>, viewed on 22 December 2016.

¹⁶ Draft Memorandum prepared by Local Connections Officer, 24 December 2014.

¹⁷ Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 1 December 2016.

¹⁸ <<http://www.dhs.vic.gov.au/for-individuals/disability>>, viewed on 22 December 2016.

¹⁹ Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 29 June 2017.

Child Protection

62. Child Protection within DHHS is targeted to children at risk of harm. Child Protection acts under the CYFA. The main functions of the service are to conduct child abuse investigations; refer children and families to services; take matters before the Children's Court if the child's safety cannot be ensured within the family; supervise children on legal orders; and provide and fund accommodation and specialist support services to children in need.²⁰ Edward became a client of Child Protection in 2010 when he was placed into out of home care by DHHS and subject to a Children's Court Custody to the Secretary Order (CTSO).²¹ He remained under the supervision of Child Protection until 2015.²²

The Senior Practitioner – Disability Team

63. The Senior Practitioner (Disability) is appointed by the Secretary of DHHS under the Disability Act²³ and is responsible for protecting the rights of people subject to restrictive interventions and compulsory treatment, and to ensure that the relevant standards are met.²⁴ The staff in the Senior Practitioner – Disability Team (SPDT) are physically located and administratively placed within the Office of Professional Practice in DHHS.

20 <<http://www.dhs.vic.gov.au/for-individuals/children-families-and-young-people/child-protection>>, viewed on 22 December 2016.

21 Child Protection Practitioner (CPP), Disposition report in support of application to extend protection order for Edward, [date of report removed], stated that Edward became subject to an Interim Accommodation Order on [date removed] 2010 and then a Custody to the Secretary Order from [date removed] 2010 when a Protection Application was found proven.

22 Victorian Children's Court Custody to Secretary Order for Edward, [date removed], order lapsed on 18 November 2014, protective involvement ceased 22 January 2015 (Edward's CTSO).

23 Disability Act section 23(1).

24 Disability Act section 23(2)(a).

The Local Connections Unit

64. Following a restructure in 2012, DHHS created the Local Connections Unit (Local Connections), which includes Agency Connections and Community Participation teams responsible for promoting 'the social and economic participation of the local community as well as managing relationships with funded agencies'.²⁵ The main functions of Local Connections regarding funded agencies are understanding agencies and service-related issues; providing input to DHHS divisional staff on Desktop Reviews and action plans; escalating ongoing agency performance issues and making recommendations for improvements; and providing advice to agencies about policies, guidelines, reporting and service agreement requirements.²⁶

Key staff

65. The key staff at DHHS and Autism Plus involved in the matters examined in the investigation were:
- Area Manager Child Protection*
 - Deputy Area Manager Child Protection
 - Team Manager Child Protection
 - IFS Manager DHHS
 - Case Manager Disability Services
 - Team Leader Disability Services*
 - Local Connections Officer
 - Senior Practice Officer SPDT
 - Director 1 Autism Plus
 - Senior Manager Autism Plus
 - Area Manager Autism Plus*
 - House Manager Smith Street, Autism Plus*
 - Regional Manager Autism Plus*

**Person is no longer employed by the relevant agency. Other individuals may now be employed in different roles.*

25 DHHS, Organisational restructure: role function description Local Connections, October 2012, provided to Victorian Ombudsman by Local Connections Officer.

26 *ibid.*

Methodology

66. The investigation involved conducting three voluntary and six compulsory²⁷ interviews with the complainant and staff across the key agencies, eight of whom attended with legal representatives or support persons.
67. In addition, the investigation examined documents from DHHS, including:
- policies, procedures and practice guidelines
 - Edward's Children's Court reports
 - Edward's statutory case and stability plans - 2012 to 2014. Section 166 of the CYFA states that a case plan includes any stability plan and is prepared by the Secretary for a child. It must contain all decisions made by the Secretary concerning a child that are 'significant' and 'relate to the present and future care and wellbeing of the child, including the placement of, and access to, the child'.
 - Edward's CRIS²⁸ case notes
 - Edward's incident report history (see Tables 1 and 2 in the Appendix)
 - review and audit records of Autism Plus²⁹ from 2013 to 2015
 - supervision³⁰ records of Area Manager Child Protection.

68. The investigation also examined documents from Autism Plus, obtained pursuant to a summons issued on 2 June 2016, including:
- policies, procedures and staff manuals operative during the relevant time
 - funding (service) agreements with DHHS and related protocols
 - Edward's Autism Plus Residential Statements and placement documents. Pursuant to section 57 of the Disability Act, a disability service provider providing residential services must give a person (and their guardian) a statement in writing when they commence residing at the service which specifies details of the services to be provided.
 - Smith Street staff sign in and out sheets from September 2014 and November 2014 to April 2014 inclusive
 - Edward's case notes including meetings and Behavioural Support Plans. Pursuant to section 54 of the Disability Act, a disability service provider must, in consultation with the person, prepare a support plan within 60 days of a person receiving ongoing disability services and review as required.
 - Autism Plus nominated email communications of Director 1 Autism Plus and her son, Senior Manager Autism Plus.
 - Office of the Public Advocate, Community Visitors Smith Street visit record.

27 A compulsory appearance (section 18 of the Ombudsman Act) takes place where the witness appears under summons, or takes an oath or affirmation when providing evidence. Other interviews and meetings with agency staff or stakeholders about an investigation are voluntary appearances (section 18D of the Ombudsman Act).

28 Client Record Information System (CRIS) is DHHS's electronic client information and case management system.

29 Heather Michaels and Associates, *Funded organisation service review: Autism Plus for DHHS North Division*, October 2015 (Heather Michaels review 2015); SAI Global Limited, *Recertification audit report for Autism Plus*, conducted 27 November 2013 and 28 November 2013 (SAI audit 2013); SAI Global Limited, *Recertification audit report for Autism Plus*, conducted 30 November 2015 to 3 December 2015 (SAI audit 2015).

30 Supervision includes formal and informal meetings between Child Protection staff and their manager in accordance with requirements contained in the *Child Protection Manual* which states the managerial function is 'to promote competent, professional and accountable child protection practice and monitor workloads'.

Relevant legislation and policies

69. The following Victorian legislation and other legal instruments were considered applicable:

- *Children, Youth and Families Act 2005* (CYFA)
- *Disability Act 2006*
- *Public Records Act 1973*
- *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter)³¹
- *United Nations Convention on the Rights of Persons with Disabilities 2007* (UNCRPD)³²
- *United Nations Convention of the Rights of the Child 1989* (UNCROC)³³.

70. DHHS also issues, and is responsible for, policies relating to Child Protection and Disability Services in Victoria, with which departmental staff and Autism Plus (in accordance with the Disability Act and its Service Agreement³⁴) are required to comply.

71. The investigation examined the following policies:

- DHHS, *Children, Youth and Families and Disability Services Operating Framework supporting integrated practice*, November 2012 (Operating Framework)
- DHHS, *Child Protection Manual*, 1 December 2015 (CP Manual)
- DHHS, *Responding to allegations of physical or sexual assault*, 2014 (DHHS assault policy)
- DHHS, *Critical client incident management instruction*, Technical update April 2014 (Incident reporting policy)
- DHHS, *Positive solutions in practice: clinical risk assessment and risk management in people with an intellectual disability*, October 2009 (Risk management guide)
- DHHS, *Human services standards evidence guide*, September 2015 (Human services standards)
- DHHS, *Looking After Children* (LAC) practice guides, 3 July 2013
- Disability Act 2006 guide for service providers, September 2006
- Autism Plus, *Staff handbook disability support services*, 20 January 2015
- Autism Plus, *Investigation policy and procedure*, undated (Investigation policy).

31 *Charter of Human Rights and Responsibilities Act 2006* section 17(2).

32 *United Nations Convention on the Rights of Person with Disabilities 2006* < <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>>, viewed on 21 October 2016.

33 *United Nations Convention on the Rights of the Child 1989* <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>, viewed on 21 October 2016.

34 Autism Plus Service Agreement.

Investigation

72. This section of the report will consider whether:
- Autism Plus failed to appropriately manage the behaviour of Edward at Smith Street, resulting in his allegedly sexually assaulting co-resident Robert
 - Disability Services and Child Protection provided adequate care, management and protection of Edward to prevent harm to Edward and other residents
 - DHHS, as regulator and funder, adequately monitored Autism Plus.

Edward's background

73. Edward was diagnosed with multiple disabilities during childhood including a moderate intellectual disability (IQ of 42), Attention Deficit Hyperactivity Disorder, Oppositional Defiance Disorder and Compulsive Neurological Deficits. Psychologist A, who was engaged by DHHS to work with Edward in 2011, described Edward as a 'low relative functioning individual who presents as significantly higher functioning than he is' who is 'opportunistic... very compulsive and impulsive' and presents with a 'high level sex drive'.
74. In early 2010 at age 13, following violent disputes between Edward and his parents, Child Protection determined that Edward was at significant risk of harm in his parents' care. He was placed into out of home care by DHHS and became subject to Children's Court orders. He resided in a series of contingency (emergency) placements initially funded through Child Protection and then in disability group homes, primarily Autism Plus, where he resided from 2011 to 2015. Edward resided at Smith Street from 1 April 2014 to 21 April 2015.

75. Edward has an extensive pattern and history of reported assaultive behaviours (see Tables 1 and 2 in the Appendix). Edward's DHHS and placement records indicate that he targets persons he perceives are weaker than him.³⁵
76. Robert, who has Autism, cognitive deficits and is non-verbal, moved into Smith Street on 12 July 2014 (three months after Edward).
77. As at 31 October 2014, Edward was 17 and Robert was 20 years old.

Key incidents

78. From 2011 to October 2014, Edward was reportedly involved in around 30 alleged incidents of physical assaults, sexual assaults and behaviour, and property damage - see Table 1 in the Appendix.
79. The investigation focused on Edward's care, management and the oversight by DHHS from October 2014 to April 2015. During this time a series of sexual assaults were reportedly perpetrated by Edward on Robert at Smith Street - see Table 2 in the Appendix. Key incidents 1, 2 and 3 (detailed below) occurred while Edward was a Child Protection client; Edward was also a Disability Services client at the time of each incident.

³⁵ Team Manager Child Protection, CRIS Child Protection closure summary, 2 January 2015, completed 22 January 2015; Email communication from Case Manager Disability Services to IFS Manager DHHS, Team Leader Disability Services and Officer Disability Services regarding Psychologist A's opinion, 16 December 2014; and Behavioural Support Plan, 30 October 2013.

Incident 1

On 31 October 2014, an Autism Plus Disability Support Worker (DSW) completed an incident report,³⁶ which stated the worker had observed Edward sexually assaulting Robert. This report was not categorised correctly or submitted to DHHS.

Incident 2

On 11 November 2014, Autism Plus submitted a Category One incident report,³⁷ which stated that, during a counselling session with his psychologist on 11 November 2014, Edward disclosed that on two separate occasions, including 31 October 2014, he had sexually assaulted Robert.

This incident report also stated that Case Manager Disability Services and Psychologist A 'were advised on Thursday 6 November 2014 of three incidents that occurred during the period of 31 October - 3 November 2014, one of the incidents involved sexualised behaviour'. It is assumed that the 'sexualised behaviour' incident is key incident 1; however, the only incident report recorded by DHHS from Autism Plus during this period was key incident 2, dated 11 November 2014 (see Table 2 in the Appendix).

Incident 3

On 10 December 2014, Autism Plus submitted a Category Two incident report³⁸ which stated that on 9 December 2014, Edward had been restrained by two staff when he allegedly attempted to sexually assault Robert.

Incident 4

On 25 January 2015, Autism Plus submitted a Category Two incident report³⁹ which stated Edward had made verbal threats to stab Robert and his parents.

Incident 5

On 16 April 2015, Autism Plus submitted an incident report⁴⁰ (with no category nominated) which summarised an incident on 14 April 2015 when Edward allegedly threatened the lone night staff member with a knife.

Incident 6

On 17 April 2015, Autism Plus submitted a Category Two incident report,⁴¹ which reported Edward had assaulted Robert by holding his top and ripping it.

Incident 7

On 19 April 2015, Autism Plus submitted a Category Two incident report⁴² which detailed an alleged attempted assault of the lone night staff member by Edward and an unwitnessed incident in the toilet between Edward and Robert, after the staff member took refuge and called police for help.

Incident 8

On 21 April 2015, Autism Plus submitted a Category One incident report⁴³ which summarised a disclosure Edward had made the previous evening during a counselling session with Psychologist A. House Manager Smith Street was also present during most of the counselling session. Edward disclosed that he raped Robert in the toilet on 18 April 2015 (see previous incident).

36 DSW, Incident Report, 31 October 2014, no category was selected on this incident report and it was not submitted as a sexual assault report to DHHS. Autism Plus email communications showed this was incorrectly categorised internally as Category Three and not formally submitted to DHHS. Category Three reports are not submitted to DHHS for follow-up.

37 Area Manager Autism Plus, Incident Report, 11 November 2014, submitted 12 November 2014.

38 DSW, Incident Report, 9 December 2014.

39 DSW, Incident Report, 25 January 2015.

40 DSW, Incident Report, 14 April 2015.

41 House Manager Smith Street, Incident Report, 17 April 2015.

42 DSW, Incident Report, 18 April 2015.

43 Regional Manager Autism Plus, Incident Report, 20 April 2015. This incident report was submitted by Autism Plus as 'Behaviour - Sexual' and was amended to 'Sexual Assault - rape' by DHHS.

Placement decisions

80. Edward was subject to Children’s Court orders placing him in Child Protection’s custody from 30 September 2010 until 18 November 2014. Following the first reported sexual assaults of Robert in October 2014, Edward’s placement was scrutinised by Autism Plus and DHHS and significant changes occurred.
81. On 19 November 2013, Edward’s CTSO was extended by the Children’s Court until 10 March 2015. This order enabled Child Protection to make placement decisions for Edward pursuant to sections 173 and 174 of the CYFA, which necessitated that Edward’s best interests be the paramount consideration for Child Protection when making placement decisions and that they also have regard to his treatment needs. Section 10 of the CYFA explains that when determining if an action is in a child’s best interests, the most important considerations are the need to protect the child from harm, protect their rights and promote their development.
82. The Child Protection Manual⁴⁴ provides guidance to practitioners on all aspects of their role, including resources on applying the best interests case practice model.

44 DHHS 1 December 2015 < <http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/case-planning/case-planning> > viewed on 25 July 2016. The manual was updated on 1 December 2015 making standards and requirements from the old manual mandatory tasks.

Key incidents 1 and 2

Key incident 1: 31 October 2014

From Autism Plus’s incident report:⁴⁵

‘...[DSW] saw that [Edward] was lying on top of that resident [Robert], both were lying on the bed fully clothed, [Edward] was moving his crutch up and down on [Robert]. [DSW] said, “[Edward] what are you doing?” [Edward] immediately got off of [Robert] and said “I am cuddling him”. As [Edward] stood up [DSW] observed that [Edward] was aroused. [DSW] asked [Edward] whether [Robert] had invited him into his room and [Edward] said “**NO**” [original emphasis]. [DSW] asked [Edward] if [Robert] had told him he could lie on top of him and [Edward] said, “**NO**” [original emphasis].’

Key incident 2: 11 November 2014

From Autism Plus’s incident report:

‘During a counselling session with [Edward] on 11 November 2014...[Edward] told [Psychologist A] that he had, on two separate occasions [including 31 October 2014]...waited until [Robert] had gone to his room and that staff were preoccupied...without asking [Edward]... got on top of him and began gyrating himself up and down on him and called it “humping” stated he “raped” him... stated they both had their clothes on and that he had...ejaculated in his clothing.’

The Area Manager Autism Plus stated on the incident report that he had spoken with Edward about his disclosures the following day. He wrote ‘[Edward] stated he knew what he was doing was wrong and that staff had previously told him not to go into other residents’ rooms. Stated he had gone into [Robert’s] room to have sex.’

45 DSW, Incident Report, 31 October 2014 (not submitted to DHHS until 11 November 2014).

13 November 2014: Disability Services' concerns about placement

83. Following Edward's alleged sexual assaults on Robert in October 2014, IFS Manager DHHS (with responsibilities including case management in Disability Services), wrote to Disability Services and Local Connections staff:

This is a really concerning incident which leads to question funding & supports to Autism Plus? I understand that [Edward] has 1:1 support...(and so are [sic] other residents - there are 4 staff, were they all busy?)

I think this needs further investigation, as well as questions about room locks. I have no confidence that the follow up actions will occur given these actions [such as 1:1 supervision] were already in place prior.

18 November 2014: Child Protection allows Edward's CTSO to lapse

84. Edward's CTSO directed the Secretary to review Edward's CTSO before the end of 12 months (or it would lapse on 18 November 2014), pursuant to section 298(1) of the CYFA. Child Protection was required to send a written notification to the Court if it assessed it was in Edward's best interests for the CTSO to continue until his 18th birthday in March 2015. Child Protection did not notify the Court and consequently, the order lapsed on 18 November 2014.

85. Although there is no review of the CTSO recorded by DHHS on Edward's CRIS file before it lapsed, the Team Manager Child Protection stated at interview that the decision to allow the CTSO to lapse was deliberate and she had discussed this with the then Area Manager Child Protection. The Team Manager Child Protection said the Area Manager Child Protection agreed that, despite the issues raised in the incident reports,

the concerns at the placement were being addressed, DCS [Disability Services] had a program they were going to refer [Edward] to support with the sexual behaviour and it was determined that the role for Child Protection was very minimal.

86. In her response to the draft report on 28 April 2017, the Team Manager Child Protection stated:

At the time the CTSO lapsed, I believed that Disability Services would facilitate [Edward] participating in the programs as had been agreed, and that these were adequate referrals to address [Edward's] assaultive behaviours that had been identified in the [two] incident reports to date...

I considered that the decision to allow the CTSO to lapse remained the correct decision, notwithstanding that I was aware that there had been an incident report in the preceding few weeks, and there was no firm placement option for [Edward] after reaching 18 years of age...

87. The Team Manager Child Protection also stated that 'It was agreed...that Disability Services would have responsibility for sourcing an alternative placement'. She further stated:

I would not ordinarily raise a plan to lapse a protection order with my Area Manager. However, given the incident reports that had occurred in the few weeks immediately prior to the CTSO lapsing, I discussed the case with my Area Manager...[who] agreed with the decision...

The purpose for initially seeking the protection order is relevant to any decision to allow a protection order to lapse...[in Edward's case] the identified protective concerns that led to the court making a protection order [in 2010] were no longer in play [and Edward] was supported by other agencies, including Disability Services...

The decision to allow [Edward's] CTSO to lapse was not made in a vacuum where [Edward] was the only client with complex needs...unlike many other Child Protection clients, he had a comprehensive care team in place.

88. At interview, the Area Manager Child Protection said she 'did not recall' details of Edward's case; and DHHS records show that she did not record any consultations, assessments or meeting notes on CRIS about this matter. In response to the draft report on 30 April 2017, the Area Manager Child Protection, who no longer works at DHHS and therefore does not have access to client records, explained:

I have no recollection of the consultation [with the Team Manager Child Protection]...case planning responsibility, CRIS completion of case closures and the final closure sign off is the responsibility of team managers. My focus as the Area Manager was the overall client numbers, adherence to phases, timelines and KPIs. It is not possible to recall detail from a matter, which occurred almost three years ago, where [Edward] was one of over 730 clients in my area and one of 200 awaiting allocation.

89. Further, in her response to the draft report, the Area Manager Child Protection stated she was not aware in late November 2014 that Edward's order had been allowed to lapse:

The extract from the Email Alert [endorsed by the Deputy Secretary on 26 November 2014] includes a statement 'Child Protection will not remain involved with [Edward] post his 18th birthday on March 11 2015. IFS is providing case management to [Edward] and will assume primary case management responsibility once Child Protection ceases involvement'. This statement illustrates the intention of Child Protection to remain involved until his 18th birthday.

If I as the author had known that [Edward's] order was no longer valid at the time of writing the Email Alert, I would have included that information.

90. In her response, the Area Manager Child Protection acknowledged that Edward's CTSO had lapsed when accommodation decisions were made in December 2014:

[Edward] was not subject to a CTSO in December 2014. However he continued to be a Child Protection client until his case was closed off in CRIS.

91. On behalf of Autism Plus, Director 1 responded to the draft report on 12 May 2017 and said:

Autism Plus had not been informed that [Edward's] order had lapsed on the 18th November 2014.

Had we known that [Edward's] order had lapsed...[Edward] would have been relocated in December therefore eliminating the risk to [Robert].

92. It is noted that the Team Manager Child Protection provided evidence that Autism Plus was advised that the order had lapsed (see 'Statutory case planning' section) and that Autism Plus did not have any legal authority to move Edward without a guardian's consent.

November 2014: Updates to DHHS staff

93. On an unknown date in November 2014, the Area Manager Child Protection prepared the Email Alert⁴⁶ for incident report one. This alert was endorsed by the Deputy Secretary on 26 November 2014 and stated in summary:
- Disability Services had identified concerns with Autism Plus's incident reporting, including timeliness and categorisation.
 - A Quality of Care review under the CYFA could not be done as Autism Plus was only funded for Disability Services clients; and Quality of Support reviews for Disability Services clients are limited to staff to client assaults.
 - Psychologist A had informed Disability Services 'that she will provide a detailed written report, including recommendations for risk management and behavioural support within the next fortnight'.⁴⁷
 - DHHS 'reinforced the requirement that [Edward] and [Robert] be provided with 1:1 support as per funding agreement. This must include line of sight monitoring at all times'.
 - Child Protection would not remain involved with Edward post March 2015.

94. On 28 November 2014, the Team Leader Disability Services, provided an email update⁴⁸ to Disability Services and Child Protection managers stating:
- Autism Plus had implemented 'line of sight' and more night monitoring
 - Autism Plus was sourcing a quote for door sensors and locks
 - the Vacancy Management Unit (VMU) within Disability Services was 'continuing to scope [Edward] for an appropriate placement'
 - Disability Services was referring Edward for assessment and intervention at the Australian Community Service Organisation Problematic Sexualised Behaviour Program (ACSO intervention).
95. The Team Leader Disability Services' email update substantially informed an Information Update on incident report one, endorsed by the Deputy Secretary on 2 January 2015. In response to the draft report, the Area Manager Child Protection said that she had 'made a recommendation of a Quality of Support review to the Acting Deputy Secretary and to the Deputy Secretary' in this Information Update. The Area Manager Child Protection noted that a review occurred 'some ten months after the original Cat 1 Incident Report'.

46 Area Manager Child Protection, Email Alert, endorsed by Deputy Secretary 26 November 2014.

47 No documents or witness testimony has been provided by DHHS to support this statement made by Psychologist A.

48 Team Leader Disability Services, Email update to Area Manager Child Protection, copied to Team Manager Child Protection, Deputy Area Manager Child Protection, and Officer Disability Services, 28 November 2014.

96. In response to the draft report, the Area Manager Child Protection also noted her role was with respect to Edward only and she had 'no role, accountability or decision-making at East Division DCS [where Robert was case managed as a client] or Local Connections'; and that Robert's Division's 'plans and strategies...were unknown at the time of the incident in November 2014'. The Area Manager Child Protection also explained that she kept her line managers 'aware of the issues in relation to [Edward] and Autism Plus' and understood that 'their counterparts in DCS and Local Connections brought the issues in relation to Autism Plus to their attention'.

4 December 2014: Meeting with Autism Plus

97. On 4 December 2014, the IFS Manager DHHS, Area Manager Child Protection and Local Connections Officer⁴⁹ met with Autism Plus's Director 1 and Senior Manager to discuss Edward's placement in the context of the alleged sexual assaults of Robert, reported in incident report one. The DHHS meeting record states in summary:

- Director 1 Autism Plus thought the alleged sexual assaults should be Category Three (which are not reported to or managed by DHHS)
- DHHS raised concerns about Autism Plus's incident reporting practices and understanding of sexual abuse; and Director 1 Autism Plus accepted there were 'gaps' in training
- Door locks and alarms had been installed without approval from DHHS for use of restrictive interventions – Autism Plus agreed to obtain approval
- Director 1 Autism Plus stated staff are pooled to work with all clients, even those funded for 1:1 care but then agreed she understood Edward needed 'line of sight' monitoring.

98. At a subsequent meeting on 4 December 2014 without Autism Plus, DHHS staff discussed Autism Plus's perceived lack of preparation for the meeting; lack of clarity around client supervision; and that a Quality of Support review should occur if endorsed by the Deputy Secretary.

99. In her response to the draft report on behalf of Autism Plus, Director 1 stated:

DHHS's concerns were not justified.

Autism Plus had several conversations with DHHS re: possible safety and security measures.

Autism Plus has expertise in managing clients with autism and complex behaviours. The expertise required by our staff to manage the level of sexualised behaviours exhibited by [Edward] was above and beyond our normal training... requests for support funding were denied.

[Incident reporting:] Autism Plus acknowledged that there was one, not several, sexual assaults that was incorrectly categorised by senior management. This was addressed and resubmitted.

[Pooling staff:] As our clients had significant complex needs in most cases the support would be on a 1 staff to 1 client. The comment about pooling staff [made at the meeting on 4 December 2014] relates to the staff's ability to undertake the required household, independent living tasks. We do not receive additional funding to cook, clean, do laundry... if a client does not want to participate the staff are required to complete the task independently whilst the remaining staff would supervise the clients.

[Client matching:] DHHS' statement presents a false premise. All Autism Plus referrals came from Senior Case Managers... the client had been through the vacancy coordination process and scoped for a respite bed unsuccessfully before Autism Plus was approached. Before placement of any client Autism Plus worked closely with case managers and the client's family in looking at compatibility, support needs, family wishes etc.

49 DHHS, North Division and Autism Plus incident report meeting, 4 December 2014.

100. Director 1 also commented on the purpose and conduct of the meeting with DHHS:

It was extremely frustrating that the individual regions [of DHHS] were not working together and looking at the complexities of the situation at the site as a whole. Autism Plus expressed these concerns. Our expectation of the meeting was to resolve the issue of 'lead region' which would facilitate decisions being made with the interest of all clients...our priority was client safety...this was not the intent of the DHHS people...the meeting began with an unexpected ambush on Autism Plus.

101. The Senior Manager Autism Plus concurred with Director 1's comments about the pooling of staff in his response to the draft report on 11 May 2017. He also stated that at a meeting Autism Plus attended with DHHS on 16 December 2014, the Southern region erroneously alleged Autism Plus had failed to submit 10 incident reports, which:

...was the start of a premeditated and deceitful attack on Autism Plus designed to pass blame and accountability.

Key incident 3

Key incident 3: 9 December 2014

From Autism Plus's incident report:⁵⁰

'As [Edward] walked towards the bathroom [he] ran past [DSW A who] pursued after [Edward] and called out to [DSW B who] was sitting in the lounge room with resident [Robert]...[Edward] ran towards [DSW B] who was standing between [Robert and Edward. Edward] yelled "I want to hump him!" and tried to push past [DSW B. The staff] were able to restrain [Edward] using a two man escort...[Edward] said...that he had done this because he felt "horny"'.

10 December 2014: Complaint from Robert's family after another alleged attempted sexual assault on 9 December 2014

102. Robert's father emailed a complaint to DHHS that asked for Edward to be moved from Smith Street and stated:

As [Robert's] parents we continue to be horrified at the sexual attacks on him and the fact that this predator is still allowed to remain in the house. But for the vigilance of the carers working last night there would have been a third attack on him. I can't think of any other situation where a repeat sexual offender would be allowed to stay in close proximity to his victim...the rights of disabled people need to be protected...he [Edward] should be removed from the facility.

50 DSW, Incident Report, 9 December 2014.

103. Later on 10 December 2014, the Case Manager Disability Services emailed Disability Services staff⁵¹ (including the IFS Manager DHHS and Team Leader Disability Services) a summary of a telephone call she conducted with the Area Manager Autism Plus:

After discussions with, and upon direction from [the Team Leader Disability Services] I phoned [the Area Manager Autism Plus] back and informed him that DCS strongly advise against moving [Edward] today, that the people responsible for [Edward] need to make decisions...as [Edward] is in out of home care and his father has signed a voluntary agreement, that the decision to move [Edward] should be collaborative and involve Child Protection and [Edward's] father to determine what's in [Edward's] best interests...[The Area Manager Autism Plus] said that they must ensure that the safety of the other residents are protected...we respectfully expect that the risks can be managed in the interim...I provided [the Area Manager Autism Plus] with [the Team Leader Disability Services'] number and [the Team Manager Child Protection's] number.

104. In response to the draft report on 21 April 2017, the Team Leader Disability Services stated that her manager, the IFS Manager DHHS, 'directed me that the department had made a decision against moving' Edward. The Team Leader Disability Services stated she believed the reasons for her manager's decision were because:

- DHHS was funding Autism Plus to provide 'one-to-one 24 hours support' to Edward
- Edward was one of the 'very first residents' at Smith Street therefore Autism Plus was responsible to ensure any subsequent clients were appropriately matched
- there were no other suitable accommodation options.

105. While a 'direction' from the IFS Manager DHHS may have occurred after 10 December 2014, the Team Leader Disability Services' response did not acknowledge her own direction to the Case Manager Disability Services detailed in an email⁵² later provided by the IFS Manager at interview on 5 May 2017.

106. This email was not saved on Edward's CRIS file. In this email sent on 10 December 2014 to both the IFS Manager DHHS and the Area Manager Child Protection, the Team Leader Disability Services stated that the Case Manager Disability Services had attended a care team meeting that morning and 'Autism Plus declared at the meeting that his management have decided that [Edward] will be removed from [Smith Street]' today. The Team Leader Disability Services reported that she had:

asked [the Case Manager Disability Services] to call [the Area Manager Autism Plus] and explain to him that we disagreed with their decision to move him today and that we need some time to have conversations with CP, [Edward's] father and some time to explore alternative options closer to [Edward's] school before moving him.

107. Further, the Team Leader Disability Services stated⁵³ that Edward had been deemed 'unsuitable' by the Vacancy Management Unit (VMU) for the only two long term placement options he had been 'scoped for' and that the VMU had 'nothing concrete to explore at the moment'. The email included a copy of the incident report of the alleged attempted sexual assault by Edward of Robert the previous evening and the comment, 'I don't know what alternatives we have at this stage however I believe that moving him today is not a good option'.

51 Case Manager Disability Services, CRIS Case note containing emails to Disability Services staff, 10 December 2014.

52 Email communication from Team Leader Disability Services to IFS Manager DHHS and Area Manager Child Protection, 10 December 2014.

53 *ibid.*

108. In her response to the draft report, the IFS Manager DHHS did not accept responsibility for making any placement decisions for Edward at any time. Her legal representative stated on her behalf on 7 April 2017:

The only direction referred to in any records that [the IFS Manager DHHS] is aware of, is the direction given by [the Team Leader Disability Services] on 10 December 2014.

When asked at interview 'specifically what happened on 10 December' and what instruction or conversation subsequently occurred with the Team Leader Disability Services, the IFS Manager DHHS responded, 'I don't recall'.

11 December 2014: Autism Plus asks DHHS to immediately move Edward and offers an alternative placement

109. Director 1 Autism Plus emailed the Local Connections Officer a complaint from Robert's father and asked that Edward be moved immediately:

Autism Plus fully agrees with [Robert's] father. Whilst [Edward] remains within the service he presents a significant and ongoing risk in particular to [Robert] as well as to the other clients. [Edward] must be removed from the setting. I would like it recorded that Autism Plus does not believe this is an acceptable risk.

Autism Plus has offered [yesterday] an appropriate alternative short term accommodation option...[Edward] would continue to be supported 1:1 with his existing known staff. [Edward] would be the only client within this facility...we are in a position to facilitate his move immediately...

We have been advised by Child Protection that currently [Edward] is not to move...this decision Autism Plus strongly disagrees with

110. In response to the draft report on 21 April 2017, the Local Connections Officer's legal representatives said that she 'did not have the power to make decisions about [Edward's] placement'. She said she escalated the request to her immediate supervisors, as well as the Team Leader Disability Services and the IFS Manager DHHS who were 'not [the Local Connections Officer's] immediate superiors, but were empowered to make client placement decisions'.

12 December 2014: Meeting between Autism Plus and DHHS at which Autism Plus agrees for Edward to stay

111. Witness and documentary evidence indicates that, at a meeting between Autism Plus and DHHS on 12 December 2014, DHHS instructed Autism Plus to keep Edward at Smith Street. There are no minutes or official record of this meeting. The IFS Manager DHHS provided handwritten notes at interview; however, these did not contain any details of the decisions made at this meeting.

112. It was disputed by the parties in attendance at this meeting if the Area Manager Child Protection and the IFS Manager DHHS gave an explicit direction to Autism Plus for Edward to remain at Smith Street, or if the outcome that Edward remain was reached by consensus.

113. The IFS Manager's notes indicate that Autism Plus proposed three alternative options at the meeting: two solo placements for Edward in homes that were not fire compliant and a placement with two other DHHS clients from other regions. In response to the draft report, Director 1 Autism Plus stated that Autism Plus 'put forward that we would put in an active night eliminating any possible objections relating to fire compliance' at the alternative placements and that 'all of [Edward's] community access programs would continue with his known staff'. The IFS Manager stated 'each one [option]... had issues...so they weren't options' and said she was 'probably' the officer who informed Autism Plus at the meeting that the options were unsuitable.

114. Following the meeting, Director 1 Autism Plus emailed the Local Connections Officer, within the context of her role as liaison officer, confirming the 'instruction' from DHHS. Director 1 Autism Plus stated:

We have met DHS this morning...we have been advised not to move [Edward] as he is currently being effectively supported and monitored...although we agree that a move would have some negative impacts on [Edward] we believe the safety of the other clients should have been the first priority. DHS did not agree.

As we have been instructed to maintain [Edward] there were a number of additional supports and safety measures we agreed to.⁵⁴

115. At interview on 6 December 2016, Director 1 Autism Plus stated that she still felt other clients were at risk when she 'agreed' to keep Edward at Smith Street, but she was 'under duress':

...the inference behind what was said [by DHHS] with the 'if we move him' was fairly strong...I interpreted legal repercussions, financial repercussions with funding, referrals but none of that was said.

116. Director 1 Autism Plus's statement at interview that she considered the risk still 'too great' after meeting with DHHS, is inconsistent with the Senior Manager Autism Plus's email⁵⁵ to Director 1 Autism Plus, Disability Services and Child Protection later on 12 December 2014:

On initial assessment Autism Plus was of the opinion...that it would be in the best interests of [Robert] if [Edward] was removed...DHS acknowledged that the handling of the incident that occurred on Tuesday the 9th of December 2014 was evidence of the current supports... working to ensure [Robert's] safety...it was openly discussed that this type of restraint [two-person restraint used on 9 December] would more than likely be needed again...

Autism Plus are confident with the additional measures we can minimise the risk to all residents.

54 Email communication from Director 1 Autism Plus to Local Connections Officer, 12 December 2014.

55 CRIS Case note containing email communication from Senior Manager Autism Plus to Case Manager Disability Services, 12 December 2014, contained agreed actions from the 12 December 2014 meeting.

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117. The Senior Manager Autism Plus responded to the draft report:
- ...this is a false perception of the email. The intent of the email was to record and document the meeting and to adjust the facts of the meeting...it was clear DHHS were going out of their way to pin blame on Autism Plus.
118. In her response to the draft report on behalf of Autism Plus, Director 1 stated:
- Moving [Edward] was considered and raised as a concern by Autism Plus at a meeting on 12 December 2014...[Edward's DHHS region]...gave little consideration of the consequences to [Robert] and his family in their decisions...[Robert's DHHS region] strongly advocated, as did Autism Plus, with support from VALID, the Disability Commissioner, Victoria Police and the Community Visitors that the 'perpetrator' should be moved, not the victim. Regardless of all the advocates listed above, Child Protection mandated that [Edward] remain at [Smith Street]. This was not 'agreed to' as our hands were tied. We were advised by Child Protection that we had no legal or legislative authority to relocate [Edward].
- [The IFS Manager DHHS] and Child Protection directed Autism Plus to maintain [Edward's] placement under the same funding conditions regardless of his escalated sexualised and assaultive behaviours. At this point there were no changes to supports provided to Autism Plus to mitigate the risk...
119. After the meeting, Director 1 asked DHHS to fund a 'sensor security system' for \$3,636.50 and an Ethical Response Training course for 10 staff for \$2,250 so that Autism Plus could be 'fully aware of their legal and ethical responses' if attempting to physically restrain Edward⁵⁶. Whilst Director 1 reported that these requests were declined by DHHS, the security system was funded by Robert's DHHS division⁵⁷, after Edward's declined to do so.⁵⁸ In an email from the Local Connections Officer to Director 1, in which Edward's DHHS division's decision not to fund the security system was communicated, the Local Connections Officer also advised that (per her manager) 'training to staff is not something the department would pay for, this would need to be covered by Autism Plus'. She also referred Director 1 to seek funding for a risk assessment directly from Edward's DHHS case management team, with whom she stated she had spoken. In her response to the draft report, the Local Connections Officer's legal representative clarified that she sent this communication 'according to her duties as liaison officer' and that she had 'no power to make funding allocation decisions'.
120. Autism Plus subsequently self-funded Positive Behaviour Management training for some of its staff in January 2015 and Director 1 said, in response to the draft report, Autism Plus had subsequently made this training 'mandatory' for staff.

56 Email communication from Director 1 Autism Plus to Local Connections Officer, 12 December 2014.

57 Email communication from Officer Disability Services to Director 1 Autism Plus, 28 January 2015.

58 Email communication from Local Connections Officer to Director 1 Autism Plus, 12 January 2015.

121. In her response to the draft report, the Area Manager Child Protection confirmed that placement decisions had been made at this meeting but that 'it was not a decision made by [the IFS Manager DHHS] or me either solely or to the exclusion of other information'. She said:

The decision [for Edward to remain at Smith Street] was made during a meeting and in consultation with Autism Plus managers present and DCS staff. As noted in the [Information Update] endorsed by the Deputy Secretary on 2 January 2015 'the meeting resulted in an agreement with Autism Plus that the proposed move was not in [Edward's] best interests or in line with his behavioural support plan'.

Any decision was made in consultation with those present at the time and in consideration of [Edward's] best interests and with agreed actions including a review of [Edward's] Behaviour Support Plan, assistance to Autism Plus by the Behavioural Intervention Support Team (BIST) to provide strategies to anticipate and respond to [Edward's] behaviour, swap of residents' rooms to provide increased monitoring and collaboration with Victoria Police in responding to [Edward's] disruptive behaviour' (Email Alert Update 1 endorsed by Deputy Secretary 2/1/2015). Furthermore, 'On 27 November 2014 the Autism Plus Area Manager advised [the division] that [Edward] was subject to line of sight monitoring since 31 October 2014'...

The [Information Update] clearly indicates that a decision had been made for [Edward] to move out of the [Smith Street] location...and that the department embarked on a process to identify possible units and match his needs...

122. On her behalf, the IFS Manager DHHS's legal representative stated in response to the draft report that she 'strongly denies making any such decision' and that she 'did not have statutory power to make such a decision' for Edward to remain at Smith Street. At interview, the IFS Manager stated:

From my perspective, the only person that could make that decision was actually Child Protection at that time.

123. When reminded by investigation officers that the CTSO had lapsed in November, she responded:

I think the understanding was that the order was still in force.

124. The IFS Manager's evidence is inconsistent with:

- Evidence from the Case Manager Disability Services interview on 24 October 2016 that 'to the best of [her] knowledge, the direction for [Edward] to remain at [Smith Street] came from [the IFS Manager DHHS] and that:

I recall a couple of times sitting in meetings with [the Senior Manager Autism Plus and Director 1 Autism Plus] and they said they felt that [Edward] needed to reside outside of Autism Plus. I recall [the IFS Manager DHHS] saying a couple of times 'We believe this placement [Smith Street] is the best support option at this time'.

- Evidence from the Team Leader Disability Services that the IFS Manager DHHS 'directed me that the department had made a decision against moving' Edward and the Team Leader Disability Services' email to the IFS Manager and the Area Manager Child Protection on 10 December 2014 about the placement issues.⁵⁹

⁵⁹ Email communication from Team Leader Disability Services to IFS Manager DHHS and Area Manager Child Protection, 10 December 2014.

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- The Local Connections Officer's response to the draft report, which stated:

[The Team Leader Disability Services] and [the IFS Manager DHHS]...were empowered to make client placement decisions.

- Autism Plus's response to the draft report, in which Director 1 stated '[the IFS Manager DHHS]...was one of the decision makers in meetings where [Edward's] placement was discussed and reviewed'.

125. When asked at interview to explain her role at the 12 December meeting, the IFS Manager DHHS stated:

Those decisions [placement] don't actually sit with me...I would need to leave the meeting and I would need to speak to my Area Director, I'd need to seek approval... [including] from our Deputy Secretary because it would mean canvassing unfunded services...we were already... putting [Edward] up for appropriate services...someone with [Edward's] profile becomes difficult to match...

I don't believe a decision was made at the meeting to move or not move... I guess from my perspective I was there to seek some understanding of what was required by Autism Plus...how we could bolster the supports.

126. The IFS Manager DHHS said she could not recall if she supported the Area Manager Child Protection's purported decision for Edward to remain at Smith Street on 12 December 2014. When asked what view she presented to the Area Manager Child Protection at the meeting, she responded, 'I can't tell you that'.

127. In response to Director 1 Autism Plus's statement that she was 'under duress', the IFS Manager DHHS responded to the draft report stating that she made 'no threats of a legal, financial or any other nature' to Director 1. She stated:

When [Director 1 Autism Plus and Senior Manager Autism Plus] requested that [Edward] be moved, they appeared to be assuming that if [Edward] were relocated to another Autism Plus facility they would continue to receive DHHS funding. As the implications of [Edward] being a contingency client were discussed, Director 1 Autism Plus came to the understanding that Autism Plus may not continue to receive funding for [Edward's] placement. Any "financial or legal repercussions" would simply have been a consequence of [Edward's] status as a young person in contingency accommodation.

128. The IFS Manager also stated:

I guess from my perspective, there were things that we were doing that I felt could mitigate some of the risks...there was no delay in our actions...we're doing the best we can with the resources that we've got...

In terms of [Edward], truth be known, if we had another option I wouldn't have wanted him there either but I had no other options...I was actively talking to my Area Director about it...I can't recall whether I specifically asked for [another] contingency option...it was certainly something I was reporting and discussing...in the context of a real push to close contingencies.

129. The IFS Manager stated she had consulted with her managers about moving Edward 'many times'.

Figure 1: Email from Senior Manager Autism Plus to Local Connections Officer regarding Community Visitors' concerns

From: [Senior Manager Autism Plus] [mailto: seniormanagerautismplus]
Sent: Monday, 15 December 2014 1:46 PM
To: [Local Connections Officer]
Cc: [Director 1 Autism Plus; Area Manager; Autism Plus Officer; Disability Services Case Manager]

Hi [Local Connections Officer]

Just to give you the heads up we had visit from the Community Visitors on Saturday. From their report. The "major issue" being [Edward's] "predatory behaviour".

"There is a need for a detailed assessment of the situation, including the matter of [Edward] suitability for the house, or locating a more permanent placement for [Edward] – asap".

Obviously we have done this and are doing this including the action resolved from the meeting last Friday.

From all accounts it would be fair to say they had been informed of the [Edward-Robert] incidents and said they attended because a "sexual predator" was living at the house.

I just wanted to advise you of this in case they had any further questions.

Regards
[Senior Manager Autism Plus]

13 December 2014: Community Visitors' Concerns

130. On 13 December 2014, the Community Visitors attended Smith Street and documented the following concerns in their report:⁶⁰

This is an emergency respite house, none of them are permanent...there are a number of issues⁶¹, including one major issue involving an attempted sexual assault by one resident towards another resident...this was very serious and the police were called. There have been other incidents with [Edward]. Both staff and parents are very concerned about [Edward's] predatory behaviour. [Edward] now has one on one 24-hour care. At night a carer sits near his room. The staff wanted to move [Edward] to another facility they have...where he could be more isolated from other residents. At present they are trying to keep him away from the other residents. However, Child Protection Services have not approved the transfer. There is a need for a detailed assessment of this situation, including the suitability of [Edward] for this house or locating a more permanent placement for [Edward]? Asap?

131. On 15 December 2014, the Senior Manager Autism Plus notified DHHS of the visit and the concerns raised about a 'sexual predator' in the house (see Figure 1). Regarding the Community Visitors' recommendation that a detailed assessment be completed urgently, or that Edward be relocated, the Senior Manager wrote 'obviously we have done this and are doing this'.

132. However, CRIS Disability Services and Child Protection case notes, records of meetings detailed in this report and witness testimony from DHHS and Autism Plus staff demonstrate that no risk assessment was completed by Autism Plus or DHHS; questions remained about Edward's supervision; and he was not moved to an alternative placement.

⁶⁰ Community Visitors, Record of visit, 13 December 2014.

⁶¹ Other issues noted by Community Visitors included debris and wiring lying in yards; evacuation pack contained no details of the residents; no incident reports were available to be viewed; mould in the bathroom; and no evidence of a safety assessment being completed.

18 December 2014 – Cross Divisional Meeting about issues with Autism Plus

133. Disability Services and Local Connections (multiple divisions) held an internal meeting⁶² (without Child Protection) to discuss issues at Autism Plus including ‘management structure and senior leadership, contingency properties and incident reporting’. Meeting notes documented the following concerns:

- ‘quality of care in contingency units is often questionable and inconsistent’
- pooling staff to supervise clients in groups is occurring, even if the clients had 1:1 support funding
- the client matching process is undertaken by Autism Plus without involvement of the Disability Services Vacancy Management Unit
- the House Supervisors are often related to the Directors; ‘relatives are investigating relatives in Quality of Support matters’
- houses are not staffed at the expected level, ‘for example 3 funded staff but only one member working on the day DHS attended’
- the quality of information provided can be ‘questionable...management appear to lack insight into what is a serious matter’
- there are a lack of incident reports received by DHHS
- Disability Services is negotiating directly with Autism Plus where houses are not fire compliant.

134. DHHS recommended at the meeting that a Desktop Review of Autism Plus continue and a memo be sent to all DHHS Area Directors detailing the ongoing issues.

135. In response to the draft report, the Local Connections Officer said she drafted a memo⁶³ that was:

In plain language, a recommendation to all Divisional management teams to stop using [Smith Street] and other Autism Plus contingency facilities.

136. However, DHHS advised that the memo was neither finalised nor sent.⁶⁴ The Area Director DHHS, who was the cross-divisional ‘lead for Autism Plus’, stated⁶⁵ that ‘the purpose of the memo was to capture work being undertaken with Autism Plus and to highlight the involvement of metro Areas in this work’ and that she discussed progress and raised issues with other Area Directors at a retreat on 5–6 February 2015, as an alternative to sending the memo. Additionally, she stated:

Communication was ongoing with Area Directors and Local Connections Managers. Communication with Area representatives happened at multiple levels, firstly at the state-wide Local Connections Managers Meetings, via email to Local Connections Managers, review meetings with Autism Plus senior representatives present and the internal cross-divisional pre-meetings. The email below was sent to Local Connections Managers state-wide with explicit instruction regarding the placement of clients. I also reinforced this message with Area Directors.

62 CRIS Case note of Autism Plus Cross Divisional Meeting, dated 18 December 2014.

63 Draft Memorandum prepared by Local Connections Officer, 24 December 2014.

64 Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 31 May 2017.

65 *ibid.*

137. The email⁶⁶ the Area Director DHHS referred to was sent on 31 October 2014 within Local Connections and contained the statement:

We have informed Autism Plus that they are not to actively promote contingency properties to departmental clients or accept any further referrals [original emphasis]

138. Despite this direction, the Local Connections Officer explained in response to the draft report that Autism Plus continued to seek new clients and DHHS continued to place clients in the service's contingency units. On 22 March 2016, one DHHS Division sent an email to the Local Connections Officer about the placement of a client at Autism Plus unrelated to the investigation, which stated:

Whilst I am cognisant of your concerns, we have had to make a decision to pursue the placement because of a lack of reasonable alternatives.

19 December 2014: Senior Practitioner Disability Team visits Smith Street – Risk Assessments and other tasks

139. Between 27 November 2014 and 19 December 2014, the Senior Practitioner Disability Team (SPDT) and the Senior Manager Autism Plus exchanged emails in which the latter asked for help:⁶⁷

...there are a number of issues we have been asked to consult the [SPDT] on... we are supporting a 17 year old male who has [allegedly] sexually assaulted another resident. We have tried to get DHS to move this person to another site and have offered other venues but this offer has been rejected by DHS. DHS are insisting he stay where he is...

Due to the serious concerns regarding behaviour of the young male, it has been suggested that a monitoring system be installed...

The young male has displayed behaviour that consisted of trying to get through staff to sexually assault another client. This has required the use of physical restraint to stop the sexual assault occurring. We have been asked to consult you as to what training might be appropriate in training staff should they need to intervene.

The matter is the highest priority for us. I believe the department secretary has been briefed [Disability Services] are involved. Child Protection have been involved. Community Visitors are involved.

66 Email communication from Local Connections Manager to [the Division] Local Connections, 31 October 2014.

67 Email communication from Senior Manager Autism Plus to Officer SPDT, 15 December 2014.

140. On 19 December 2014, the Senior Practice Officer SPDT met with Autism Plus for the first time and emailed Autism Plus a 'summary of the outcome' of this visit. The agreed outcomes included:

- Robert's family have 'verbally informed Autism Plus that they are very concerned that [Edward] is still residing in the same house as [Robert] and have indicated they may contact the media...we discussed the importance of documenting strategies in place including our duty of care...'
- 'in order to manage the risks associated with [Edward's] behaviour, Autism Plus are going to develop a risk management plan, in collaboration with [Edward's] treating clinician, staff, DCS [Disability Services] and CP [Child Protection], which addresses how staff will respond to the earliest indicators/warning signs to act preventatively in managing risk...both the Safety Plan and Risk Management Plan should be developed as a matter of priority...'
- a recommendation that Autism Plus speak with Psychologist A 'and the rest of the team' about using the Dynamic Risk Assessment and Management System (DRAMS) tool, to 'enable staff to understand and respond to changes in [Edward's] risk'.
- Autism Plus would liaise with Psychologist A and the professionals involved to source a risk assessment for Edward.
- Edward's Behaviour Support Plan to be updated 'to reflect the inappropriate sexualised behaviour to ensure all staff are fully informed of his risks and appropriate strategies to apply'.

141. The Senior Practice Officer SPDT emphasised in the email that the risk assessment:

'is extremely relevant to guide our decision making around effective risk management, service provision, intensity/nature of treatment and which legislative framework would most suit [Edward's] situation'.

142. Notably, DHHS's Email Alert for Key Incident 2, endorsed by the Deputy Secretary on 26 November 2014, stated that within two weeks, Disability Services would obtain the risk assessment directly from Psychologist A. The Team Leader Disability Services' subsequent email update stated Disability Services would also refer Edward to the ACSO Intervention.⁶⁸ Autism Plus made enquiries with DHHS in late December 2014 regarding training on using the DRAMS assessment tool; however, there is no record of either party progressing these enquiries and Autism Plus ultimately did not implement the tool at Smith Street.

143. In response to the draft report, Director 1 Autism Plus said 'DHHS declined to support the advice' of the Senior Practice Officer to utilise the DRAMS.

144. A formal risk assessment should only be administered and interpreted by registered clinicians with expertise in sexual offending, psychopathy and psychometric theory and post graduate qualifications in behavioural or biomedical sciences.⁶⁹ However, there were clinicians and organisations with the capability and experience to conduct an assessment for Edward who routinely accept referrals from DHHS.⁷⁰

68 Team Leader Disability Services, Email update to Area Manager Child Protection, copied to Team Manager Child Protection, Deputy Area Manager Child Protection, and Manager Disability Services, 28 November 2014.

69 The Office of the Senior Practitioner, October 2009 *Positive solutions in practice: clinical risk assessment and risk management in people with an intellectual disability*, viewed 13 July 2016; Vicpsych Plus, 20 August 2009 Info sheet: *Why sex offence risk assessment is important*, viewed 11 November 2016.

70 For example, Vicpsych Plus and Gatehouse.

145. In response to the draft report on 24 May 2017, the Senior Practice Officer SPDT explained that the DRAMS is a risk management tool that could have been used by non-clinical disability support staff at Smith Street and that it is validated for clients like Edward; however, a 'forensic psychologist, who is an expert in the area of assessing risk for persons with an intellectual disability who engage in harmful behaviour, must also be involved'. Additionally, the officer stated, a formal, written risk assessment and DRAMS are:

not mutually exclusive actions...

The DRAMS tool is an appropriate tool used to monitor behaviour over days and weeks so that immediate actions can be put in place in consultation with a clinician

The DRAMS scoring then feeds into a comprehensive structured risk assessment, which is undertaken at least annually.

146. In response to the draft report, the Senior Practice Officer stated that the SPDT 'could not procure either the risk assessment or the [ACSO Intervention]', which had been identified as required by DHHS in response to Key Incident 2. The officer explained that the SPDT:

continued to request that a risk assessment be undertaken in relation to [Edward] for the purposes of assessing legislative requirements for compulsory treatment and/or use of restrictive interventions including on 19 December 2014, 29 January 2015, 19 February 2015

and on two other occasions until September 2015 after Edward had already left Smith Street.

147. Contrary to Disability Services' expressed intentions to obtain a risk assessment and refer to ACSO, the Senior Practice Officer identified Autism Plus as responsible for 'ensuring appropriate client assessments are undertaken for the purposes of using restrictive interventions', which is consistent with the SPDT advice to Autism Plus which appeared to defer responsibility to the agency for some of these tasks.

148. The Case Manager Disability Services, who had initially followed up provision of a formal risk assessment from Psychologist A and then Autism Plus in her role as Case Manager, acknowledged that no specialist risk assessment was completed while Edward was at Smith Street.

149. The Case Manager Disability Services also stated at interview that she was unsure why the referral for the ACSO Intervention was not made by DHHS. In March 2015, she referred Edward to a Family Planning Victoria (FPV) 'education/information program about sexual health, relations and the law'; however, he only attended one session before leaving Smith Street and there is no record of DHHS seeking any feedback from FPV.⁷¹

⁷¹ Interview with Case Manager Disability Services dated 24 October 2016; CRIS Case note of email communication from Case Manager Disability Services to Officer Temporary Staff Agency, 20 May 2015.

Figure 2: Child Protection closure summary

<p>11. REASON FOR CLOSURE</p> <p>12. REFERRAL DESCRIPTION</p>

Figure 3: Child Protection closure summary

<p>17. DIFFERENT PERSPECTIVES</p> <p>No current information available.</p>

150. In relation to the two-week timeframe for the specialist risk assessment on the Email Alert, the Area Manager Child Protection stated this was information provided to her from Disability Services, which it had obtained directly from Edward's psychologist. Importantly, in her response to the draft report, she identified Disability Services as accountable for obtaining the assessment and stated:

It is DCS's role and responsibility to ensure that the appropriate assessments are conducted in line with [Edward's] behavioural support plan, in addition to DCS funding such assessment, any discrepancy as to the viability of this assessment should have been clarified by DCS prior to presenting the information for inclusion in the Email Alert.

January 2015: Child Protection closes case after incident reports

151. The Child Protection Manual states 'it is appropriate to close a case when child protection involvement is either no longer possible, or no longer necessary'.

152. On 2 January 2015, the Team Manager Child Protection recorded a case note stating she had reviewed Edward's Child Protection case:

Following a review of the case and the support afforded to [Edward] through disability services a decision was made not to continue with the CTSO...[Edward] resides in a placement through disability services and this will continue...[Edward] has been involved in inappropriate sexual behaviours however disability services are making referrals to services that can assist... therefore there is no role for CP services. [The Area Manager Child Protection] aware of and in agreement with the decision.

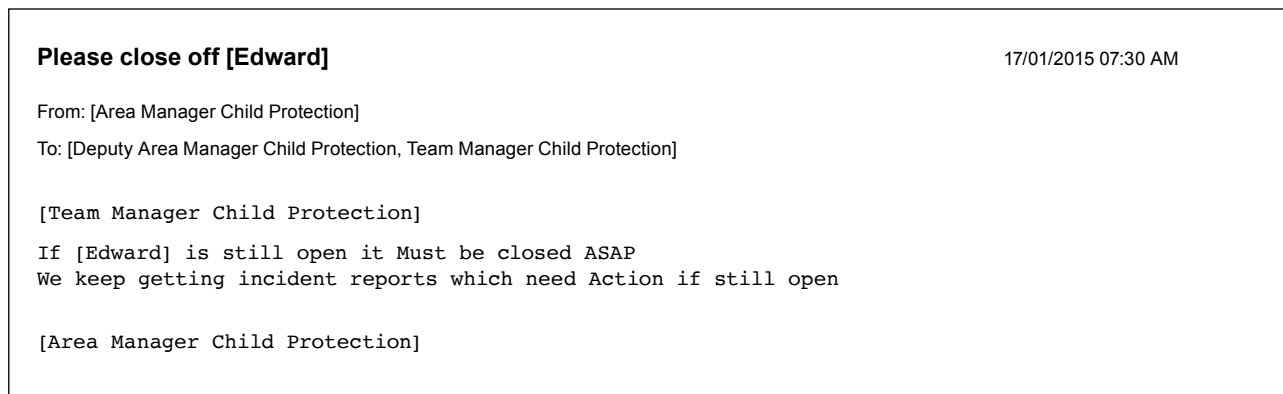
153. The Team Manager Child Protection did not make a statement in the 'safety and wellbeing' section of her case note and did not record a reason for closure in the 'closure summary' or details of any proposed referrals, or their progress, to assess risks posed by Edward or connect him with intervention services such as ACSO (see Figure 2).⁷²

154. Additionally, there were no differing perspectives recorded regarding Child Protection's decision to close⁷³ (see Figure 3).

⁷² Team Manager Child Protection, CRIS Child Protection closure summary dated 2 January 2015, completed 22 January 2015.

⁷³ *ibid.*

Figure 4: Please close off Edward



155. On 17 January 2015, the Area Manager Child Protection sent an email to the Team Manager Child Protection (see Figure 4).

156. When the Area Manager Child Protection was asked at interview whether she had instructed the Team Manager Child Protection to close the case on the basis of the work required to respond to the incident reports, including reports about alleged sexual assaults, the Area Manager said this was not the case. However, she noted the pressure her unit was under to bring case numbers down:

No, I wouldn't have, I don't think that's right. I wouldn't have said close the case because we don't want to be managing sexual assault allegations. I think what is probably missing here is the context of how we were operating at the time. There was a lot of focus on closing cases in a timely way. There was lots of work around having a rationale for why a case would be open for more than five days if it was in the closure phase.

157. In her response to the draft report, the Area Manager Child Protection added:

In an effort to manage the workload I read incident reports during my [recreational] leave...I believe that I sent the email whilst reading incident reports on a Saturday morning...

The email was in line with the closure of cases within the 14 days once in the Closure Phase. I state the phrasing of the email was poor. The focus was to close the case within the prescribed timelines. My email goes more to the pressure of closing cases which had been in closure phase over 14 days. It was not about closing a case as not to respond to incident reports.

158. When asked at interview if the decision to close Edward's case was consistent with the legislation and Child Protection Manual, the Team Manager Child Protection responded:

there was significant Disability involvement that would continue and they were actually able to make the referrals required to address those concerns, including the work with the placement... we still need to progress cases.

159. The investigation also asked what assessment the Team Manager made of the email direction from the Area Manager and if she spoke with the Area Manager or her supervisor, the Deputy Area Manager Child Protection, about the rationale for the closure. The Team Manager responded that she did not conduct any further assessments, 'no...I closed the case'.

160. In her response to the draft report, the Team Manager also added:

I consider that this decision was appropriate in the circumstances...this decision was in accordance with the Child Protection Manual, and followed after consultation with and direction from my Area Manager.

[The email from the Area Manager Child Protection asking for the case to be closed] is presented in the [report] out of context and in a way that suggests it was sent with a particular intent; namely, that Child Protection was motivated to close cases because it did not want to carry out work in response to incident report relating to [Edward]. I disagree with any such suggestion. The incident report did not cause us to close the case; rather, it was inappropriate and unhelpful to the client for incident reports to continue to be sent to Child Protection in circumstances where the CTSO had lapsed and Child Protection had no lawful basis on which to make decisions about [Edward's] care.

161. In her response to the draft report, the Team Manager Child Protection stated that before she closed the case she 'sought updates from [the Case Manager Disability Services] as to steps that were being taken to refer [Edward] to services to deal with his sexualised behaviour issues' and 'consulted with [Edward's] father...[He] was happy for Child Protection to cease its involvement'. She said that, at the time, she was not aware of the fact and content of the 4 December 2014 meeting; Robert's father's 10 December 2014 complaint; the request from Autism Plus that Edward be moved; and the DHHS decision that Edward should remain at Autism Plus.

162. The Team Manager Child Protection also commented at interview about the four incidents reported to DHHS after Edward's order lapsed (see Table 2 in the Appendix), including a third alleged attempted sexual assault of Robert resulting in Edward to be unlawfully restrained. The Team Manager stated:

There was a number of concerns about the incident reports...the reports were not very accurate...there were questions about what one to one supervision looked like...

163. In her response to the draft report, she added:

At the time, it was my view that these incident reports were able to be managed by the professionals already involved with [Edward] and did not require ongoing Child Protection involvement.

164. The Deputy Area Manager Child Protection was the Team Manager Child Protection's supervisor during the events referred to in the draft report and was included in the Area Manager's email instruction to the Team Manager to close Edward's case (see Figure 4). In response to the draft report on 12 May 2017, the Deputy Area Manager's legal representative explained that the Area and Team Managers made decisions on Edward's case independently from her, specifically:

Following notification of the first alleged sexual assaults to Child Protection in November 2014 the Area Manager soon took over the lead in managing the direction of [Edward's] case...

[The Deputy Area Manager's] involvement was very limited and she was not involved in relevant decisions which were undertaken by the Team Manager under supervision of [the Area Manager]...

[The Deputy Area Manager] had no involvement in the decision to leave [Edward] at Autism Plus following the Incident Reports, nor was [she] involved in the decision to close the case with Child Protection. [The Team Manager] did not discuss the case closure decision directly with her...

In instances when [the Area Manager] was emailing Team Managers supervised by [the Deputy Area Manager], she would usually copy [the latter] into emails so [she] was aware of the direction/information being provided to her Team Managers.

Child Protection's involvement in Edward's placement

165. In respect of the case closure by Child Protection, the Operating Framework⁷⁴ for dual clients of Child Protection and Disability Services states that Child Protection's expertise includes 'issues of safety and wellbeing'. The Operating Framework provides that:

Preparation...should be undertaken collaboratively to ensure that there are no significant concerns or further risk of harm and that all necessary supports related to the person's disability are being provided.

166. At interview, Edward's Case Manager, Disability Services, raised concerns about Child Protection's limited involvement in Edward's placement:

There was so little involvement from anyone from Child Protection around the placement of [Edward] and that sadly is sometimes the case when you are leaving care and have a disability and turning 18...its absolutely a system issue...its sort of that corridor chat [Child Protection saying] 'they are almost 18, they are not our problem'.

167. However, the Case Manager Disability Services reported that she had seen effective collaboration and transition planning for dual clients before but 'I don't recall any of that happening for [Edward], nothing'.

168. In response to the draft report, the Team Manager Child Protection, acknowledged that she had never visited Edward nor sought his views. She 'agree[d] that Child Protection should have visited [Edward] more frequently' but said 'I consider that the decisions I made with respect to [Edward's] case were reasonable'.

⁷⁴ DHHS, November 2012 <http://www.cpmanual.vic.gov.au/sites/default/files/Disability-and-CP-Operating-Framework-Nov-2012-2813.pdf> viewed on 1 September 2016..

Impact of workload pressures

169. Child Protection staff involved in this matter each commented on the workload pressures in Child Protection in their responses to the draft report.

170. The Team Manager Child Protection stated in response to the draft report:

The system is meant to function in such a way that the core duties of a Team Manager relate to overall supervision of his or her team, and the Team Manager is then able to pick up and manage the few 'awaiting allocation' cases from time to time when the remainder of the team has no capacity. In fact, as result of the demands on the system and difficulties with recruiting and retaining staff, the Team Managers are often burdened with the biggest caseload of everyone in the team - in addition to all of their other duties.

Managing unallocated cases is a significant pressure on all Team Managers, and causes significant stress and anxiety. It also, undeniably, increases client vulnerability.

171. The Team Manager Child Protection further explained that she lodged a DINMA (Disease Injury Near Miss Accident) report in December 2014 'due to concerns I had about my ongoing workload' which was provided to her Operations Manager and triggered meetings with her line managers. However, 'no changes of any substance were put into place to assist me to better manage the workload'.

172. In her response, the Deputy Area Manager Child Protection further echoed these concerns:

Child Protection Practitioners and Team Managers, had a substantial case load...Team Managers...had 20-35 unallocated cases to manage...in addition to their supervisory responsibility of between 70-100 allocated cases managed by the 6-7 Child Protection Practitioners in each team...at most times, the number of unallocated cases exceeded the state wide target of 10%...On 1 December 2014 [I] sent an email to [the Area Manager Child Protection] advising that the number of cases in her unit were causing high levels of stress for her Team Managers.

173. The Area Manager Child Protection also reported significant concerns about the impact of work load pressures on Child Protection:

The pressure to reduce the overall client numbers and reduce the number of children awaiting allocation was immense.

An under-resourced, overworked and overwhelmed staff group including myself as the Area Manager, was expected to close off cases within a 14 day period of order expiry, close cases where the risk is minimised, move cases to the next phase, write court reports for children who had been provided a minimal case management response and manage the complexity of issues for children involved with Child Protection.

Each of the five Team Managers managed approximately 30-40 children awaiting allocation...the numbers had remained constant since 2014...[and] case carrying staff vacancies averaged about seven at any given time in my Area.

[The Deputy Secretary] chaired a 'Performance Meeting' each fortnight... my written and verbal contribution to the reports included information that the number of case carrying staff remained insufficient to meet the numbers of children awaiting allocation... [and] strategies to address awaiting allocation had limited impact due to the increasing overall client numbers, staff vacancies and disproportionate staff to client ration numbers.

Key incidents 4 to 8

Key incident 4: 25 January 2015

From Autism Plus's incident report:

[Whilst having dinner], '[Edward] continued to [get] heightened and at that point grabbed the knife used for cutting his food and started in a motion as to cut himself...[Edward] at this point threatened to stab other clients and in particular identified one client and discussed how he wished to hurt his parents'. [A staff member confirmed] 'that the verbal threats were made towards client [Robert] and his parents.'

12 April 2015: Autism Plus cancels sleepover night staff to save money

174. At interview, Director 1 Autism Plus advised that on 12 April 2015, she made the decision to cancel the sleepover night support at Smith Street, leaving one active night staff member to work alone.
175. DHHS defines an 'active night' as a 'stand up' staff member who remains awake at night providing active supervision and assistance throughout the night. Whilst a sleepover staff member is permitted to sleep, this additional staff member's role includes providing additional support to supplement the active staff member and attending to significant incidents when required.⁷⁵
176. Director 1 stated at interview she cancelled the sleepover to save money: 'basically it was a financial reason'. Four serious incidents followed.

Key incident 5: 14 April 2015

From Autism Plus's incident report:

'At 22:20 [Edward] came out of his room and started banging on the tables and chairs...at 22:30 [Edward] walked out of his room and took a butter knife from the cupboard and stated to [the DSW] that he was going to cut himself with it and then took the knife to his room, he immediately came back out of his room and stated that he was going to throw it at me...[Edward] then took another butter knife from the drawer...[The DSW] evacuated into a secure location...[Edward] came to the door and started banging on the door and placing knives under the door sporadically till [sic] 23:30... [Edward] stayed at the door on the floor till [sic] 12:30am. [Edward] became tired and went to bed. Once deemed asleep [the DSW] went in his room and checked for knives, there weren't any.'

Key incident 6: 17 April 2015

From Autism Plus's incident report:⁷⁶

'This morning [Edward] was walking out of the house to go to school...[Robert] was sitting at the table having breakfast... [Edward]...came into the kitchen and approached [Robert], [the DSW] intervened while standing in between [Robert] and [Edward] and verbally prompted [Robert] to move on, [Edward] held [Robert's] top and it got ripped.'

⁷⁵ DHHS, Program requirements for residential care in Victoria April 2015 <http://www.dhs.vic.gov.au/__data/assets/word_doc/0008/721835/Program-requirements-for-residential-care-0415.doc>, viewed on 6 February 2017. It is noted that this document relates to placements funded under the CYFA, Edward's placement was funded under the Disability Act; no documents were located that defined 'active night' for disability placements.

⁷⁶ House Manager Smith Street, Incident Report, dated 17 April 2015.

Key incident 7: 18 April 2015

From Autism Plus's incident report:

'At 22:05 [Edward] came out of his room to throw an iron towards staff. Staff went into the office to call [the House Manager Smith Street] at 22:05. [Edward] stood at the door with two knives and he was putting it under the door. [Edward] was banging the door harder and harder like the door was going to break for 30mins. Staff called the police at 22:45 and the police arrive[d] at 23:00...the police told [Edward] to stay in his room and left at 23:20. At 23:33 staff came out to do the rest of the housework [Edward] came after me again, this time he was close and staff ran back to the staff room and did not lock the middle door and ran into the office. [Robert] came out of his room at 23:47 to the toilet and [Edward] came in the toilet aswell [sic]. Staff did not know what happened but I called the police again at 23:47 and the police arrived at 23:58... the police checked to make sure that all other clients were not hurt and they left. Police advised me to keep all the doors locked and not to get out there.'

Key incident 8: 18 April 2015

From Autism Plus's incident report:⁷⁷

Edward 'had disclosed that on Saturday 18 April during the night, he had gone to the bathroom where [Robert] was sitting on the toilet. [Edward] then reported he punched [Robert] several times in the stomach and then "humped" [Robert's] body while sitting on his lap reaching around him. [Edward] reports that [Robert] then stood up and [Edward] put his penis in [Robert's] bottom. [Edward] reports that [Robert] made vocalisations and left the bathroom and [Edward] left the area.'

From Psychologist A's police statement:

'[Edward]...then went on to report that he had threatened to kill a member of staff and the staff member then locked themselves in the staff office...[Robert] was sitting in the toilet...he approached [Robert] and tried to punch him in the stomach...he entered the toilet on two occasions to punch [Robert].

[Edward] then stated that he had "humped" [Robert] in the toilet. He reported rubbing/touching [Robert's] bottom when he was sitting on the toilet...he got [Robert] to stand up and attempted to anally penetrate him. He claimed he was successful...that he had an erection but did not ejaculate...at some stage [Robert] ran to his room with [Edward] following and locked the door. [Edward] told him to come out and that he wanted to hurt and kill him. He stated the Police arrived around this time.'

77 Regional Manager Autism Plus, Incident Report, 20 April 2015.

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177. At interview, Director 1 Autism Plus said she did not reconsider the decision to cancel the sleepover shift after being notified of the above incidents at Smith Street on 14, 16 and 17 April 2015, including one in which the lone night staff member was threatened with knives by Edward. The lone staff member who worked on 14 April 2015 is the same staff member who worked alone the night Robert was allegedly raped by Edward.
178. In her response to the draft report on behalf of Autism Plus, Director 1 stated:
- The statement [in the report that she made the decision] ‘to save money’ is subjective and we had been financially funding this ‘active’ night support to comply with Edward’s line of sight since November 2014. The department refused to allocate any additional supports or funding to mitigate the risks. The incidents on 14, 16 and 17 April 2015 did not represent a threat to [Robert].
179. As detailed in this report (including Director 1’s response to the draft report in the ‘Supervision and support’ section), Autism Plus was required by DHHS to fund the active night support since Smith Street was opened as it was not compliant with DHHS’s contingency home requirements.
180. Director 1 also responded to the draft report stating that Edward’s ‘Residential Statement states sleepover only. Active nights were not added to his guaranteed supports until he was relocated from [Smith Street]’. Director 1 provided another copy of Edward’s Residential Statement, dated 6 March 2015, to support her claim. However, her response is inaccurate; as detailed in the ‘Supervision and support’ section of this report, both sleepover and active night were ‘guaranteed supports’ from 6 March 2015 and Edward was not relocated from Smith Street until 21 April 2015.
181. The use of a two-person restraint had been identified on 12 December 2014 (when Autism Plus agreed to keep Edward) as a safety response likely to be required if another sexual assault was attempted. The cancellation of the active night staffer prevented Autism Plus staff from being able to use a two-person restraint.
182. Director 1 stated at interview that there was an on-call system whereby staff who live close to Smith Street could be called upon at short notice to assist, although it is noted that no additional staff were provided on 14 and 18 April 2015 after the lone staff member was attacked and police were contacted three times.
183. At interview on 15 December 2016, the House Manager Smith Street disagreed that there was an on-call system as did the Regional Manager Autism Plus in response to the draft report on 26 April 2017. The Regional Manager stated, ‘I was asked to draft and trial a new after hours support system which I did but was unable to trial due to staff resistance’. In response to the draft report, Director 1 Autism Plus stated the House Manager had access to senior managers via telephone ‘24hrs a day, seven days a week’.
184. The House Manager Smith Street also said at interview that he had raised concerns about Robert’s safety in the placement and insisted the sleepover support resume after the staff member was attacked on 18 April 2015 (the alleged rape was not disclosed until two days later). The investigation confirmed the sleepover was reinstated on 19 April 2015.

185. Autism Plus Officer A also stated at interview they had prepared the rosters for this period, before the House Manager Smith Street commenced in the role on 7 April 2015, and they had complained to Director 1 about the decision to cancel the sleepover when staff told the officer their night shifts had been cancelled:

[Robert] is an epileptic, [Edward] had very bad predatory [behaviour]...he would get up looking for people...my plan was to always keep an active and sleepover because one person cannot be in two places...I told [Directors 1 and 2 Autism Plus] "this isn't working".

186. At interview, Director 1 denied any complaints by staff were made about her decision to cancel the sleepover. She said she asked staff 'are you comfortable and confident with that?' Director 1 advised the investigation she was 'as satisfied as we could be' when she cancelled the sleepover shift; and stated 'I believe Autism Plus went over and above to do everything we could'. This is at odds with her emailed statement noted earlier in this report that on 12 December 2014, when she 'agreed' to keep Edward at Smith Street with two night staff rostered on, that she considered the risk still 'too great'.

Local Connections' and Autism Plus staff's concerns about Autism Plus and Edward's placement

187. The Local Connections Officer explained in her response to the draft report that funding decisions are made by the Local Connections managers and Area Directors of each Division with ultimate approval by the Division Secretary:

Where a facility houses clients from multiple Divisions (such as [Smith Street]) consensus is typically required between the Area Directors of each Division before a significant funding decision can be made.

Regular meetings occur between these managers, the VMU and Child Protection to determine funding requests and placements.

188. The Local Connections Officer's response stated she was responsible for 'monitoring trends, themes and issues' so that the 'viability of the service agreement' could be periodically reviewed. She said she regularly conducted training with Autism Plus to improve its capabilities in areas including 'policy-based obligations' and 'incident reporting'; however, concerns continued to arise. In 2014 and 2015, the Local Connections Officer offered Autism Plus further training on incident reporting, which she said Director 1 Autism Plus 'rejected'. Nevertheless, the Local Connections Officer delivered this training in April 2015 (after Edward left Smith Street). Further, the Local Connections Officer recommended Autism Plus consult with ACSO to obtain training for staff on improving their understanding of sexual behaviour and assault, an area of concern identified at the 4 December 2014 meeting; however, Autism Plus did not do so.⁷⁸

⁷⁸ Email communication from Local Connections Officer to Director 1 Autism Plus and Senior Manager Autism Plus, 12 December 2014 with ACSO program details.

189. As early as 2013,⁷⁹ the Local Connections Officer raised concerns about fire compliance issues in Autism Plus's contingency units; and in 2014 and 2015, escalated serious concerns within DHHS about Edward's placement and Autism Plus contingency units in general. She recommended that Edward be moved, albeit she did not have authority to make placement decisions, as stated in her response to the draft report. In response to the draft report, the Local Connections Officer's legal representative detailed some of the concerns raised and the actions she took:

When notified in January 2015 that Autism Plus were seeking new clients to add to the roster at [Smith Street] and in like facilities, the [Local Connections Officer] immediately instructed Autism Plus not to take on additional clients.

[She] still held concerns about Autism Plus's compliance with incident reporting policies...she suggested to her superiors [the IFS Manager DHHS and Area Manager Child Protection] that a Quality of Support Review be undertaken.

Within an hour of receiving Autism Plus's email [containing Robert's parents' complaint] the [Local Connections Officer] escalated the request to [the Team Leader Disability Services and IFS Manager DHHS who] were empowered to make client placement decisions.

[The Local Connections Officer] again on 22 December 2014 received an escalated correspondence from Autism Plus concerning [Edward's] placement... [she] acted in this way because she did not want [Edward] staying any longer in an Autism Plus contingency unit. [She] had serious concerns about [Edward's] placement and Autism Plus's contingency units in general and repeatedly expressed these concerns to her supervisors.

190. At interview, the House Manager also detailed concerns he had raised within Autism Plus about the agency's capabilities. He stated that when he commenced in the role of House Manager at Smith Street on 7 April 2015, he was:

...telling people 'get him [Edward] out, there is no other choice, you have to look after the guy that is being assaulted'...knowing there is a person who sexually assaulted another in the building is unheard of.

More generally, he declared:

...it is a very poorly run company...poorly organised...no support from Head Office whatsoever...the nepotism has driven me out of there...all the managers are all family members...one of the houses a friend of... [Director 1 Autism Plus's son]...is managing - he is a bricklayer...that screams at me... he has no training or qualifications in working with people with disabilities.

191. In her response to the draft report, the Regional Manager Autism Plus, who was employed at Autism Plus in 2015, expressed similar concerns:

The majority of Autism Plus staff is related to the CEOs and founders of Autism Plus either directly or by marriage...

Autism Plus did not have in place several key documents and work practices required to provide services to people with a disability...I was extremely dissatisfied with the lack of resources available for me to perform my role...

The more I mentioned missing things or concerns...the more the relationship between myself and [Director 2] Autism Plus declined...this was further impacted by [the] fact that information or tasks that were missing were the responsibility of [Director 2's] close family (children and husband) or staff that she had close personal relationship with.

⁷⁹ Email communication from Local Connections Officer to Officer DHHS, 1 August 2013.

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192. The Regional Manager Autism Plus said 'the situation' with Edward could be attributed to the 'systemic failure by Autism Plus to train staff to respond to incidents according to best practice standards'; to maintain accurate records; to maintain an effective workplace culture; and also to a 'lack of working relationships and effective communication between Autism Plus, DHHS and external parties'.
193. In response to the draft report, Director 1 Autism Plus stated that 'less than 5% of people are directly related to the Directors' and that Autism Plus has a 'robust Conflict of Interest policy'. She stated that the only 'ex-bricklayer currently employed...is a Disability Support Worker' and that the House Manager Smith Street's comments about the lack of support provided to him and the management of Autism Plus were 'without context...disparaging, unfair and without merit'. She 'encouraged' the investigation to obtain evidence from the Regional Manager Autism Plus; however, as detailed in this report, she also reported significant concerns about Autism Plus.

Current placement of Edward

194. Following Edward's exit from Autism Plus's care, he resided in another contingency placement from 12 May 2015 to 16 June 2016, constituting more than six years of contingency placements since being removed from his parents' care. This is despite his psychologist recommending in 2014 that it would be in Edward's best interests for him to live with his family, at least on a shared-care basis. This was an option that was never formally assessed by DHHS.⁸⁰ Edward's Behaviour Support Plan dated 5 December 2014⁸¹ stated that one of his personal aspirations was 'to live at home with either my mother, father or other family member'. Edward had a right for his views about where he lived to be properly considered.
195. On 16 June 2016, Edward moved into a permanent group home placement, after a:
- considered process that spanned a number of months and involved several departmental staff from Disability Services Case Management, Disability Accommodation Services and the Vacancy Management Unit.

After less than two months, Edward was moved again to a contingency placement managed by Secure Services after 'several [alleged] incidents of client to staff assault and property damage' by Edward.

80 Email communication from Case Manager Disability Services to IFS Manager DHHS, Team Leader Disability Services and Officer Disability Services regarding Psychologist A's opinion, 16 December 2014; Email communication from Officer Disability Services to Case Manager Disability Services and Team Leader Disability Services, 29 April 2015.

81 Autism Plus, Behavioural Support Plan dated 5 December 2014, indicates Director 1 Autism Plus approved the document on 5 December 2014 but the document provided to Victorian Ombudsman was not created until 14 May 2015 and was not received by DHHS until 25 May 2015, after Edward left Autism Plus's care.

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196. On 21 September 2016 the Ombudsman received a new complaint about the group home in which Edward had been placed due to concerns that a young co-resident with a disability, whose parents were reportedly not advised of Edward's history of assaultive behaviours, had been placed at immediate risk of harm. The investigation made enquiries and were advised by DHHS that Edward had already been moved and that he was the sole client at his new contingency placement with 2:1 staff to client support.
197. On 22 November 2016, Edward moved into his current accommodation as the sole client with 2:1 staff to client support during the day and sleep-over support at night. This accommodation is only available for an additional 12 months and was initially funded by DHHS until Edward's funding transferred to the NDIS in December 2016.

Statutory case planning

198. The CYFA requires that Child Protection prepare a case plan for Edward containing all significant decisions, including his present and future care, wellbeing and placement. It requires that the plan be reviewed within six weeks of a new CTSO being made by the court and as necessary. Due to his age and time in care, a stability plan for Edward was also required to address long-term care and his social, emotional and behavioural development.⁸²
199. The Operating Framework guides integrated practice for Child Protection and Disability Services to 'drive positive outcomes for vulnerable children'. It states that 'Child Protection takes the lead responsibility' for the case plan and case management for dual clients of both services.
200. The Child Protection Manual also provides guidance to Child Protection practitioners on all aspects of their role, including resources on applying the best interests case practice model. It provides that, for high-risk youth, a 'detailed assessment and thoughtful, trauma-informed case planning and intervention are essential to effective risk management' and that 'good practice is founded on multiservice collaboration and coordination, clinical consultation and relationship based engagement with the young person'. High-risk youth are defined as 'generally aged 12-17 years...with multiple, complex difficulties [who] need intensive, sustained support'. It appears Edward's circumstances warranted Child Protection to consider him a 'high-risk youth'.⁸³

82 CYFA section 169.

83 In her written response to the draft report, 28 April 2017, the Team Manager Child Protection stated 'relative to other Child Protection clients, Edward was not a high-risk youth'; however, in her written response to the draft report, 30 April 2017, the Area Manager Child Protection stated 'Upon reflection Edward may have benefited from consideration about his eligibility to a High Risk Panel'.

Allocation of Edward's case to Team Manager Child Protection, November 2014

201. The Team Manager Child Protection stated at interview that she started working with DHHS in January 2014. She said Edward's case was initially managed by practitioners in her team, for whom she was the case planner, and then solely by her as an 'unallocated case' from November 2014.
202. When interviewed, the Team Manager Child Protection said she did not arrange a handover or file review in November 2014, when Edward's allocated practitioner left, as there were 'a number of pressures... we had a high number of unallocated cases...I was out of the office for 23 days over three months for court'. She stated that now that she has been promoted to Deputy Area Manager 'there are lots of positive developments'. However, her own evidence suggested that the number of unallocated cases supervised by Team Managers had increased: the Team Manager stated that in November 2014, she was managing 30-50 unallocated cases and that team managers she supervised at the time of her interview were holding 50-70 unallocated cases each.
203. The Team Manager recalled attending one meeting with Autism Plus and said she did not visit Edward in relation to his case closure because 'with his disabilities there were concerns that would be confusing for [Edward]'. DHHS's records of previous visits to Edward by Child Protection do not document any difficulties communicating with him. It is also a legislative requirement for Edward to be 'given adequate opportunity to participate fully in the decision-making process' and be 'provided with sufficient information...by a method that [he] can understand'⁸⁴.

204. In response to the draft report, the Team Manager stated:

To express my thinking more clearly now, I had never met [Edward] before, and was concerned, based on my understanding of [Edward's] circumstances from his file and from having spoken to professionals from [Edward's] care team, that a brief visit from a stranger might be confusing for him, and possibly more detrimental than helpful.

Edward was last visited on 19 October 2011, despite the Child Protection Manual recommending that 'generally, for allocated cases, fortnightly contact [between Child Protection and the child] is a reasonable minimum' and that the child and family be visited 'no more than 10 days before case closure'.

Case plan review 2014

205. The Child Protection Manual states that practitioners should 'engage the child and family in any discussions about changes to the case plan'; visit the client to provide 'purposeful intervention'; and ensure 'all professionals and services noted in the case plan are aware of and agree to their roles'. This would include consultation with Edward's psychologist.
206. Importantly, the case plan must be reviewed 'no later than six weeks before the CTSO expiry date'. In Edward's case this would have necessitated the case plan being reviewed by the first week of October 2014, allowing parties an opportunity to request a review of the decision by Child Protection to allow Edward's CTSO to lapse.⁸⁵

84 CYFA sections 11(f) and 11(h)(i).

85 CYFA section 331..

207. When Edward's CTSO lapsed on 18 November 2014 (see 'Placement decisions' section of this report), he did not have a current case plan. The Team Manager Child Protection acknowledged at interview that Edward's case plan was not reviewed after his order was extended on 19 November 2013, and conceded that this is a requirement in the CYFA and the Child Protection Manual. She stated that she was new to Child Protection in Victoria in 2014 and that this was an 'oversight of mine'.

208. When the investigation asked the Team Manager Child Protection why Disability Services appeared to be providing primary case management and planning for Edward when the Operational Framework states this is Child Protection's responsibility, she stated that Disability Services 'had a relationship with the placement and [Edward]... they had always maintained the primary engagement with [Edward] and services'. In her response to the draft report, the Team Manager stated 'I do not agree that case management was deferred to Disability Services'. She said:

Child Protection worked closely with Disability Services to make decisions for [Edward's] care. Child Protection is capable of exercising primary responsibility while still utilising other DHHS resources such as those of Disability Services, who are expert and experienced in their particular field.

209. At interview, the IFS Manager DHHS initially did not accept that Disability Services appeared to be providing primary case management of Edward; however, she later stated:

In my supervision of staff that was an ongoing issue...they struggled with getting responses from our colleagues in Child Protection but that doesn't mean that we take over. We continue to do our job as assertively as we possibly can...which is why actually I intervened quite a lot and spoke with [the Area Manager Child Protection]... with the understanding that we would end up carrying case management of a client... [Edward] isn't the only one in that situation.

210. At interview, the Team Manager Child Protection said that she conducted a case plan meeting and later provided a CRIS case note of a meeting held with Disability Services, Autism Plus and Life Without Barriers on 17 November 2014. This is not recorded as a 'case plan meeting' and the views of Edward, his family and his psychologist were not sought. Contrary to her evidence at interview, this meeting record states that the Life Without Barriers placement was deemed unsuitable as it offered insufficient support for Edward, making the placement 'potentially risky for other residents'. The Team Manager also wrote in the meeting record that she raised supervision concerns with Autism Plus in the context of the sexual assault incidents and that the Area Manager Autism Plus, responded that he was 'working with the staff to address'. The Team Manager ended the meeting notes with:

Discussed that [Edward's] order has expired as there were no concerns.⁸⁶ Agreed that CP [Child Protection] do not have a role with [Edward] as disability services will have an ongoing long term role with [Edward].

⁸⁶ The Team Manager Child Protection subsequently stated in her written response to the draft report, 'it is not that there were no concerns whatsoever...however it was my view that these concerns were able to be managed by the professionals already involved...'

211. This assessment appears to be inconsistent with the supervision concerns and lack of an available alternative placement discussed at the meeting. The Team Manager Child Protection also documented a conversation she held with Victoria Police on the morning of the case plan meeting, during which police reported Autism Plus had advised them that Edward could not remain at Smith Street once he turned 18. In the 'case planning decisions' section of the case note, the Team Manager wrote '[Edward's] sexual behaviour is of concern'.⁸⁷ In addition, an incident report was also received by Child Protection that day detailing that Edward had physically assaulted Smith Street staff (see Table 2 in the Appendix).

212. The Team Manager Child Protection prepared and endorsed a new case plan for Edward dated 3 December 2014. The goals, tasks and timelines mirrored the previous case plan dated 24 August 2013. It did not contain any specific long-term placement, stability or leaving care plans for Edward, as required in the CYFA⁸⁸ and the Child Protection Manual, nor perspectives of Edward or any other parties except Child Protection. There is no record that the case plan was discussed with or provided to Edward and his parents as required.⁸⁹ However, the Team Manager wrote to Edward's mother on 30 December 2014 to advise that Child Protection had allowed his order to lapse.

213. At interview, the Case Manager Disability Services, who attended the 'case plan' meeting, stated she did not recall Child Protection seeking her views at this meeting and that she had never seen the 2014 case plan prepared by the Team Manager Child Protection. When provided with a copy by the investigation, she stated:

...if that's the whole document that's one of the slimmest case plans I have ever seen...my understanding was [Edward] was on a CTSO until his 18th birthday.

214. In response to the draft report, the Team Manager Child Protection stated that the Case Manager's 'views were sought by way of her invitation to, attendance at and participation in the meeting of 17 November 2014'. The Team Manager also stated:

...significant decisions made...during the [case plan] meeting included that...Disability Services would refer [Edward] to two programs aimed at people with disabilities...

At the time the CTSO lapsed, I believed that Disability Services would facilitate [Edward] participating in the programs as had been agreed, and that these were adequate referrals to address [Edward's] assaultive behaviours.

In my view, Child Protection had indeed considered its ongoing role in light of the Life Without Barriers placement being unsuitable, and that [Edward] was not likely to be able to remain at Autism Plus. One of the relevant factors we considered was that, throughout the duration of [Edward's] care as a Child Protection client, Disability Services had taken responsibility for sourcing appropriate placement options for [Edward]. This was necessary because Child Protection did not have access to the type of placement that [Edward] required. I believe that it had no service arrangements with any specialist disability placements.

It was agreed that Disability Services would have an ongoing, long term role with [Edward], and that Child Protection did not have a role to play...as early as August 2014, [Edward's] care team (including Disability Services) understood the CTSO would lapse imminently (potentially as early as October 2014).

87 DHHS, CRIS Case note of telephone communication from Team Manager Child Protection to Police Officer C, 11 November 2014.

88 CYFA sections 170(1)(b) and 170(4).

89 CYFA section 167(1).

215. It is noted that the Team Manager Child Protection asserted that it was the role of Disability Services to secure a new placement for Edward as 'Child Protection did not have access to the type of placement that Edward required'. However, at interview, the IFS Manager DHHS stated that Disability Services could not have done more to move Edward as requested on 10 December 2014 'because Disability doesn't have options for children'.

216. Regarding compliance with case planning procedures and legislative requirements, including an opportunity for relevant parties to oppose any Child Protection decisions, the Team Manager Child Protection responded to the draft report:

I was advised as early as 27 August 2014 it had been made clear to the care team that Child Protection did not have a role in [Edward's] life...and given an opportunity to oppose that decision...had concerns been raised, I could have considered those views and, if necessary, applied to extend the CTSO that day or the following day.

217. It is noted that neither Edward nor his parents were present at this meeting. In response to the draft report, the Team Manager Child Protection stated 'I consulted with [Edward's] father prior to closing the case. [He] was happy for Child Protection to cease its involvement'.

218. Additionally, the Team Manager Child Protection acknowledged in her response some deficits in her practice, which she attributed to the demands of the role and a lack of training:

I agree that I did not comply with every procedural requirement under the Child Protection Manual, and that aspects of the case planning would ideally have been more comprehensive. However, Team Managers are in reality often constrained from adhering to best practice due to the demands of the role...

I was not provided any formal training at the commencement of the role but was expected to step straight into the role, performing full duties.

Supervision and support for Edward

219. Autism Plus was funded \$266,923.58 by DHHS to care for Edward in 2014-15.⁹⁰ The position description for the Disability Support Workers who cared for Edward at Smith Street indicates their role included:

Assist clients in undertaking a range of activities of daily living including personal and self-care, food preparation, general household duties, maintenance of personal hygiene...

Active support and person centred approach to clients to enable them to participate positively in community activities and at home whilst aligning to support plans and duty statements.

⁹⁰ Administration Officer Autism Plus, Email communication to Team Leader Disability Services, 28 May 2015. Contingency funding approved 1 July 2014 to 30 June 2015; figure not adjusted to include additional costs after Edward left Smith Street.

220. As a funded service, Autism Plus was required to provide its services in accordance with the Human Services Standards issued by DHHS, which provide:

- services are to be delivered in an environment where clients are free from abuse, violence and preventable injury
- clients' assessments are reviewed, updated and evaluated regularly
- clients understand their rights and responsibilities and have an opportunity to exercise them
- the approach to service delivery enhances clients' wellbeing.

221. The investigation sought clarification about the specific agreement between DHHS and Autism Plus regarding Edward's care and supervision and the support plans implemented by the workers at Smith Street. However, there is no single document which details this arrangement. Furthermore, no witness interviewed from Autism Plus or DHHS was able to articulate exactly what supervision Edward was provided at Smith Street in a 24-hour period, or refer the investigation to a document that correlated with their position. This confusion between the parties is demonstrated in quotes displayed in Figure 6 at the end of this section of the report.

222. In an attempt to understand the reasons for this confusion and the care and management of Edward at Smith Street, the investigation examined documents relating to:

- 'Looking After Children'
- 'Residential Statements'
- 'Behavioural Support Plans'

Looking After Children (LAC)

223. DHHS'S guidelines state that the LAC is a framework for considering how a child's needs will be met in a Child Protection placement. It provides that the service providing the care should complete a review of the LAC care plan at least every six months.

224. The Senior Manager Autism Plus stated that the LAC care plan contained the agreement made with Child Protection when Edward was placed at Autism Plus in 2013 and continued until he was 18. However, this document is substantially blank with the exception of family and professional contact details (that were current in March 2013) and contained medical, emotional and behavioural information not updated since 2012. Witnesses from Disability Services and Child Protection had not viewed this document or contributed to updating it during their involvement

225. In response to the draft report, Director 1 Autism Plus stated:

Autism Plus is cognisant of the requirement relating to Children Living out of Home... [Edward's] Case Managers, Disability and Child Protection, can at any time ask for copies of the documentation, amend, add, modify the documentation. They did not.

Residential Statements – active support

226. The investigation also examined the Residential Statements prepared by Autism Plus as required under the Disability Act. It is a legislative requirement⁹¹ for statements to be provided to clients, including the type of services to be provided. Witnesses from Disability Services and Child Protection stated they had not seen these documents until provided by the investigation for comment.

227. At interview Director 1 Autism Plus stated that statements are not required for ‘under 18s or those on a Child Protection order’; however, no evidence was provided or identified by the investigation to support this position.

228. Nonetheless, a statement for Edward was prepared in 2013, which⁹² indicated that he would receive:

- residential services from direct care staff between 7am to 9am and 3pm to 10pm on weekdays and between 7am to 10pm on weekends
- ‘sleepover’ support at night.
- The staff to client ratio was not detailed. This agreement was not updated when Edward moved into Smith Street in April 2014 but was replaced by a new statement on 6 March 2015⁹³ that indicated he would receive:
- residential services from direct care staff between 7am to 9am and 3pm to 10pm on weekdays and between 7am to 10pm on weekends
- both ‘sleepover’ and ‘active’ support at night.

229. The staff to client ratio was detailed in a ‘safety plan’ attached to the document. This plan stated:

[Edward] is supported 1:1 and by ‘**line of sight**’ [original emphasis]. This level of support is required **AT ALL TIMES** and commences when [Edward] awakes and continues until he goes to sleep.

If [Edward] attempts to attack another resident in the house and that resident is in immediate danger of being assaulted and where there are two staff who have received training from a DHS authorised and recommended trainer/organisation and both staff feel competent in performing a ‘two person escort’, they **CAN** remove [Edward] from this area using this particular form of escort.

230. At interview, Director 1 Autism Plus stated that Edward had constant 24-hour supervision, even at night, and that Autism Plus had been forced to provide active night support for Edward due to his assaultive behaviours. She said DHHS refused to pay for this service, despite repeated requests for this funding. She stated the active night support cost approximately \$140,000 per annum compared to \$40,000 for a sleepover staff member. Director 1 Autism Plus referred to the Residential Statement as a ‘pseudo-legal document’ and that if it stated a particular night support would be provided then Autism Plus would be ‘locked into that’.

231. At interview, the House Manager Smith Street explained that Autism Plus had been required to fund the active night support because the property was not fire compliant and that the active night support continued after Edward left the placement for this reason.

91 Pursuant to section 57 of the Disability Act a disability service provider providing residential services must give a person (and their guardian) a statement in writing when they commence residing at the service which specifies details of the services to be provided.

92 Residential Statement, 15 September 2013 to ‘open’.

93 Residential Statement, 6 March 2015 to 6 March 2016.

232. Director 1 Autism Plus agreed to provide documentary evidence post interview of Autism Plus's requests to DHHS to fund active night support. On 13 December 2016 she provided a series of emails written by the Senior Manager Autism Plus that confirmed the active night support was being provided at Autism Plus's cost due to fire compliance issues (see Figure 5). None of the emails contained requests for DHHS to fund active night support for Edward until after he left Smith Street and Autism Plus did not provide case notes of its meetings with DHHS at which it states this issue was discussed. Whilst the Senior Manager stated in his email to then Regional Manager Autism Plus that he had requested funding at a 'regional meeting and was flatly denied', there is no evidence in Autism Plus or DHHS records that this occurred.

233. In her response provided to the draft report, Director 1 Autism Plus confirmed Smith Street 'has been operating under [DHHS] code 7.11 requiring an active night for compliance until the department confirms the compliance requirements for the site'. However, she stated:

When [Edward's] requirement for line of sight supervision became evident the requirements and responsibilities of the role of the active night staff changed significantly. The night staff was directed to stay over [Edward's] side of the property, security door locked and always remain within visual sight of [Edward's] whereabouts. They were not able to perform the duties which normally would be applicable to active night staff e.g. cleaning, laundry etc.

Behaviour Support Plans

234. It is a requirement in the Disability Act⁹⁴ for a disability service provider to prepare a support plan and update this as required. The legislative framework underpinning Edward's Behaviour Support Plan (BSP) also includes consideration of his rights enlivened in the UNCRPD⁹⁵ and the Charter⁹⁶ due to the use of restrictive interventions⁹⁷ (see 'A human rights perspective' section).

235. The Disability Act Part 7 defines these interventions as any restrictions on the rights or freedom of movement including chemical restraints, seclusion, physical restraint or locking doors and cupboards. Disability service providers must obtain approval from the Secretary of DHHS to use restrictive interventions and their use must be the least restrictive and included in the person's Behaviour Support Plan, in consultation with DHHS's Senior Practitioner at the Office of Professional Practice.

94 Pursuant to section 54 of the Disability Act a disability service provider must, in consultation with the person, prepare a support plan within 60 days of a person receiving ongoing disability services and review as required.

95 *United Nations Convention on the Rights of Person with Disabilities 2006* Articles 7, 15 and 16.

96 Charter of Human Rights and Responsibilities Act sections 10 and 12.

97 Disability Act sections 133-150.

Figure 5: Active night being provided as a fire safety measure

Message from [Regional Manager Autism Plus] on Mon, 20 April 2015 5:02:44 +1100
To: [Senior Manager Autism Plus, House Manager Smith Street]
Subject: RE: [EDWARD]
Thanks [Senior Manager Autism Plus]

I have left a message today for [Edward's] case manager and will be chatting to her regarding supports so will revisit this with her.

Kind Regards
[Regional Manager Autism Plus]

From: mailto: [Senior Manager Autism Plus]
Sent: Monday, 20 April 2015 3:03 PM
To: [Regional Manager Autism Plus; House Manager Smith Street]
Subject: re [EDWARD]

Hi [Regional Manager Autism Plus and House Manager Smith Street]
Just to give you the heads up DHHS do not pay for the active night. Even though it is part of the safety plan for the residents.
After the incidents on the weekend I would be revisiting this with DHS. The active night was put in by us initially as a fire safety measure during the assessment stage.
We should be putting pressure on DHHS to cover this.
I tried this at a regional meeting and was flatly denied...time now to revisit.

[Senior Manager Autism Plus]

236. Edward's Behaviour Support Plan (dated 30 October 2013 to 29 October 2014), authored and approved by Director 1 Autism Plus, reveals that the plan:

- was not updated when Edward moved into Smith Street in April 2014
- was not updated in October 2014 following alleged sexual assaults of Robert⁹⁸
- did not contain details of or approval for chemical, environmental and physical restrictive interventions being used to manage Edward's behaviour at Smith Street
- stated Edward was no longer demonstrating assaultive behaviours towards 'less confident' staff, which is inconsistent with his incident reporting history (see Tables 1 and 2 in the Appendix) and later comments in the document that Edward 'targets staff he feels he is able to dominate'
- did not provide an update to his Protection Order status from 2010, including the order lapsing and Child Protection closing
- referred to Psychologist A's report dated 2012 for communication strategies but not her current advice
- listed access visits with his mother as a 'like', however, she moved overseas in 2011
- listed living at home with a family member as a personal aspiration
- listed multiple sexual assaults of another resident which is inconsistent with Director 1 Autism Plus's comments at a meeting with DHHS on 4 December 2014 that Edward 'did not have previous concerns regarding sexual behaviour'⁹⁹
- instructed staff to 'secure all items that can be used as weapons' including 'locking the drawer to the knives'; however, the incident reports from Smith Street indicated Edward attacked staff with knives to which he had access.

⁹⁸ DHHS, Critical client incident management instruction - technical update, April 2014 <<http://www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services>> viewed on 22 September 2016. Page 19 states that following a sexual assault a client's Behaviour Support Plan should be reviewed.

⁹⁹ DHHS, CRIS Case note of a DHHS Division and Autism Plus incident report meeting, 4 December 2014.

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237. DHHS requested Autism Plus provide an updated Behaviour Support Plan for Edward on multiple occasions from December 2014 to May 2015, including at the meeting on 12 December 2014 when Edward's placement options were discussed in detail. DHHS advised¹⁰⁰ the investigation that it only received a draft updated Behaviour Support Plan after Edward left Autism Plus's care. This draft had an approval date by Director 1 Autism Plus of 5 December 2014. The only restrictive interventions documented in the updated plan are two medications for 'anxiety, agitation and aggression'. This draft was also provided to the Ombudsman by Autism Plus on summons and substantially mirrors Edward's 2013-2014 plan (with the deficiencies detailed in this report), with the exception of access visits with Edward's mother as a 'like' being deleted.
238. In response to the draft report, Director 1 Autism Plus provided another copy of the draft Behaviour Support Plan dated 5 December 2014 and claimed that this plan was 'in date and valid', that the 'Office of Professional Practice during 2014-2015 made no reference to any concerns over use of restrictive meds'; and that the plan was completed and emailed to the Case Manager Disability Services on 15 December 2014. However, it is noted that the email provided to the Ombudsman to support this contained no attachments and that the then Area Manager Autism Plus (the email sender) referred to two documents being attached in response to a specific request from the Case Manager for those documents (neither being Edward's Behaviour Support Plan).

239. Director 1 Autism Plus's claim is inconsistent with all other documentary and witness evidence that an updated plan, with details about Edward's behaviour, medication reviews or proof of any Secretary approval of restrictive interventions was not provided. This evidence includes meeting records at which Director 1 Autism Plus was present, emails and witness evidence of conversations with her and other Autism Plus managers about the urgent need for an updated Behaviour Support Plan.
240. It is also noted that Autism Plus provided emails on summons dated 1 May 2015 between the Senior Manager Autism Plus, Director 1 Autism Plus and House Manager Smith Street in which the House Manager submitted a first version of an updated Behaviour Support Plan for Edward to Director 1 to approve, in order to respond to DHHS's requests for the plan. These requests were outstanding when the House Manager commenced at Smith Street in April 2015.

¹⁰⁰ Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 24 May 2016, contained a draft BSP dated 5 December 2014.

241. At interview, the Case Manager Disability Services stated:

It was a major concern for me that the BSP was outdated...I asked for all of his planning to be delivered to DHHS to drive accommodation options...the medical, who is signing off his treatment sheets?... where is the residential statement with the restrictive practices listed in there? Where is the BSP, it doesn't contain chemical restraint approval? Where is the two person restraint? It was a total shemozzle...to me that was a huge in-house management issue.

All these recommendations from [Psychologist A] were not being followed...less restrictive options like take him for a run rather than chemical restraint they were using...

the service provider is responsible for the BSP...at no point were we requested to assist, but as an area we offered our support for these things.

242. Similarly, the House Manager Smith Street stated at interview that he raised concerns with the Regional Manager Autism Plus, his line manager, who commenced her role on 13 April 2014, that:

There was a lot of paperwork that was outstanding or non-existent...person centred plans had been repeated [copied] for years...there was no development.

243. He also stated that he had only just commenced in the role as House Manager; he had received 'a single two-hour handover' from the Senior Manager Autism Plus; and he felt unsupported by DHHS as staff 'did not give a high amount of support, [and were] insisting I write a BSP for someone I didn't know'. He also said he had never prepared a BSP before.

244. In response to the draft report, the House Manager Smith Street's legal representative added that he:

was not in a position of sufficient authority 11 days into his tenure to prevent the incident from occurring, or to implement or agitate for operational changes that may have led to the incident being avoided.

245. The Regional Manager Autism Plus responded to the draft report, 'I strongly reject any suggestion that the requests for updates to the BSP were due to any professional failing or negligence on my behalf'. She explained:

I identified on my first day [13 April 2015] that residents within Autism Plus did not have current BSPs on the DHHS system or in hard copy at Smith Street... [the House Manager Smith Street] and I had considerable discussions with the Directors of Autism Plus in order to attempt to locate documentation.

In an attempt to comply with legislative requirements, [the House Manager] and I worked together to put in place a short term work plan which consisted of supervision notes, regarding priority documents, completing the BSP for [Edward] and other residents...On many occasions, [the House Manager] and I were informed that [Edward] would not be able to be placed with another agency until such time as a BSP was completed.

...I attribute the delays and lack of approvals to a complete failure for DHHS to communicate with myself and [the House Manager Smith Street].

Figure 6: Key agencies' understanding of Edward's supervision

- Area Manager Autism Plus said '[Edward] has had line of sight monitoring since 31 October 2014. All staff have been made aware...[we] were never told from [Psychologist A] or DHHS to provide this.'
Disability Services
- 'When I reported back to [the IFS Manager DHHS] that they [Autism Plus] were never told to do that [line of sight monitoring] there was a bit of shock about that as it was not the case.'
Disability Services
- '[Case note:] Strategies to keep [Robert] safe: more monitoring in the evening/active night when all five residents are in the house' - 'I am unclear from reading that [interviewee's statement] how many people are actually on at night.'
Disability Services
- 'Director 1 Autism Plus did not understand that 1:1 staff requirement was shadowing.'
Disability Services and Child Protection
- 'There does not appear to be clarity on 1:1 staff funding or contingency funding. It appears that funding is pooled for a number of clients to run a service.'
Disability Services and Child Protection
- 'The "two man escort" [of Edward] was the minimum restraint required in these circumstances to ensure the safety of [Robert]...Behaviour Support Plan to be reviewed.'
Autism Plus
- '[Edward] is support [sic] by line of sight 100% of the time. No exceptions!!! If you are assigned to [Edward] you do not leave his side for one second.'
Autism Plus
- 'If you have one active night, that person will be responding to all client needs.'
Disability Services
- '24 hours a day, line of sight monitoring one to one...but I do not know if that was being provided...there were alarm bells going off.'
Disability Services
- '[The Regional Manager Autism Plus] advised today that the current ISP does not provide funding for active nights? [She] spoke to LEO.'
Disability Services (after the alleged rape)
- '[Smith Street] wasn't fire compliant so you needed an active night...that is why Autism Plus were funding the active night...[Robert] would go to the loo several times in the night as part of his Autism.'
Autism Plus
- '[Supervision] was constant...active night beside his door, 24 hours...the clients we had there usually slept all night...DHHS refused to pay...it was basically a financial reason [to cancel the sleepover]...obviously you can't do a two-man escort.'
Autism Plus
- 'I'm not making any excuse for my son but where was the supervision of staff.'
Edward's father.

A human rights perspective

246. The importance of human rights, particularly for those with disabilities who are less able to protect themselves, cannot be overstated. The Charter itself states that ‘human rights are essential in a democratic and inclusive society that respects the rule of law, human dignity, equality and freedom’.
247. Child Protection instructs staff to ‘assess ALL [original emphasis] relevant rights when you are making a decision’ and to ‘act in accordance with the CYFA’ and the Charter.¹⁰¹ Disability Services states that ‘people with a disability are some of the most vulnerable in our society, therefore there are specific laws in place to protect [their] rights’ and specifies obligations under the Charter and UNCRPD.¹⁰²
248. The Ombudsman has a role to investigate whether any administrative action taken by a public authority is incompatible with Charter rights.¹⁰³ Importantly, section 5 of the Charter does not limit any other rights recognised under law, including international law, the common law, the Australian Constitution and a law of the Commonwealth. Actions and decisions relating to Edward’s care and management at Smith Street raise human rights issues, under the Charter, the UNCROC and the UNCRPD.
249. Section 38 of the Charter provides that it is unlawful for a public authority to act incompatibly with a human right contained in the Charter or, in making a decision, to fail to give proper consideration to a relevant human right.
250. Section 4 defines public authorities to include entities, such as Autism Plus, ‘whose functions are or include functions of a public nature, when it is exercising those functions on behalf of the State or a public authority (whether under contract or otherwise)’. Additionally, DHHS provides guidance to service providers on how to self-assess if they are performing ‘public functions’, to ensure providers understand the human rights obligations in the Charter that apply to public authorities. DHHS states that ‘public functions’ includes ‘out of home care services for children, community-based child and family services and disability services.’¹⁰⁴
251. Section 17(2) of the Charter provides that every child has ‘the right, without discrimination, to such protection as is in his or her best interests’. The ‘best interests’ of the child are not defined in the Charter. Guidance can be drawn from the ‘best interests principles’ in Articles 3,9 and 20 of the UNCROC and section 10 of the CYFA.¹⁰⁵
252. The CYFA emphasises that protecting a child’s rights is in the child’s best interests and must be of paramount consideration; these rights are not defined in the Act. Section 10 of the CYFA provides that when determining if a decision or action is in the best interests of a child, ‘the need to protect the child from harm, to protect his or her rights and to promote his or her development’ must always be considered and that supporting a child to gain access to appropriate accommodation is another ‘best interest’ consideration.

101 DHHS, 1 December 2015 *Child Protection Manual: Human rights and child protection* <<http://www.cpmanual.vic.gov.au/our-approach/roles-responsibilities/human-rights-and-child-protection>> viewed on 25 July 2016.

102 DHHS, 6 August 2014 *Your rights* <<http://www.dhs.vic.gov.au/for-individuals/disability/your-rights>> viewed on 8 March 2017.

103 Ombudsman Act section 13(2).

104 DHHS, Policy 4.9 *Victorian Charter of Human Rights and Responsibilities*, 29 June 2016 <http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/4.departmental-policies-procedures-and-initiatives/4.9-victorian-charter-of-human-rights-and-responsibilities> viewed 8 March 2017.

105 See *Charter of Human Rights and Responsibilities Act, section 32(2) and ZZ v Secretary, Department of Justice & Anor* [2013] VSC 267 (22 May 2013).

253. Australia ratified the UNCROC in 1990 and ‘has a duty to ensure that all children in Australia enjoy the rights set out in the treaty’. It makes the best interests of the child ‘a primary consideration’ in actions and decisions concerning children and, like the Charter, defines ‘child’ as a person under 18 years of age. Several articles in the UNCROC are particularly relevant to placement decisions made regarding Edward, including Articles 3, 12 and 25, which protect a child’s right to have decisions made in their best interests, have their views considered and be reviewed regularly when they are living in care.

254. According to Justice Bell in the Victorian Supreme Court decision in *Secretary to the Department of Human Services v Sanding*:¹⁰⁶

It is unquestionably important for the voice of a child to be heard in matters affecting them. As I have said, children bear rights personally, and are entitled to respect of their individual human dignity.

255. Australia ratified the UNCRPD in 2008 and all governments are now bound by the treaty. Article 16 of the UNCRPD requires that parties take appropriate legislative and administrative action to protect persons with disabilities from violence and abuse, including effective design and monitoring of programs and facilities.

Placement decisions

256. In order to act compatibly with the Charter, DHHS and Autism Plus needed to properly consider Edward’s best interests and right to protection when making placement decisions.

257. With respect to the best interests of Edward, it is noted that at the time of the decision for Edward to remain at Smith Street:

- Smith Street had been assessed by Autism Plus and DHHS as unsuitable to meet Edward’s long-term needs.
- DHHS had concerns about Autism Plus, including its response to incidents, supervision and training of staff.
- There was no current Behaviour Support Plan for Edward, which DHHS said supported this decision.
- There had been no specialist risk assessment or intervention service provided to Edward, nor evidence of proper consideration of the alternative placements offered by Autism Plus or other contingency placements DHHS could fund.

¹⁰⁶ *Secretary to the Department of Human Services v Sanding* [2011] VSC 42 (22 February 2011) at [209].

Restrictive interventions

258. The use of restrictive interventions to manage Edward's assaultive behaviours also enlivens rights in the Charter and the UNCRPD. Section 10 of the Charter offers protection from cruel, inhuman or degrading treatment and section 12 protects a person's right to freedom of movement (see 'Supervision and support' section beginning page 54).
259. The rights of children like Edward under the Charter are not absolute and may be limited or balanced with other rights. This ensures that in protecting one person's rights, the rights of another (such as the other residents and staff at Smith Street) or more broadly the public interest are not unreasonably affected. Limitations on rights, however, must have a clear basis and must be reasonable and necessary in the circumstances.
260. A decision to use restrictive interventions on a child must give proper consideration to, and be compatible with, the child's rights under sections 10, 12 and 17(2) of the Charter. In making such a decision, the public authority should ask whether there is another reasonable way forward that is safer and less restrictive on the child's human rights.
261. In this regard, it is noted that Autism Plus failed to seek approval of the Secretary to use restrictive interventions. It is therefore unclear whether Edward's rights under the Charter were properly considered in the use of these interventions or whether they were the least restrictive means to manage his behaviour.

Other issues

Additional allegations of sexual assaults at Autism Plus

262. On 21 April 2015, when the alleged rape of Robert by Edward was reported, DHHS was also advised that Edward had made up to nine other sexual assault disclosures.¹⁰⁷ The Case Manager Disability Services recorded the following case note on 21 April 2015, regarding a telephone conversation with Edward's psychologist (Psychologist A) who advised the Case Manager that Edward had made a 'whole host of other allegations' in the presence of herself and the House Manager Smith Street the previous night:

[Edward] said that he had humped girls from behind (they had clothes on) 2-3 times a day at placement in the toilet at [previous Autism Plus accommodation]

he had humped [Steven¹⁰⁸] a couple of times whilst at Autism Plus program downstairs

[Edward] has also humped [Jane and Mark]

[Edward] was too scared to tell [the Area Manager Autism Plus] because he knew he would get into trouble...[Psychologist A] thought...he doesn't understand the implications of this information...[Edward] was not boasting he said 'I need to tell the truth'...when she told [Edward] 'What you've done is quite serious' he sat there looking stunned.

¹⁰⁷ CRIS Case note of telephone communication by Case Manager Disability Services with then Regional Manager Autism Plus, 21 April 2015.

¹⁰⁸ The names of the residents and the group home have been anonymised to protect the privacy of individuals.

263. At interview, the House Manager stated that when Edward made the disclosures he had described hiding near a bathroom close to his bedroom, where staff could not see him, and assaulting day program clients from behind in the toilet, including 'groping them' and 'using [their] hands to touch [himself]'. The House Manager explained at interview that due to the change in his employment and time lapsed, he was now unable to recall the names of those allegedly assaulted. However, he acknowledged that the names had been disclosed by Edward in his presence.

264. There is no evidence that DHHS requested further information from the House Manager or Psychologist A at the time about these disclosures. The disclosures included multiple instances of sexual contact that may constitute additional alleged rapes of other Autism Plus clients.¹⁰⁹ The police statement of Psychologist A contained further details of these allegations:

**Police statement of Psychologist A:
20 July 2017**

From Autism Plus's incident report:¹¹⁰

[After disclosing that he had allegedly raped Robert] '[Edward] then went on to report that he had anally penetrated a person called [Luke] 2-3 times a day at his placement. He also stated he had done the same to a male called [Steven]. He reported humping a person called [Mark] a few times in the toilet. He stated that he also touched a female called [Mary] and another named [Jane] over their clothes in the toilet at [Smith Street]. He indicated he had done this on numerous occasions.'

Policy and legal rights

265. The DHHS incident reporting policy¹¹¹ provides guidance to funded agencies, including the categorisation of sexual assaults and the requirement for these incident reports to be submitted to DHHS within 24 hours. Additionally, the policy states the relevant DHHS divisional office is responsible for actions including:

- ensuring, in the first instance, that the immediate needs of the clients have been met and appropriate follow-up actions are taken or planned
- providing detailed guidance on investigation processes where appropriate
- ensuring that the local level service provider has informed all relevant authorities including, but not limited to, Victoria Police...
- undertaking compliance checks.

266. The DHHS Local Connections staff are responsible for:

- ensuring that community service organisations are aware of and comply with the instruction (DHHS policy).

109 Written response to draft report by Victoria Police 9 August 2017, which contained Psychologist A's police statement 20 July 2015.

110 *ibid.*

111 DHHS, April 2014 < <http://www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services> > viewed on 22 September 2016.

267. The DHHS assault policy¹¹² states that when allegations of physical or sexual assault are made against a client of a disability services provider, it is mandatory for the provider to make a police report. The next of kin or guardian (family) of the client alleged to have been assaulted must also be contacted if the client is under 18 and receiving disability services. Clients over 18 are able to make their own decisions about whether their family is contacted. However, families of adult clients must be notified by the service provider of any allegations, and asked if they wish to attend any police interviews, if a client has a cognitive disability and is unable to make an informed decision regarding contact. Autism Plus did not provide any evidence that any of the clients identified declined contact to be made with their families or provided informed consent to support such a decision.

268. Although Director 1 Autism Plus stated that it was the responsibility of other staff to report these assaults to the police, her organisation's investigation policy¹¹³ states that post internal investigation 'Directors will then decide what actions, if any, should be taken and notify the applicable parties i.e. client, staff, HR Manager, police, DHHS'. Whilst the policy does state that 'all relevant reporting requirements should be followed' there is no reference to the DHHS policies which detail these requirements.

269. People with a disability have the right to effective access to justice, including as a witness, in accordance with Article 13 of the UNCRPD.

Incident report

270. Autism Plus did not submit an incident report containing Edward's 20 April 2015 additional disclosures until 25 April 2015¹¹⁴. DHHS advised the investigation that Local Connections Officer received a copy of the incident report, prepared by the House Manager Smith Street, on 25 April 2015 and that Autism Plus had advised DHHS that it had made a police report. The Local Connections Officer confirmed this at interview on 18 May 2017 and stated that it was Disability Services' responsibility to ensure that a police report had been made. The Local Connections Officer said she sent the incident report to the Team Leader Disability Services for follow up and then in October 2015, the Local Connections Officer received an internal investigation report about these matters from Autism Plus, prepared by the Regional Manager Autism Plus.

271. The incident report, prepared by the House Manager Smith Street:

- incorrectly categorised the disclosures as 'Behaviour-Sexual' rather than the more serious 'Sexual assault'
- did not identify the alleged sexual assaults as rapes or other Category One incidents
- did not include any names of the clients identified by Edward or details of the disclosed assaults against them.

112 See n 39.

113 Autism Plus, *Investigation policy and procedure*, undated.

114 CRIS Case note of email communication from Officer Disability Services to Local Connections Officer, stated 'Autism Plus have not completed an incident report regarding 9 sexual assault disclosures from [Edward] related to other assaults he made towards other clients', 23 April 2015; Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 12 August 2016.

272. In his response to the draft report, the House Manager Smith Street said:

- an Autism Plus manager advised him to classify the incidents as 'behaviour sexual' and not to include the names of the identified clients on the incident report as Autism Plus 'could not yet corroborate the information'.
- he was never asked to resubmit the incident report with client names.
- he presumed a staff member in the day program, from which he stated the clients named were participants, would deal with the matter after he submitted the incident report.

273. The incident report stated 'police were contacted in regards to other investigation [the alleged rape of Robert]'.

274. DHHS requested Autism Plus resubmit the incident report (for the other alleged assaults) as part of the initial incident report containing Edward's disclosure that he had raped Robert. There is no record of this occurring. On the copy of the incident report provided by DHHS containing these other allegations, the 'Internal DHHS Review' and endorsement by manager and executive sections are blank and there is no reference number attributed to the report.

275. At interview, the Case Manager Disability Services recalled asking the Regional Manager Autism Plus for the reports of the other alleged assaults several times and that the Regional Manager responded that she had 'walked into chaos' and 'I'm drowning'. In her response to the draft report, the Regional Manager stated, 'I reject [this] reference...on the basis that it is incorrect...the communications that occurred between [the Case Manager] and I were minimal'. However, the Regional Manager did state 'my period of employment was very reactive. I was moving from one spot fire to another' and that it was the most 'negative professional experience' she had ever had.

276. The Regional Manager Autism Plus also stated, 'I believe I was acting within instructions from DHHS in relation to how the [incident] report was completed and submitted'. She did not agree that she was asked to resubmit the incident report, rather 'I was informed that this report would be attached to the original incident report relating to [the alleged rape of Robert]'.

277. The Case Manager Disability Services stated at interview she did not follow up with Victoria Police as she 'ordinarily would' as the Regional Manager Autism Plus never provided her with any client names or specific assault information to do so. However, the Case Manager recorded that she advised Psychologist A on 21 April 2015 that:

DCS [Disability Services] will take all the necessary steps to ensure the safety of residents was upheld and that the correct procedures are implemented following the incident report.

278. On 29 April 2015, Psychologist A informed DHHS she had conducted a telephone counselling session with Edward and that he 'still maintained that the disclosures were true'.¹¹⁵

115 CRIS Case note of telephone communication by Officer Disability Services with Psychologist A, 29 April 2015.

Autism Plus's internal investigation

279. Autism Plus conducted an internal investigation and prepared a report¹¹⁶ which stated it was an 'investigation into the disclosures' Edward made on 20 April 2015 including 'inappropriately touching and sexual penetration' against five clients; however:

...due to the nature of the disclosures, the time lines provided...and the findings of the report, families of individuals mentioned...were not informed.

280. Autism Plus's investigation report stated that it had commenced an investigation into 'the disclosures made to Psychologist A and [the House Manager Smith Street]' which included:

participants mentioned to have attended Autism Plus day service at times when [Edward] was supported by Autism Plus [in] contingency accommodation

...

[during] Victorian school holiday dates

...

[the] location of and environmental layout of the day service located at [other service address] were commenced

...

it was ascertained that a period of time between January 2012 and December 2013 would be explored.¹¹⁷

281. The Autism Plus investigation did not include interviews with Edward or the affected clients. The report stated Autism Plus considered the absence of families or group home staff reporting changes in behaviour or health concerns with these clients, and the perceived 'low possibility' of Edward being unsupervised, as key evidence that the disclosures were not true.

282. Director 1 Autism Plus acknowledged at interview that it was Victoria Police's role to investigate sexual assaults. She stated Autism Plus's investigation was 'merely examining staff actions... we reported that to the police...the police took over the investigation'. She identified the Regional Manager Autism Plus and House Manager Smith Street as responsible for reporting to police.

283. In this regard, Autism Plus's investigation report stated:

[The House Manager Smith Street] reports that disclosures made on the night of 20/4/15 were mentioned to Police...on Wednesday 22 April 2015 where [Edward] attended to make a statement to police about the incident alleged to have occurred on 18 April 2015¹¹⁸ [the alleged rape of Robert].

Police are reported to not have discussed this further or addressed it with [Edward] due to the inconsistent information that was provided. Separate reports of the incident or follow up interviews were not conducted. Therefore Autism Plus note that the disclosures of behaviour sexual client to client as documented in the above incident report were not reported separately to Police. As reported to DHHS.

¹¹⁶ Regional Manager Autism Plus (name not written on report), Untitled internal investigation report, 27 May 2015* (not submitted to DHHS until October 2015).

¹¹⁷ The Autism Plus investigation reported stated 'These dates reflect the time when Autism Plus provided day service support at [other service address] and also provided supported to [Edward] with contingency accommodation. It is noted that Edward did not limit his disclosures to these dates or only participants of the day program at this other service.'

¹¹⁸ This report stated 19 April 2015 as the date of the alleged rape of Robert, however, all other documentation contains the date 18 April 2015 which has been used in this quote to avoid confusion.

284. When the investigation showed Director 1 Autism Plus the unsigned investigation report at interview she confirmed the author was the Regional Manager Autism Plus and that she had reviewed this report. Director 1 agreed that if Edward had disclosed names of clients he reportedly assaulted, these should have been documented in the investigation and incident reports. However, Director 1 then stated 'there have been no circumstances that we have seen that give reason for us to believe that he [Edward] assaulted anybody else' and that she was not aware of any other names (except Robert) being disclosed by Edward.

285. It is noted, however, that the investigation report stated 'Disclosures of incidents of sexualised behaviours towards participants (5) at Day Service programs...were made by [Edward]...[The Regional Manager Autism Plus] located information regarding participants **named** [added emphasis] by [Edward]'.¹¹⁹ Additionally, the report stated that 'due to the dates of the alleged sexualised behaviour disclosed and significant time that had elapsed a forensic examination of those **named** [added emphasis] was unable to occur'.

286. In her response to the draft report, the Regional Manager Autism Plus explained that Autism Plus management was aware of the identity of the clients involved and that these are contained in the investigation report, albeit this information is not clearly identified. There is a dot point under 'documentary evidence considered' which stated 'Participant starting dates information, protective skills information and other client profile information of participants: [initials of five Autism Plus clients]'.

287. Despite evidence to the contrary presented to her at interview, including the Autism Plus investigation report, a week later Director 1 Autism Plus wrote to the investigation again denying that Edward had made any 'further disclosures', other than those relating to Robert:

Autism Plus has no evidence nor have we been given any information that there were any other disclosures made by [Edward] relating to other clients... Autism Plus's investigation report, which relates to the incident on the 18th April 2015, on information available to us it is our belief that the incident was only related to [Robert and Edward]. Under DHHS Incident Reporting guidelines only clients involved are named on the report. Autism Plus are very aware of the serious nature of the incident and therefore the requirement to ensure that we follow correct protocols re clients, families and staff privacy and confidentiality.

288. In response to the draft report regarding whether other alleged assaults had been disclosed by Edward, Director 1 stated:

When questioned in regard to any further disclosures made by [Edward], my answer related to possible additional unknown disclosures about the residential setting, in which I believed there was nil.

289. Director 1 also stated:

All internal investigations completed by Autism Plus into category one incidents follow the recommended Disability Services Commissioner guidelines and protocol...

Autism Plus did not contact the families of the other clients as we had little information to give.

¹¹⁹ Regional Manager Autism Plus (name not written on report), Untitled internal investigation report, 27 May 2015 (not submitted to DHHS until October 2015).

290. In response to the draft report regarding the investigation report she prepared, the Regional Manager Autism Plus stated she was guided by Director 1 and that she was new to Autism Plus and received little to no training. She said that she faced 'difficulties locating information [during her investigation]...due to a lack of cooperation from some Autism Plus staff and lack of documentation', for example 'sign in sheets' for day placement attendees. The Regional Manager said that the clients named by Edward were 'provided verbally to Director 1 Autism Plus on the night of the disclosures' and discussed on multiple occasions with both Directors subsequently. She claimed that she had 'experienced backlash' after disagreeing with the Directors on an unrelated issued and so:

As a result of this intimidation, I followed the instructions of my managers not to inform the families of the individuals that were mentioned in the disclosures. In any event, informing families, at all times was the responsibility of [Director 1 Autism Plus], who had previously advised me that she would contact families relating to other significant communications... it was not in my job description.

291. The Regional Manager Autism Plus further stated in her response that DHHS did not request the names of the clients who were the subject of Edward's disclosures. She declared that the support provided by DHHS to Autism Plus in April-May 2015 'was poor and unsupportive'.

Victoria Police involvement

292. On 19 October 2016, Victoria Police advised the Ombudsman that it had not received any reports about the up to nine additional alleged sexual assaults at Autism Plus reportedly disclosed by Edward on 20 April 2015. In accordance with section 16L(1)(a) and (b) of the Ombudsman Act the Ombudsman provided information about these alleged assaults to Victoria Police. DHHS also confirmed that the families of the clients identified by Edward, as subject to possible sexual assaults by him, had not been notified of the disclosures by DHHS.

293. At interview, the House Manager Smith Street provided the investigation a copy of an amended statement he made to Victoria Police on 24 October 2016. However, this statement did not contain the identities of the clients involved.

294. Victoria Police advised that it was unable to progress its investigation of these other allegations due to the clients affected being primarily non-verbal and because witnesses from Autism Plus did not provide clear statements. Additionally, the Office of Public Prosecution had determined not to proceed with the trial for criminal charges against Edward in relation to Robert, due to both parties' disabilities.

295. Subsequently, in his response to the draft report, the House Manager Smith Street's legal representative revealed that he had reported the allegations to Victoria Police 'sometime after 21 April 2015'. He said he had a conversation with Detective A from Victoria Police and he asked 'whether he should include the nine other alleged victims in [his] police statement'. He said Detective A instructed him to 'only write about the assault in respect of [Robert], as it was that incident that police were currently investigating'.

296. In response to further enquiries with Victoria Police, Detective A confirmed the House Manager Smith Street had informed her of additional alleged assaults. Detective A stated on 23 May 2017¹²⁰ that she recalled:

This information was given in brief when we first heard of the offence [by Edward against Robert], and no details of any victims or offending was provided to us. As such, I did ask [Edward] during his interview if he had assaulted anyone else and he stated he hadn't. This was all we could go on at the time, much like the offence he was being interviewed for.

When I asked him [the House Manager] about the other residents' ability to communicate I was informed it was the same as [Robert] - unable to communicate. As such, it was not included in the brief, and not necessary to put in his statement which was for the incident we had details of.

297. Detective A also provided an extract of an email written by the House Manager Smith Street on 15 August 2016 in which he stated:

During the disclosure [Edward] mentioned that [Robert] was not the only one that he sexually assaulted while he lived at the Autism Plus properties...he said to [the House Manager Smith Street and Psychologist A] that he had sexually assaulted another 8 people that used the service, either utilising the day service and accommodation. He mentioned detailed accounts of where and what he did as well as the other people's reactions, they were both male and female. As I, [House Manager Smith Street], was in and out of the room discussing these details with [the Regional Manager Autism Plus], I do not have the details of the other disclosures, however both [Autism Plus Officer B and the Regional Manager] were taking notes and details that [Edward] was revealing.

I cannot really remember all the details, there were other Autism Plus staff that will be able to help if required that are mentioned above.¹²¹

298. On behalf of Autism Plus, Director 1 responded to the draft report. She provided the following information about communication with police:

These additional disclosures were reported immediately to...Victoria Police on the 22nd April 2014.

A thorough internal investigation was completed to enable us to provide the police with additional information from service and client records as well as confirming the names of possible victims...this information was given to the department and Victoria Police. Neither the department nor Victoria Police came back to us requesting further detail.

120 *ibid.*

121 Written response to draft report by Victoria Police 4 August 2017.

299. Victoria Police provided a detailed response to the draft report stating:

[Detective A] advises that from the accounts obtained during the investigation it was apparent that the offender should not have been placed at this premises owing to risks he posed to other residents.

The offender was asked if he has assaulted anyone else at the premises and he replied that he did not. In the absence of specific allegations this line of questioning was not pursued further at this point. The absence of particularisation meant that these acts were not included on the brief of evidence as either charges or uncharged acts.

...further material was sought from Autism Plus for the preparation of the brief of evidence but [Detective A] has no recollection or notes of being provided with a copy of the Autism Plus investigation report.

300. I note, however, that the House Manager Smith Street's email to Detective A, dated 15 August 2016, alerted Victoria Police to the identities of Autism Plus staff who could provide further details.

Autism Plus training and audits

301. At interview, Director 1 Autism Plus stated that, 'compared to six years ago', Autism Plus is 'far more sophisticated and better at induction and training'. The training records for her organisation show that only 11 of 134 staff have completed incident report writing training, which first took place on 14 August 2015.¹²² She stated that the DHHS audits of Autism Plus had consistently resulted in the organisation being reaccredited and DHHS looked at 'all of our records... our audits are evidence based'.

302. Whilst the DHHS audits conducted in 2013 and 2015¹²³ found Autism Plus to be compliant in all areas, only a small sample of its records were examined. In contrast, the review conducted by Heather Michaels and Associates in October 2015, as a result of Quality of Support concerns raised by DHHS, was more critical and examined all incident reports between 18 August 2014 and 13 August 2015, which includes the time period of the investigation.

303. This review found some incident reports had not been categorised correctly; others were not reported to DHHS or police within required timeframes; follow up actions were contradictory; and content lacked detail and knowledge. This review stated:¹²⁴

...concerns continue to be raised about the quality of incident reports submitted by Autism Plus to the Department. Concerns about aspects of incident reporting by Autism Plus have been included in Desktop Reviews undertaken by the Department in 2011, 2012, 2013 and 2014.

304. Heather Michaels and Associates cited 'systemic analysis of incident reporting at Executive meetings' and 'the new appointment of staff with advanced qualifications and industry experience' as measures Autism Plus was taking to remediate these issues.¹²⁵

122 Spreadsheet of training records of Autism Plus (undated) provided with summons.

123 Heather Michaels review 2015; SAI audit 2013; SAI audit 2015.

124 Heather Michaels review 2015.

125 *ibid.*

Record keeping

305. The investigation identified an absence of key records in relation to DHHS's and Autism Plus's management of Edward, key decisions, incident report management and meetings between Autism Plus and DHHS; other records were incomplete or inaccurate.

306. The Ombudsman's investigations into Child Protection in 2009 and 2011 both identified poor recording keeping, including an absence of a detailed analysis of key decisions on files.

Legislation and policy

307. All Victorian public sector employees, government agencies and service providers performing public functions must comply with mandatory standards and specifications, established under the authority of the Public Records Act, for managing the records they create and receive in their work.¹²⁶ Additionally, the Child Protection Manual¹²⁷ instructs practitioners and refers to their professional and legal requirement to comply with the Public Records Act.

308. The Child Protection Manual states that 'case recording is an important aspect of statutory child protection practice' with important functions including to 'articulate the assessment and rationale behind case decisions' and to 'fulfil professional and legal accountabilities'. CRIS case notes are specifically structured so that risks and key decisions are clearly identifiable. The manual provides guidance to practitioners:

General case notes must always contain:

- the purpose and outcome of the event
- key issues discussed or arising
- changes to risk assessment or wellbeing
- decisions made
- action taken or required, and;
- reference to any other relevant information on either the electronic or the paper file.

Child Protection

Missing and inaccurate information

309. Child Protection's records during the period of the investigation were limited and contained inaccurate information about Edward. For example, the Team Manager Child Protection recorded on Edward's closure summary that he had Autism; however, Edward does not have a diagnosis of Autism.

¹²⁶ Public Record Office Victoria, PROS 10/10 FS2 *Recordkeeping Responsibilities for Public Sector Employees* 2015 <http://prov.vic.gov.au/government/standards-and-policy/all-documents/pros-1010-fs2> viewed on 14 January 2017.

¹²⁷ DHHS, 1 December 2015 *Child Protection Manual: Case recording* < <http://www.cpmanual.vic.gov.au/our-approach/roles-responsibilities/case-recording> > viewed on 17 January 2017.

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310. No risk assessments, case planning decisions or safety and wellbeing statements were completed on CRIS case notes, and there are designated sections in the structure of the notes for this purpose. There was no record of a consultation with Practice Leaders regarding case closure or placement decisions. Sections of the case plans and the closure summary were blank, including 'reason for closure'. The court screens on CRIS were also contradictory and practitioners had not recorded notes so DHHS was unable to confirm when the last CTSO expired and under what circumstances. This necessitated clarification by the investigation with the Children's Court.
311. The reports to the Children's Court did not disclose that Edward was last visited by Child Protection in 2011; that he wanted to live with his family¹²⁸, as recommended by Psychologist A¹²⁹; and that this had not been formally assessed. Additionally, the reports did not state that Edward was in contingency placements and had been exhibiting an escalating pattern of assaultive behaviours, which had not been formally assessed. The final court report¹³⁰ stated that Edward 'has been thriving in his current placement' and that actions required to promote his best interests included remaining in this placement, which was not possible, as it was a contingency placement. One week before the report was submitted Edward had allegedly perpetrated a serious physical assault on a co-resident and staff member (see Table 1 in the Appendix). These details were also not included in the court report. Edward's 'rights' section was blank.

Accountability for record-keeping

312. At interview, the Area Manager Child Protection stated that it was the role of her direct reports to document consultations they conducted with her as Area Manager and for her own managers to document those she had with them in supervision records. She was unable to explain why she had not recorded case planning and closure decisions made in relation to Edward's placement or why there was no record of communication with the Team Manager Child Protection (who was managing Edward's 'unallocated' case) following her meetings with Disability Services and Autism Plus. The Area Manager stated that she used a 'day book' to hand-write notes of these consultations and directions to staff but that she destroyed this book when she resigned from DHHS in 2015 as she considered it her records. The investigation obtained the Area Manager's supervision records, which did not contain any reference to Edward, Robert or Autism Plus.

128 Autism Plus, Behavioural Support Plan dated 5 December 2014, indicates Director 1 Autism Plus approved the document on 5 December 2014 but the file provided to Victorian Ombudsman was not created until 14 May 2015 and was not received by DHHS until 25 May 2015, after Edward had left Autism Plus's care.

129 Email communication from Case Manager Disability Services to IFS Manager DHHS, Team Leader Disability Services and Officer Disability Services regarding Psychologist A's opinion, 16 December 2014; Email communication from DHHS Officer to Case Manager Disability Services and Team Leader Disability Services, 29 April 2015.

130 CPP, Disposition report in support of application to extend protection order for Edward, [date of report removed].

313. When asked at interview, the Team Manager Child Protection agreed that Child Protection's decision for Edward to remain in his placement in December 2014, after the CTSO had lapsed, should have been recorded in CRIS, including the details of the staff member who made this decision and the authority used. Whilst the Child Protection Manual states that the 'team manager must record case planning decisions' it does not appear that this decision was communicated to the Team Manager. The Team Manager also raised concerns about critical information, known to the Area Manager Child Protection, missing from Edward's records:

There was a lot of information I didn't know...I feel quite distressed...there was information that would have impacted on my decision making...I would be quite concerned if I had that level of information and didn't give it to my managers.

314. As detailed earlier in this report, the Team Manager provided a crucial email sent to her from the Area Manager Child Protection requesting that Edward's case be closed. This was not recorded in CRIS (see Figure 4).

315. In her response to the draft report, the Team Manager added:

I was not aware of information and events that occurred during this period, including:

- a. the fact, and content, of the meeting that occurred between Child Protection, Disability Services and Autism Plus on 4 December 2014
- b. the complaint made by [Robert's] father via email on 10 December 2014
- c. the request from Autism Plus on 11 December 2014 that [Edward] be moved to another placement option that they had identified; and
- d. the decision apparently made by Child Protection and Disability Services on 12 December 2014 that [Edward] should remain at Autism Plus...

It had not been raised with me that a specialist risk assessment had been identified as needed.

316. Additionally, while the Child Protection Manual instructs staff to record all 'critical incident reports' on CRIS, the Team Manager Child Protection stated that she had only seen one of the four incident reports (see Table 2 in the Appendix), received by DHHS between 11 November 2014 and 18 November 2014, when she made the decision for Edward's CTSO to lapse.

317. The Area Manager Child Protection responded to the Team Manager Child Protection's evidence in the draft report that she had not shared information with her about concerns at Edward's placement:

[Her] statement is contrary with the information [in the draft report] which outlines the case note recording by [the Team Manager] on 2 January 2015 '[Edward] has been involved in inappropriate sexual behaviours...'

It is not probable that I did not update [the Team Manager] as to the concerns and issues in relation to [Edward's] placement.

More generally, the Area Manager Child Protection stated:

Consultations and discussions about cases in Child Protection frequently occur outside supervision...the absence of any notes about this matter in [my] supervision books is a reflection that there was not a recording of that information by my direct line manager.

There was no specific practice policy within Child Protection to maintain or store daily handwritten notes. There has not been a practice instruction to retain daily work books. The DHHS Child Protection Manual remains silent on the issue of archiving and storing all documents in the course of child protection work.

Child Protection practitioners were advised repeatedly over the years not to store handwritten notes due to a shortage of archiving space...Child Protection practitioners who exit Child Protection destroy their daily work books.

318. In response to the draft report, the Deputy Area Manager Child Protection's legal representative stated on her behalf:

While critical emails would be saved on CRIS, it was not procedure to save all emails related to a matter on CRIS. What would normally happen is that the Team Manager or the Child Protection Practitioner would document significant case information on CRIS. In relation to Critical Incidents, CRIS documentation would include follow up action undertaken.

319. However, the Child Protection Manual does not instruct staff to use their discretion to record only 'significant case information' on CRIS. It states 'any emails' are to be recorded on CRIS or the paper file (with a corresponding file note in CRIS).

Disability Services

320. The Case Manager Disability Services recorded detailed notes, but raised concerns with the investigation at interview that she was unable to provide records of some key internal consultations, meetings and placement decisions as other DHHS staff had not documented these on CRIS. She stated:

It was a direction to not put internal discussions around this sort of placement on CRIS...so there are things you are not privy to with this investigation... they have been deleted...it was the most complex case I had worked on so I thought 'maybe this is what happens [with the records]' and that direction has probably impacted on this case.

Autism Plus

321. Autism Plus's records relating to its performance of public functions, on behalf of DHHS, such as providing residential care and disability services to DHHS clients at Smith Street were largely inaccurate, missing or out of date. As detailed in this report, public record management issues identified at Autism Plus included:

- documents relating to Edward's placement at Smith Street and an agreement with Child Protection about care he was to receive were missing or did not accurately reflect the care and supervision Autism Plus provided¹³¹
- Edward's Behaviour Support Plan, dated 2014, was incomplete, inaccurate and not submitted to DHHS¹³²
- records of key communications with DHHS, such as Edward's case plan meeting on 17 November 2014; meeting with DHHS on 12 December 2014 to determine Edward's placement; and related funding requests could not be provided to the investigation by Autism Plus¹³³

- several incident reports were not categorised, or were categorised incorrectly, including the additional alleged sexual assaults disclosed by Edward on 21 April 2015, which contained only Edward's name, not those who were the subject of the sexual assault allegations
- Autism Plus's internal investigation report of this incident did not list an author; identify clients clearly with associated details of the sexual assaults alleged to have been perpetrated on them; or include known deficiencies in Edward's supervision as evidence to support that assaults may have occurred.

¹³¹ Unknown author, *Looking After Children 15+ Care and Transition Plan* dated 13 March 2013; Residential Statement dated 15 September 2013 to 'open'; Residential Statement dated 6 March 2015 to 6 March 2016; Interview with Case Manager Disability Services, 24 October 2016; Interview with House Manager Smith Street, 15 December 2016.

¹³² Autism Plus, Behavioural Support Plan dated 5 December 2014, indicates Director 1 Autism Plus approved the document on 5 December 2014 but the document provided to Victorian Ombudsman was not created until 14 May 2015 and was not received by DHHS until 25 May 2015, after Edward left Autism Plus's care.

¹³³ Team Manager Child Protection, CRIS Other meeting record dated 17 November 2014, emailed by Team Manager Child Protection to Victorian Ombudsman, 28 October 2016; Interview with Director 1 Autism Plus, 6 December 2016; Email communication from Director 1 Autism Plus to Victorian Ombudsman, 13 December 2016.

Victorian Auditor-General's report – March 2017

322. The Victorian Auditor-General's Office's (VAGO) report, *Managing Public Sector Records*, examined whether DHHS's record keeping practices complied with Public Records Act standards. VAGO found a number of 'weaknesses', including inadequate training for staff and contractors on their records management responsibilities; storage of records in staff email boxes; and a failure of DHHS to monitor service providers' compliance with legal requirements for managing public records. VAGO concluded that DHHS was 'not managing all of their records in accordance with all legal requirements'.
323. VAGO noted that DHHS is developing initiatives to improve staff records management capability; however, several solutions to address risks identified by VAGO in 2008 have not been implemented by DHHS. Ms Kym Peake, Secretary of DHHS responded to VAGO's report and stated 'VAGO's recommendations are welcome and:
- ...they will further support my department to continue the work we are undertaking to improve records management, in particular, to improve management of records for individuals who experienced institutional or out-of-home care as children or young people.'
324. DHHS provided an action plan to VAGO including implementing a Records Management Compliance Program Plan by October 2019 and changes to the way service providers' compliance with records management is monitored by DHHS for the funding period commencing from 1 July 2017.

Conclusions

325. Children who have been removed from their parents have a right to the highest standard of care and to protection of their best interests and rights by DHHS and its service providers.
326. The Ombudsman commented in the 2009 *Investigation into the Department of Human Services Child Protection program*, that the majority of child protection staff are highly committed to achieving positive outcomes for children. Equally dedicated are most of the workers in the disability sector who passionately support and advocate for the rights of people with a disability. The failures identified in this report should not be seen to reflect on the dedicated staff working in such challenging circumstances.
327. The evidence in the investigation has shown that there were serious deficiencies in Edward's supervision and care at Smith Street. Repeated failures by Autism Plus and DHHS, both by individuals and systemically, contributed to an unacceptable risk of significant harm to other clients, staff and Edward. According to Edward's disclosures to his psychologist, for at least three residents, including Robert, the consequences of these failures were of the severest kind. This is not acceptable.
328. Repeated concerns were raised within DHHS about the quality of care being provided by Autism Plus. These concerns included failures to adequately identify, categorise and report instances of alleged assaults by Edward. Despite this and concerns from Autism Plus itself regarding its ability to adequately cater for Edward's needs, DHHS did not take sufficient action to ensure suitable accommodation and supervision for Edward.
329. Edward had been a DHHS Child Protection client for nearly five years before he turned 18 and it was obvious that he would need continued support as a Disability Services client. However, there is no evidence that his long-term care was adequately planned for or effectively managed by either Child Protection or Disability Services.
330. The actions and decisions which underpinned the failures identified in Edward's care and management by DHHS and Autism Plus were not consistent with rights afforded to children and persons with a disability. Residents at Smith Street were not protected from harm and Edward, a vulnerable child with complex needs, was not provided with alternative accommodation or intervention services when he needed them to ensure his best interests were protected.

Autism Plus

331. The evidence shows that Autism Plus had concerns about its ability to manage Edward. Yet in December 2014, DHHS instructed the agency to keep Edward at Smith Street. Director 1 Autism Plus reluctantly agreed, at least in part, for fear of losing government funding.
332. In April 2015, Director 1 cut staff supervision of Edward at night from two staff members to one, in contravention of Edward's 'guaranteed supports' in his Residential Statement provided under the Disability Act. This decision was made despite objections from staff and meant that the two-person restraint, identified by Autism Plus as a necessary response to assaults by Edward, could not be implemented if required at night. Within days of this decision, a staff member was repeatedly attacked and Robert was allegedly raped.

333. Autism Plus did not comply with the Disability Act, DHHS policies and Human Service Standards (including protection and promotion of human rights to ensure that residents were protected from violence and abuse), by failing to have up to date Looking After Children documents, Behaviour Support Plans or approval from the Secretary for DHHS to use restrictive interventions to manage Edward's behaviour.¹³⁴
334. In addition, Autism Plus did not comply with the DHHS assault policy, or its own investigation policy, regarding the alleged assaults by Edward against clients other than Robert.
335. The Autism Plus investigation was not evidence-based. For instance, Autism Plus's conclusion that Edward would not have had an opportunity to perpetrate the alleged assaults does not reflect the known deficiencies in his supervision.
336. Director 1 did not acknowledge any of the failings by Autism Plus when provided with evidence at interview, including the dereliction of her duty as a Director to ensure that all families of the clients Edward identified in his sexual assault disclosures were notified, as detailed in the Autism Plus Policy.¹³⁵ This, as well as failures by DHHS and Victoria Police's decision not to investigate the alleged assaults, compromised the affected clients' rights and denied them access to justice.

DHHS

Placement decision that Edward must remain at Smith Street

337. The evidence indicates that both Child Protection and Disability Services staff made the decision for Edward to remain at Smith Street despite the obvious risk to Robert, as well as other clients and staff, and requests from Autism Plus and Robert's father that Edward be moved.

338. Neither the Area Manager Child Protection nor the IFS Manager DHHS recorded their reasons for decisions they made as managers at the key placement meeting on 12 December 2014, nor the authority on which they relied for the exercise of this power.

339. At the time:

- Smith Street had been assessed by Autism Plus and DHHS as unsuitable to meet Edward's long-term needs.
- DHHS had concerns about Autism Plus, including its response to incidents, supervision and training of staff.
- there was no current Behaviour Support Plan for Edward, which DHHS said supported this decision.¹³⁶
- there had been no specialist risk assessment or intervention service provided to Edward, nor evidence of proper consideration of the alternative placements offered by Autism Plus or other contingency placements DHHS could fund.
- DHHS's decision that Edward remain at Smith Street did not promote his best interests¹³⁷ nor right to protection¹³⁸ and it disregarded other Smith Street residents' rights to be protected from violence and abuse.¹³⁹
- In the months following this decision, Edward attacked Autism Plus staff members and allegedly raped Robert. He also disclosed sexually assaulting at least five other Autism Plus residents and/or day program participants.

¹³⁴ Disability Act sections 54, 57, 133-150.

¹³⁵ Autism Plus, *Investigation policy and procedure*, undated.

¹³⁶ Area Manager Child Protection, Information Update No 1 endorsed by Deputy Secretary 2 January 2015.

¹³⁷ United Nations *Convention on the Rights of the Child* 1989 Article 3; CYFA sections 10 and 174(1)(a).

¹³⁸ Charter of Human Rights and Responsibilities Act section 17(2).

¹³⁹ United Nations *Convention on the Rights of Person with Disabilities* 2006 Article 16.

Child Protection visits and consideration of Edward's views

340. Child Protection's failure to visit Edward for more than three years, and to consider his views and those of his treating psychologist and family regarding his final case plan, was contrary to the requirements of the CYFA.

341. In determining what action to take in the best interests Edward, section 10(3)(d) of the CYFA required DHHS to consider:

the child's views and wishes, if they can be reasonably ascertained, and they should be given such weight as is appropriate in the circumstances

342. Section 11 required consideration of the following decision-making principles:

- a) the child's parent should be assisted and supported in reaching decisions and taking actions to promote the child's safety and wellbeing;
- ...
- c) the decision-making process should be fair and transparent
- d) the views of all persons who are directly involved in the decision should be taken into account;
- e) decisions are to be reached by collaboration and consensus, wherever practicable;
- ...
- g) the decision-making process should be conducted in such a way that the persons involved are able to participate in and understand the process, including any meetings that are held and decisions that are made; and
- h) person's involved in the decision-making process should be provided with sufficient information, in a language and by a method that they can understand...to allow them to participate fully in the process.

343. It is telling that the 'rights' section of Edward's last court report submitted by Child Protection was blank.

344. The Team Manager Child Protection said that she had not visited Edward as required when closing his involvement with Child Protection because of his disability, despite no record of concerns with his communication at previous visits. This decision failed to respect the capabilities of persons with disabilities and their right to have their own voice and opinions heard and considered.

Child Protection order lapse

345. In the absence of any assessment to determine the treatment needs and suitability of alternative placement options for Edward in accordance with the CYFA,¹⁴⁰ Child Protection made the decision to allow Edward's CTSO to lapse on 18 November 2014. This occurred one day after purportedly telling Disability Services and Autism Plus that the CTSO had already lapsed because there was no role for Child Protection. Child Protection's decision:

- was made without adequate referrals to services to address Edward's assaultive behaviours
- did not consider the ongoing role for Child Protection given that alternative placements had been deemed unsuitable, that Disability Services had limited placements for children and that multiple complaints had been made to DHHS about Edward placing others at risk at Smith Street; Victoria Police had also reported that Autism Plus were not willing to keep Edward at Smith Street once he turned 18
- did not consider the legal implications of Child Protection's lack of authority to make subsequent placement decisions once the CTSO lapsed, including that a new Children's Court order could not be obtained, if required, due to Edward's age¹⁴¹
- eliminated the opportunity for Autism Plus, Disability Services and other relevant professionals and family members to oppose this decision, in accordance with the CYFA, as they had been provided insufficient notice and wrongly been told by the Team Manager that the CTSO had already lapsed.

¹⁴⁰ CYFA sections 174(1)(b) and (d).

¹⁴¹ A protection order can be made for a child which section 3 of the CYFA defines for this purpose as a person who is under the age of 17.

Closure of Child Protection's involvement in January 2015

346. The Area Manager Child Protection instructed the Team Manager to close Edward's case in January 2015. This was despite eight incident reports¹⁴² revealing alleged sexual assaults against Robert, physical assaults of staff and self-harm by Edward, and Child Protection's responsibility to provide leadership on 'issues of safety and wellbeing'.¹⁴³ The Area Manager's email stated 'If [Edward] is still open it Must [original emphasis] be closed asap. We keep getting incidents reports which need Action if still open'.¹⁴⁴ This instruction was not recorded on CRIS.

347. This decision was not consistent with the CYFA, the Child Protection Manual and Edward's rights.¹⁴⁵ At the time of Child Protection's decision to close Edward's case:

- Child Protection had wrongly deferred responsibility for case management and planning to Disability Services
- an alternative placement had been identified as urgently needed but not sourced
- supervision issues remained evident at Smith Street
- referrals had not been made for the ACSO Intervention or the educational Family Planning Victoria program, despite being identified as necessary actions following the alleged Category One sexual assault incidents
- a specialist risk assessment had not been conducted.

¹⁴² Eight reports from 11 November 2014 to 11 January 2015, see Table 2 in the Appendix of this report.

¹⁴³ DHHS, *Children, Youth and Families and Disability Services Operating Framework supporting integrated practice*, November 2012 <http://www.cpmanual.vic.gov.au/sites/default/files/Disability-and-CP-Operating-Framework-Nov-2012-2813.pdf> viewed on 1 September 2016.

¹⁴⁴ Email communication from Area Manager Child Protection to Team Manager Child Protection, 17 January 2015, see Figure 4.

¹⁴⁵ Charter of Human Rights and Responsibilities Act section 17(2); *United Nations Convention on the Rights of the Child* 1989 Article 3.

Disability Services

348. Disability Services failed to obtain the specialist risk assessment, which the Deputy Secretary was advised on 26 November 2014 would be procured within a fortnight, or refer Edward to the specialist intervention program at ACSO. Disability Services also failed to ensure that Autism Plus completed tasks assigned following meetings with the agency and those recommended by the SPDT, such as training Edward's carers to understand or respond appropriately to sexual assaults and implement the DRAMS tool to predict Edward's assaultive behaviour.
349. Similarly, Disability Services took insufficient action to ensure that Edward's Behaviour Support Plan was updated or that medical reviews for the prescription of psychiatric drugs were completed while he was at Smith Street – tasks which were barriers to Edward being able to move to any new placement.
350. Importantly, the key parties appear confused about who held primary responsibility for procuring the specialist risk assessment – Child Protection argued Disability Services was responsible but did not conduct follow ups to ensure an assessment was obtained; the SPDT identified Autism Plus as responsible, at least in respect of restrictive intervention treatment plans; and Disability Services staff seemed unsure whose responsibility this was, or why the assessment was not procured. Disability Services did not provide funding for any other party to obtain the risk assessment and continued to consult with Psychologist A about her availability and costs as late as February 2015.

351. Whilst it will never be known if conducting the assessment, implementing the DRAMS tool or linking Edward with the ACSO Intervention could have prevented the alleged sexual assaults after November 2014, it is clear that senior staff at DHHS deemed them necessary actions owing to Edward's escalating behaviour.
352. DHHS subsequently advised the investigation that 'in October-November 2016 a comprehensive risk assessment and management plan commissioned by the department was developed for [Edward] by Complex Psychology'¹⁴⁶ – two years after Disability Services advised the Deputy Secretary a risk assessment would be procured in the next fortnight.

The Senior Practitioner – Disability Team (SPDT)

353. While the SPDT appears to have fulfilled its stated role to provide 'practice leadership and evidence-informed directions and recommendations'¹⁴⁷ to Autism Plus; similar to Disability Services, the SPDT appeared to transfer responsibility for important tasks such as procuring the specialist risk assessment of Edward from Child Protection and Disability Services to Autism Plus. Autism Plus did not obtain this assessment, implement the DRAMS risk assessment tool or update Edward's Behaviour Support Plan. Autism Plus had not demonstrated a capacity to address the risks at Smith Street as incidents continued to occur after November 2014, yet the SPDT reported it continued to follow up with Autism Plus to complete these tasks for nearly a year until September 2015.

146 Email from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 29 June 2017.

147 DHHS, Office of Professional Practice 5 December 2016 < <http://www.dhs.vic.gov.au/about-the-department/our-organisation/organisational-structure/office-of-professional-practice> > viewed on 1 September 2016.

354. Whilst the SPDT cannot make placement decisions or enforce DHHS's service agreement with Autism Plus, it has powers conferred under the Disability Act to 'ensure that the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with'.¹⁴⁸ However, it failed to take adequate action¹⁴⁹ to protect Edward's rights, such as issuing a written direction to Autism Plus or escalating issues of risk at Edward's placement within DHHS – despite knowing that Autism Plus was using restrictive practices without lawful approval and without formal assessments to support these decisions.

Managing dual clients

355. The Operating Framework requires that Child Protection demonstrate leadership in case planning and case management for dual Child Protection and Disability Services clients. However, in this case, Child Protection effectively deferred primary responsibility for these tasks to Disability Services. Case Manager Disability Services reported that Child Protection provided her no assistance, did not share information and did not seek her views or specialist disability knowledge. She had only commenced working with Edward in August 2014 and stated Edward was her most complex client. The investigation found the Case Manager to be a credible witness who kept detailed records and raised issues with her managers.

356. As manager of Disability Services' case management, the IFS Manager DHHS denied that Child Protection had deferred case management and planning responsibilities to Disability Services; however, she conceded at interview that this issue had been raised in regard to Edward and other clients by staff in her team, including a failure of Child Protection staff to respond to Disability Services. This led the IFS Manager to raise the issue directly with the Area Manager Child Protection.

357. It appears that Child Protection's deferral of its responsibilities with respect to Edward as a Disability Services client may not be an isolated incident, particularly given the apparent workload pressures for Child Protection staff and the increasing number of unallocated cases that witnesses reported to the investigation that had an impact on Edward's care and management.

DHHS as regulator

358. DHHS is required to regulate funded agencies, including Autism Plus under the service agreement,¹⁵⁰ to ensure that all 'providers registered by the department meet the Human Services Standards'.¹⁵¹ In Edward's case, Autism Plus failed to meet the Human Service Standards 1.2, 3, 3.1, 3.4 and 3.5,¹⁵² which DHHS failed to adequately monitor or intervene to remedy.

148 DHHS, Office of Professional Practice 5 December 2016 < <http://www.dhs.vic.gov.au/about-the-department/our-organisation/organisational-structure/office-of-professional-practice> > viewed on 1 September 2016

149 DHHS, Disability Act 2006 Senior Practitioner information sheet 13 for service providers 2011 < http://www.dhs.vic.gov.au/__data/assets/pdf_file/0004/713551/sp_disact_infosheet_13_senior_practitioner.pdf > Powers of the Senior Practitioner include options to 'give a disability service provider a written order directing them to discontinue or alter a practice, procedure or treatment, to observe or carry out a practice, procedure or treatment, or to provide a practice, procedure or treatment to a person with a disability.'

150 Autism Plus Service Agreement.

151 Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman, 1 December 2016

152 Standards 1.2, 3, 3.1, 3.4 and 3.5 DHHS, Human services standards evidence guide, September 2015, <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/human-services-standards-evidence-guide-and-resource-tool> viewed 1 December 2016.

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359. The investigation uncovered evidence of staff across DHHS raising concerns about Autism Plus's practices, including supervision of complex clients and fire safety, with desktop reviews consistently finding Autism Plus's incident reporting practices were not compliant.¹⁵³ Despite the action taken by DHHS to raise some of these concerns with Autism Plus, it appears evident that Autism Plus did not demonstrate a capacity to change or display insight into its deficiencies of practice. This is consistent with Autism Plus's response to the draft report.
360. Accordingly, DHHS should have reassessed Autism Plus's suitability to continue to care for DHHS clients and enforced its service agreement.
361. DHHS's SAI audit 2013 and SAI audit 2015 found Autism Plus to be compliant in all areas. It is difficult to accept that these audits did not identify issues within Autism Plus, including those detailed in this report such as unreported assaults; out of date or inaccurate Looking After Children records and Behaviour Support Plans; unapproved use of restrictive practices; and care being provided contrary to required supervision in Residential Statements. It seems unlikely that the multi-dimensional problems identified with Autism Plus regarding Edward are isolated to his case.
362. It is unsatisfactory that so many DHHS and Autism Plus staff were aware that Edward had disclosed assaulting other clients - including multiple rapes¹⁵⁴ as revealed to the investigation in 2017 - yet the intervention of the Ombudsman was required to ensure both Victoria Police and DHHS had recorded correctly recorded specific details of the sexual assault disclosures. This triggered DHHS and Victoria Police to notify the clients' families in April and May 2017, as Autism Plus had failed to do so.
363. In the 2015 report *Reporting and investigations of allegations of abuse in the disability sector*, the Ombudsman raised concerns there was often 'a failure to escalate incident reports or communicate' with relevant agencies such as the police.
364. On 12 January 2017, DHHS advised¹⁵⁵ the investigation that it will implement a new client incident management system and guidelines for Victoria Police to respond to reports later this year.

153 Heather Michaels review 2015.

154 Written response to draft report by Victoria Police 9 August 2017, which contained Psychologist A's police statement 20 July 2015

155 Email communication from DHHS Protected Disclosure Coordinator to Victorian Ombudsman 12 January 2017.

Review of Autism Plus

365. Following adverse media attention, on 27 March 2017, the Hon Martin Foley MP, Minister for Housing, Disability and Ageing announced a Service Review of Autism Plus and restrictions on the use of their service by DHHS:

There is no place for abuse in our community – it cannot and will not be tolerated – especially for a person with a disability to whom we owe a special duty of care.

I have asked my department to undertake an independent review of Autism Plus. Until we are confident that Autism Plus is providing a service that meets the needs of clients in a safe and secure environment, no new clients will be placed with the organisation.

I have asked the department to contact the families of current Autism Plus clients to hear directly about their experience and any concerns they may have.

Every Autism Plus location will be inspected by the department and employee compliance checks will be completed. This is to ensure that each site is operating appropriately and with adequate supervision in place for its staff.

On 8 August 2017, DHHS provided an update about actions taken as part of this ongoing review:

- DHHS has issued a notice of intent to apply conditions to Autism Plus's registration
- conditions have been applied to Autism Plus's current contract
- an internal review of DHHS clients who are currently residing in contingency placements is commencing, with 14 clients identified as being 'in scope for this and the main objective is to ensure clients' well-being'.

366. The Ombudsman remains concerned about Autism Plus's suitability to provide disability services to some of the most vulnerable members of our community.

Autism Plus's response to the draft report

367. In her response to the draft report on behalf of Autism Plus, Director 1 made several criticisms of the investigation and did not appear to accept any responsibility for the deficiencies identified. She stated:

I note at the outset that 'the system', not Autism Plus, failed not only [Edward] but also [Robert]. The system of care including each region as defined by the Department of Health and Human Services (DHHS), presented as only having considerations in regards to 'their own' client...DHHS maintained that [Smith Street] was the best service for [Edward].

The draft report is heavily weighted with communications from DHHS which seek to relay 'concerns' with Autism Plus. Most if not all such concerns are refuted and I would suggest that reciting such concerns propagates falsehoods against Autism Plus.

I have not been allowed access to the statements or transcripts of interviews [of other witnesses]...

The review of the support provided to [Edward] and the ongoing risks identified to [Robert] has highlighted a number of systemic issues within DHHS that as an agency significantly impacted on our ability to adequately provide support and care for both [Edward and Robert]. Autism Plus was the only agency that was advocating on behalf of both parties.

The Senior Manager Autism Plus also stated:

The draft report portrays a picture of Autism Plus as dimly as possible without any allowance for the difficult environment we work within. Personally, I find it disheartening that every opportunity has been taken to find inconsistencies in what I have said...

Autism Plus has had to and indeed has improved its practices in reporting.

Opinion - section 23(1) Ombudsman Act

368. On the basis of the evidence obtained in the investigation the Ombudsman has formed the following opinions in accordance with section 23(1) of the Ombudsman Act, in relation to particular decisions and actions of the key agencies.

369. The decisions of DHHS to:

- allow Edward's CTSO to lapse
- insist that Autism Plus keep Edward at Smith Street and
- close Child Protection's involvement in January 2015

were unreasonable pursuant to section 23(1)(b) of the Ombudsman Act.

370. The failure by Child Protection to visit Edward for 39 months (from October 2011 to January 2015), or discuss with him the decision to close its involvement before he turned 18, was wrong pursuant to section 23(1)(g) of the Ombudsman Act.

371. By keeping Edward at Smith Street and failing to protect Robert and other residents from alleged harm, DHHS was wrong pursuant to section 23(1)(g) of the Ombudsman Act.

372. As Edward's CTSO had been allowed to lapse on 18 November 2014, neither Child Protection nor Disability Services had the lawful authority to make placement decisions on behalf of Edward after this time. Pursuant to section 23(1)(a), DHHS appears to have made decisions contrary to sections 10(2), 10(3)(p), 167(2), 174(1)(b) and (d) of the CYFA¹⁵⁶ when it insisted Autism Plus keep Edward at Smith Street in December 2014. These decisions were also incompatible with the right of Edward to protection of his best interests in section 17(2) of the Charter.

373. Autism Plus's:

- decision to cut staff supervision of Edward at night from two staff members to one was unreasonable pursuant to section 23(1)(b) of the Ombudsman Act; it placed other residents at risk of foreseeable harm and was inconsistent with Edward's residential statement, provided under the Disability Act
- failure to comply with DHHS policy to notify families of additional alleged assaults was wrong pursuant to section 23(1)(g) of the Ombudsman Act
- failure to comply with sections 54, 57, 134 and 135 of the Disability Act regarding residential care, approval of restrictive practices and Behaviour Support Plans appear to have been contrary to law pursuant to section 23(1)(a) of the Ombudsman Act.

¹⁵⁶ As in place at the time.

Recommendations

Recommendation 1: Dual Disability Services and Child Protection clients

DHHS review its management of dual Disability Services and Child Protection clients to identify:

- ways to improve practitioners' knowledge of the Operating Framework
- barriers to compliance with the Operating Framework
- ways to ensure collaborative statutory case and stability planning for children and young people transitioning into adulthood
- systems to monitor regular contact with clients by both services
- systems to document and monitor practitioners' key decisions, including the legislative basis and authority
- ways to create more placements for children with disabilities and effectively monitor these.

DHHS's response:

The department accepts this recommendation, noting that:

The Children, Youth and Families and Disability Services Operating Framework (2012) remains in place in all areas except where NDIS has been rolled out. This provides a framework for the case management of dual clients.

Where the NDIS has been implemented, an interim practice guide for child protection practitioners has been developed. The department will confirm this interim practice guide is consistent with current operating framework, and reinforce appropriate practice as NDIS rolls out.

Recommendation 2: Risk assessments

DHHS improve current training and supervision of Child Protection and Disability Services practitioners on:

- conducting and recording practitioner risk assessments that are dynamic and evidence-based
- identifying high-risk and/or complex clients for whom external, specialist risk assessments are required
- resources available for staff to make timely and high quality referrals for specialist risk assessments.

DHHS's response:

The department accepts this recommendation, noting that:

The department's learning and development unit has commenced preliminary work to strengthen the current training provided to the child protection workforce, aimed to ensure child protection staff understand the complex needs of children with a disability, and how to work with parents who may have a disability.

Information sessions for the child protection workforce regarding NDIS, are being delivered in transitioned areas, and the information delivered draws upon the Child Protection NDIS interim guidelines.

Recommendation 3: DHHS internal coordination to reduce risk to clients

DHHS examine ways to achieve better coordination between operational divisions and areas of DHHS and between business areas which fund service providers, monitor service providers (including Local Connections and the Office of the Senior Practitioner), make placement decisions and manage individual clients (case managers).

DHHS's response:

The department accepts this recommendation.

Recommendation 4: Suitability of Autism Plus as a service provider

DHHS assess Autism Plus's suitability to provide programs and care for DHHS clients.

DHHS's response:

The department agrees and supports the premise on which this recommendation is based. In particular, the department agrees that the concerning nature of matters uncovered throughout your investigation had necessitated the suitability of Autism Plus as a continuing service provider be rigorously tested...

The department has two separate and independent roles with this agency - one as funder (where the East division is the contract manager) and also as regulator (Health and Human Services Regulation Branch).

Role as funding body

The department in its capacity as the funding body engaged KPMG to conduct a full and comprehensive service review. Specific consideration has been provided to the suitability of Autism Plus to continue to be funded as a service provider, and what ongoing measures and supports need to be implemented to facilitate this. The East Division contract manager responsible for funding, has placed additional requirements on Autism Plus to demonstrate governance deficiencies and breaches of contractual obligation have been addressed. The operational Deputy Secretary of the East Division is meeting with Autism Plus management fortnightly to assess whether sufficient progress is being made to address quality, governance and performance concerns. A further service review is scheduled for late September 2017 to determine Autism Plus' suitability to continue to receive public funds. No further department residential clients are being referred to Autism Plus in the intervening period.

Role as regulator

The department's Health and Human Services Regulation Branch has proposed strict conditions on the registration of Autism Plus, in addition to the requirement for Autism Plus to act promptly to address deficiencies. The proposed conditions have been informed by service review findings of deficiencies of governance and potential breaches of the Human Services standards, provided to the Health and Human Services Regulation Branch by the East Division as funding manager. A decision on the imposition of these conditions, taking account of further material submitted by Autism Plus is imminent.

Recommendation 5: Oversight and audits of funded service providers

DHHS improve its oversight and audits of funded service providers' compliance with their Service Agreements and Human Services Standards including training staff and auditors to identify:

- the use of unapproved restrictive interventions and other human rights issues at services
- non-compliance with DHHS incident reporting requirements
- absent, out-dated or unapproved Looking After Children, Residential Statements, Behavioural Support Plans and other key placement and support documents in client records
- services that are not being staffed in accordance with individual client's planning, especially for clients funded for one-to-one care
- non-compliance with safety screening policies including currency of police checks and WWCC status checks.¹⁵⁷

DHHS's response:

The department accepts this recommendation.

Incident reporting

The Ombudsman made the following recommendations relevant to this investigation in the report *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 incident reporting*:

That DHHS amend the Critical client incident management instruction (CCIMI) to ensure client wellbeing is the primary purpose of incident reporting and management.

That DHHS ensure the new incident report form and system:

- is person-centred
- records accountability for, and completion of, follow-up actions; the outcome of the response to the incident; and feedback to service providers on incident reporting and management.

DHHS advised on 9 June 2017 that its new Client Incident Management System (CIMS) will be implemented on 1 October 2017.

The Ombudsman continues to monitor the implementation of the recommendations from the Phase 2 incident reporting investigation.

¹⁵⁷ This part of the recommendation relates to the second allegation, which was reported separately to the relevant Minister and Secretary.

Appendix 1

Edward's incidents – pre Victorian Ombudsman investigation

Incident reports for Edward - pre investigation			
Date	Category by Autism Plus	Incident Type	Summary
02/08/2011	UK*	Behaviour - sexual	Co-resident expressed attraction to Edward, Edward entered their room
21/06/2011	UK	Sexual assault	Edward grabbed and pinched co-resident's breast causing significant injury and bruising
06/10/2011	UK	Physical assault	Edward threatened staff with knife
14/10/2011	UK	Behaviour - disruptive	Edward kicked staff car door and windscreen, grabbed steering wheel
15/10/2011	UK	Physical assault	Edward attempted assault staff, punched co-resident 4 times
24/10/2011	UK	Physical assault	Edward stabbed staff member in eye with knife
26/10/2011	UK	Behaviour - disruptive	Edward kicked walls and windows
05/11/2011	UK	Physical assault* submitted as Behaviour - disruptive	Edward banged on doors and walls, attempted to physically assault staff member
26/01/2012	UK	Behaviour - disruptive	Edward refused to come out from under his bed
25/03/2012	UK	Behaviour - disruptive	Edward hitting and kicking windows, staff pulled over x 2
22/04/2012	UK	Physical assault* submitted as Behaviour - disruptive	Edward hit windows then threatened to hit staff and kill staff's pet bird
13/05/2012	UK	Physical assault, Behaviour - disruptive, Property damage	Edward broke window, swears and threatens to kill female staff, throws her to the ground and restrains her while hitting her
16/09/2012	UK	Property damage	Edward breaks windows, refuses to get out of bed
25/11/2012	UK	Physical assault	Edward ran at co-resident and slapped face; ran at and kicked female staff
15/12/2013 Edward moved from Autism Plus to another group home by Child Protection			
28/12/2012	Not in Autism Plus care	Property damage	Edward threw bricks at house and hit door with broom
11/01/2013	Not in Autism Plus care	Victim; Property damage	Co-resident blocked exit from room; Edward punched wall
18/01/2013	Not in Autism Plus care	Physical assault	Edward strangles female staff with his hands then restrains her arms behind her back
02/02/2013	Not in Autism Plus care	Physical assault	Edward strangles all 3 male staff then a co-resident
04/02/2013	Not in Autism Plus care	Physical assault	Edward threatens female staff then restrains her with her arms behind her back and hands on throat
05/02/2013	Not in Autism Plus care	Physical assault	Edward removed seat belt and attempted to grab female staff while driving; hit staff with water bottle and assaulted co-resident by grabbing throat and arms and later lunging at

Incident reports for Edward - pre investigation			
Date	Category by Autism Plus	Incident Type	Summary
13/03/2013 Edward moved from group home by Child Protection due to violence Returned back to Autism Plus			
24/03/2013	UK*	Self harm; Behaviour - disruptive* (not submitted as physical assault also)	Edward stated wanted to run away, hit himself, disruptive opening drawers and doors; poked co-residents
30/10/2013	UK	Physical assault	Edward restrains co-resident by hair and hits in chest and head; Edward punched staff in face who intervened
01/02/2014	UK	Physical assault; Self harm; Behaviour - disruptive	Edward hit wall and windows then hit staff in head with clenched fists and tried to bite 2 x staff
02/02/2014	UK	Physical assault; Self harm; Behaviour - disruptive	Edward hit walls and windows; hit co-resident in face and head
01/04/2014 Edward moved to new Smith Street group home (Autism Plus)			
15/07/2017	UK	Behaviour - sexual	Edward was kissed by co-resident on his lips at Edward's request* not on DHHS records
16/08/2014	UK	Physical assault	Edward attacked co-resident without indication or motive* not on DHHS records
23/08/2014	UK	Physical assault	Edward attacked co-resident and staff members* not on DHHS records
06/09/2014	UK	Self Harm	Edward scratched himself with razor blade and tried to attack staff
11/10/2014	UK	Physical assault	Aggressive behaviour against staff members* not on DHHS records

*UK: unknown

Appendix 2

Edward's incidents – during period relevant to the investigation

Incident reports for Edward - during investigation			
Date	Category by Autism Plus	Incident Type	Summary
31/10/2014* not submitted to DHHS	[1] no category on report	Sexual Assault* classified as Behaviour - sexual	Edward followed Robert to his bedroom when staff were not monitoring him. Staff later observed Edward aroused and lying on top of Robert, moving his crutch up and down. Edward confirmed this contact was 'uninvited' by Robert when asked by staff
11/11/14	1	Sexual Assault* classified as Behaviour - sexual	Edward told Psychologist A he had followed Robert to his bedroom when 'staff were preoccupied' and 'dry humped' Robert ejaculating in his clothes on 31/10/14 and at least once before
01/11/2014	2	Property Damage/ Physical Assault	Edward tried to attack co-resident but was prevented by staff
03/11/2014	2	Physical Assault	Edward assaulted co-resident biting him on the arm and neck
17/11/2014	2	Physical Assault	Edward kicked staff members
09/12/2014	2	Sexual Assault	Edward attempted to hump Robert, two person restraint required
10/12/2014	2	Self-harm	Edward had hit himself in the eye
13/12/2014	2	Self-harm	Edward was biting himself on the right forearm
11/01/2015	2	Self-harm	Edward scratched himself on his arms and neck
25/01/2015	2	Behaviour - dangerous classified as self harm	Edward threatened to stab Robert and his parents
01/02/2015	2	Behaviour - disruptive	Unsettled behaviour
01/02/2015	2	Property Damage	Edward damages to window panes
01/02/2015	2	Physical Assault	Edward hit staff member in the face
13/02/2015	2	Physical Assault	Edward attacked staff member
14/02/2015	[2] No category on report	Behaviour - dangerous	Edward broke his window and tried to punch Robert
16/02/2015	2	Medication error	Edward given wrong medication
19/03/2015	UK	Self-harm	Edward had a few scratches over his neck, right arm and forehead
14/04/2015	UK	Behaviour - dangerous	Edward threatens lone staff over the night with a knife
16/04/2015	2	Property Damage / Disruption	Edward punched the walls and broke a window

Incident reports for Edward - during investigation

Date	Category by Autism Plus	Incident Type	Summary
17/04/2015	2	Physical Assault	Edward attacked Robert and ripped shirt off
18/04/2015	2	Behaviour - dangerous	Edward threatened lone night staff member with a knife
18/04/2015	[1] submitted at category 2	[Sexual Assault - rape] submitted as Behaviour - sexual	Edward told Psychologist A on 20/04/15 that he had raped Robert in the bathroom after attacking lone night staff member who did not lock alarmed door
19/04/2015* not submitted to DHHS until 28/5/15	2	Behaviour - dangerous	Edward tried to attack staff and broke a window
20/04/2015* not submitted to DHS until 25/04/15 without victim details	[1] No category on this report	[Sexual Assault] Submitted as Behaviour - sexual	Edward told Psychologist A on 20/04/15 that had committed up to 9 other sexual assaults on Robert and 5 other clients during previous two years (approximately) DHHS asked Autism Plus to add this to 18/4/15 sexual assault - rape
21/04/2015 Edward moved from group home after instruction from police to DHHS			

Glossary

Behaviour Support Plan (BSP)	A plan prepared in accordance with the Disability Act to support the person with a disability. It is prepared in the context of where the person lives and includes activities; programs; person-centred planning; and behaviour management strategies.
Case plan (statutory)	Case planning in Child Protection practice specifically relates to the processes of planning with children and their families in accordance with the Children, Youth and Families Act and DHHS policy requirements relating to the preparation, provision and review of case plans.
Child Protection Manual	The DHHS manual that provides essential practice guidance for professionals that work with vulnerable children, young people and families in Victoria. The manual reflects the legislative requirements of the Children, Youth and Families Act and contains research, knowledge and practice requirements for statutory child protection practice information in Victoria.
Child Protection Practitioner (CPP)	The DHHS manual that provides essential practice guidance for professionals that work with vulnerable children, young people and families in Victoria. The manual reflects the legislative requirements of the Children, Youth and Families Act and contains research, knowledge and practice requirements for statutory child protection practice information in Victoria.
Community Visitor	Community Visitors are volunteers from the Office of the Public Advocate who visit supported disability accommodation, mental health facilities and supported residential services. They monitor the services provided and report on any issues residents or patients are experiencing.
Contingency (accommodation)	Short-term emergency accommodation.
Custody to the Secretary Order (CTSO)	A Protection Order for a child made by the Victorian Children's Court in accordance with the Children, Youth and Families Act as at the time of the investigation.
CRIS	The department's Client Relationship Information System that stores Disability Services and Child Protection client records.
Disability	Disability is as defined in the Disability Act.
Disability Support Worker (DSW)	For the purposes of this report, a DSW is a support worker at an Autism Plus supported disability accommodation service (group home) whose duties may involve supporting residents who display challenging behaviour, assisting people with a disability with their personal hygiene and medication, and assisting people with a disability to access the community as defined in the Disability Act.
Protection Order	A court order for a child made in accordance with the Children, Youth and Families Act.
Residential statement	A written statement specifying details of services to be provided by a disability accommodation service made in accordance with requirements in the Disability Act
Senior Practitioner - Disability Team (SPDT)	For the purposes of this report, refers to the team of staff within DHHS employed in the Senior Practitioner's team in the Office of Professional Practice.
Sexual assault	Unwanted sexual actions forced upon a person against their will, through the use of physical force, intimidation and/or coercion.
Sexual assault - rape	Alleged penetration or attempted penetration (anal, oral or vaginal) through the use of physical force, intimidation and/or coercion without the other person's consent.
Stability plan	A stability plan for a child must plan for stable and long-term out of home care for the child and is prepared as part of a child's case plan in accordance with the Children, Youth and Families Act and DHHS policy requirements.
Vacancy Management Unit (VMU)	Divisional units within DHHS that manage client's applications and offers for disability accommodation.

Victorian Ombudsman
Level 2, 570 Bourke Street
Melbourne VIC 3000

Phone 03 9613 6222
Fax 03 9602 4761
Email ombudvic@ombudsman.vic.gov.au
www.ombudsman.vic.gov.au