OmbudsmanSA

Report

Full investigation - *Ombudsman Act 1972*

Complainant	Ombudsman 'own initiative' investigation, section 13(2) *Ombudsman Act 1972*
Department	Department of Human Services
Ombudsman reference	2019/03083
Department reference	18TCEO/204; 20TCEO/256
Date complaint received	13 November 2018
Issues	1. Whether the department's handling of concerns expressed by Victoria and James in relation to the care of their nephew, Mitchell, was unreasonable or wrong 2. Whether the delay in the placement of a full care team at the Residence between December 2016 and May 2017 was unreasonable or wrong 3. Whether the level of communication between Mitchell's support workers and management at the Residence about incidents and behaviours of concern between December 2016 and August 2017 was unreasonable or wrong 4. Whether department failed to properly investigate a letter received by Victoria and James, detailing threats against Mitchell's safety and wellbeing, and whether this failure was unreasonable

Jurisdiction

This matter concerns specific incidences in the Department of Human Services' care for a Disability Services client, Mitchell, and its response to concerns of Mitchell's family.

The matter was referred to my Office by the former Independent Commissioner Against Corruption (**the former Commissioner**) pursuant to section 24(2)(a) of the *Independent Commissioner Against Corruption Act 2012* (**the ICAC Act**), as raising potential issues of maladministration within the meaning of the ICAC Act.

The referral arose out of a report that I made to the Office for Public Integrity in accordance with section 20(3) of the ICAC Act, and the former Commissioner's Directions and Guidelines. I made that report following a media report about the 2017-2018 Annual Report of the former Principal Community Visitor of the South Australian Community Visitor Scheme.

On the information available, there is no clear indication of a particular officer's conduct that, in my view, may have amounted to substantial mismanagement in or relation to the performance of official functions.[1] Rather than commencing an investigation under the ICAC Act, I decided to commence an own initiative investigation under section 13(2) of the *Ombudsman Act*.

Section 16 of the Ombudsman Act provides that the Ombudsman must not entertain a complaint if it is made 12 months after the complainant first had notice of the matters alleged in the complaint, unless it is proper to do so 'in all the circumstances of the case.' Some of the matters alleged date back to December 2016.

However, as I have decided to conduct an investigation of my own initiative, there is no complainant for the purposes of my investigation. I therefore do not consider that section 16 of the Ombudsman Act prevents me from considering the matter.

Finally, I note that my investigation was originally confined to the concerns of Victoria and James, and how the department had responded to these concerns. In the course of my investigation, two issues in the department's care for Mitchell were identified. The issues warranted my attention and now form issues two and three, detailed above.

Investigation

My investigation has involved:

- assessing the information provided by Victoria, James, and the former Principal Community Visitor, Mr Maurice Corcoran.
- seeking responses from the department
- considering:
  - the Incident Management Guidelines
  - the RiskMan Incident Reporting Manuals for default level users and managers
  - the Managing Admissions and Relocations in Accommodation Services Standard
  - the Managing Misconduct Guidelines
  - documents created by the department in the course of Mitchell's care
  - an investigation report prepared by the department's Incident Management Unit, and relevant additional documents
- providing Victoria, James, and the department with my provisional report for comment, and considering their responses
- revising two of my foreshadowed recommendations and providing them to the parties for comment
- preparing this report.

Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[2] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are

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1 *Independent Commissioner Against Corruption Act 2012*, section 5(4)(a)(ii).

2 This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

> considerations which must affect the answer to the question whether the issue has been proved … .[3]

Procedural fairness

On 25 September 2020, I provided my provisional report to the department, and to Victoria and James.

In response to my provisional report, Victoria and James made lengthy submissions, including:

- further factual information related to the issues in my investigation
- new issues outside of the scope of my investigation
- their views on the information provided by the department[4]
- their views on the actions of the department in its care for Mitchell.

I have carefully considered these submissions but am not persuaded to alter my conclusions or recommendations. I have addressed some of the submissions, where necessary, in the body of this report.

In response to my provisional report, the Chief Executive of the department, Ms Lois Boswell, offered no comment in response to my conclusions on issue one. Ms Boswell also accepted the first, fourth and sixth recommendations foreshadowed in my provisional determination, without detailed comment.

In response to my provisional view on issue two, Ms Boswell explained that:

> I do not consider there was a lack in staffing for [Mitchell] on arrival at [the Residence].
>
> During the period between December 2016 and May 2017 the Department had two staff supporting the one client 24 hours per day, with supervisor attendance twice per day for shift changeover. This was the highest level of support provided to any client in the service at this time.
>
> In addition, support was also provided from a psychologist to both the team and [Mitchell].
>
> Where there are clusters of home units such as [the Residence], a supervisor is present full time during the day. In many cases community houses share a Shift Supervisor with another location. It is not regular practice to allocate one Shift Supervisor to each property and while the units were not fully occupied, it was standard practice to share a Shift Supervisor with another location.
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> Importantly I ask that you note, following a major restructure within Accommodation Services in late 2019, the new Team Supervisor role has replaced Shift Supervisors. The main change for this role is that they are based exclusively in the houses and expected [to] cover support shifts 70 per cent of the time, providing increased support for our Disability Support Workers and importantly our clients.
>
> There will continue to be fewer supervisors than houses necessitating travel between some locations, and this is still considered standard practice across the sector.[5]

However, Ms Boswell also accepted the second recommendation, arising from my conclusion on issue two. I have addressed the department's submissions in the body of this report.

On issue three, Ms Boswell noted that the department had no comment in regard to my conclusion, and that the corrective action detailed at paragraph 44 of my provisional report,

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3 *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

4 As summarised in my provisional report. The department's responses to my enquiries, and information provided in those responses, were not provided to any other party.

5 Letter from Ms Lois Boswell to my Office, 29 October 2020.

and below at paragraphs 43 to 47, is still in place. In regard to the relevant recommendation, Ms Boswell provided further information about the department's incident monitoring processes.

Finally, on issue four and recommendation six, which concerned the department's response to a letter that threatened harm against Mitchell, Ms Boswell explained:

> I consider that the Director, Accommodation Services and Director, Incident Management Unit (IMU) did properly investigate the letter. This included the referral of the letter to SAPOL and actions taken to ensure [Mitchell's] safety…
>
> I request that under section 122 the report is changed to state the investigation commenced in March 2018, when the Director, Accommodation Services contacted the Director, Incident Management Unit. Following this contact strategies were put in place to ensure the safety of [Mitchell] and the enquiries were commenced to identify the author of the letter. It was at this point that I consider this the commencement of the investigation.
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> …
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> I have consulted with both the current and former Directors of the Incident Management Unit and they are both of the view that there is nothing more that could have been done at the time, or now. They do not consider the investigation in 2018 'preliminary enquiries', or that there was any additional level of specialist investigative skill that could have been used at the time which may have resulted in a different outcome. It is important to note that the current and former Directors have significant long-term experience in both detective and prosecution fields with the South Australian Police, collectively over multiple decades.
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> As part of the investigation, the Department ensured that all staff at [the Residence] were spoken to about the letter and in particular those with direct connection with [Mitchell], telling staff about the letter and asking what they knew about who sent the letter and encouraging then to come forward with information. The IMU investigator was satisfied that there was nothing more that could have been done.
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> It is now over two years since the original letter was sent and the ability to undertake any further meaningful enquiries is unrealistic. There have been significant staff changes within Accommodation Services and in the department's opinion further enquiries would not identify the author, which would be the only real basis for conducting further enquiries.
>
> If in your opinion you believe there to be other investigative methods that could be employed outside of what the Department has undertaken to date I would welcome a conversation with you.[6]

In light of this response, and the information Ms Boswell provided about the department's incident monitoring processes, I considered it necessary to revise recommendations 3 and 6.

My revision of recommendation 3 is minor, having regard to existing departmental policies.

In my provisional report, I foreshadowed the following:

> 6. That the department complete an investigation of the letter and inform Victoria and James of the outcome of that investigation.

I have not been persuaded by the department's argument that its investigation of the letter in 2018 was sufficient. I do not agree that, at the time, nothing more could have been done to identify the author of the letter. I remain of the view that there were other investigative steps that could have been taken by the department, including those detailed below at paragraph 151.

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[6] Above n 5.

However, Ms Boswell's submissions as to the efficacy of further, meaningful investigation at this stage have caused me to reconsider my recommendation. Staffing changes within Accommodation Services at the department are particularly persuasive in this regard.

That said, I am still very concerned that the author appears to have been a department employee, and they may still be engaged in the care for vulnerable people such as Mitchell.

I therefore do not consider it appropriate to remove my foreshadowed recommendation entirely. Instead, I have amended it as provided at the end of this report.

I recognise that the recommended actions may be difficult. Nevertheless, given the letter's very serious nature, I consider they are necessary and an appropriate use of the department's resources in light of its responsibility for the safety and wellbeing of the vulnerable people in its care.

As these revisions would not alter the majority of my report, I advised the parties of the proposed recommendations by letters dated 7 December 2020.

Victoria and James agreed with my revised recommendations and provided further submissions as to the specificity of recommended actions by the department. I have considered these submissions but am not persuaded to alter my recommendations further.

The department accepted my revised recommendations and noted that instructions had already been given for further enquiries to be conducted.

Background

1. Mitchell is a 38 year old man. He has an intellectual disability and complex care needs. Mitchell has a close family network and is a longstanding Disability Services client of the department. He has been supported by the department's assisted living services for many years.

2. The Public Advocate was, at the relevant times in this matter, appointed Mitchell's limited guardian in relation to his health care and accommodation. Mitchell's aunt, Victoria, was otherwise his guardian at the relevant times. She and her husband, James, were and continue to be involved in Mitchell's day-to-day care and wellbeing. They engage with support workers and management at his places of residence, as well as with the department at a higher level. I understand that Victoria and James have also been regularly involved in the staffing arrangements for Mitchell's care since at least 2016.

3. At the relevant times, Mitchell lived in a single bedroom assisted living unit in [redacted], South Australia (**the Residence**), where he was supported by a team of Disability Services Officers (**support workers**) and their supervisors. Mitchell has lived at the Residence since 2016.

4. In November 2018, Mr Maurice Corcoran, the then Principal Community Visitor for the South Australian Community Visitor Scheme, issued his annual report. The report noted that Mitchell's family had contacted the Community Visitor Scheme, raising the following concerns about the care being provided to Mitchell:
   - the department failed to notify his family of a medical incident that occurred on 7 January 2017 that resulted in Mitchell attending a hospital
   - seven months passed after Mitchell moved to the Residence before a full care team was in place
   - a support worker had allegedly taken Mitchell to a 'topless' restaurant and his family were not advised or consulted beforehand

- for a number of months in early 2017, there had been an escalation in Mitchell's behaviors but this was not being reported. During this time, Mitchell's family had been assured that communication channels between carers and management were functioning well
- without consulting with Mitchell's family, the department adopted a protocol for staff to contact SA Police when staff safety was at risk and the situation could not be de-escalated
- allegations had been made by staff that Mitchell's family had been contacting them up to 15 times a day
- the department had installed an intercom that had video capacity in Mitchell's unit but had not advised his family of the extent of its surveillance capabilities until they incidentally became aware of it nearly a year later.

5. My investigation has considered how the department responded to the concerns of Victoria and James in each of the instances identified above.

6. Mr Corcoran's annual report also detailed an incident where Victoria and James received an anonymous letter that threatened serious harm against Mitchell. The letter appeared to be from a person involved in Mitchell's care. According to Mr Corcoran's report, the department and SA Police failed to investigate the source of the letter and Mr Corcoran noted that the author may have been continuing to work with people with disabilities. My investigation has considered the department's response to the letter.

Whether the department's handling of concerns expressed by Victoria and James in relation to the care of their nephew, Mitchell, was unreasonable or wrong

7. I have grouped my consideration of the department's response to each of Victoria and James' concerns, as outlined above, according to my view of whether an administrative error occurred.

Provisional view of no error

Failure to notify Victoria and James of Mitchell's hospital attendance

8. On the afternoon of 7 January 2017, Mitchell cut his foot on the back gate of his unit. It appeared that Mitchell had kicked the gate and cause it to come off of its hinges. Support workers present called their supervisor and applied first aid. Mitchell was then taken to [redacted] Hospital. The department's record of the incident note that Mitchell was not admitted to a ward at [redacted] Hospital and was discharged that evening.

9. Victoria and James were not informed of the incident. According to Victoria, 'almost 24 hours later, while chatting with him on a phone call [Mitchell] brought it up in conversation' and that 'Family were always informed about medical incidents prior to this.'[7] On the evening of 8 January 2017, Victoria emailed the Accommodation Manager to express disappointment, and note that supervisors at Mitchell's previous residence had 'always kept us up to date with such matters'.[8]

10. The department advised the Public Advocate of the incident on 9 January 2017. By that point, Victoria and James had already notified the Public Advocate.

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7 Document titled 'Timeline mid 2016', Victoria, provided by email from Mr Maurice Corcoran to my Office, 13 November 2018.

8 Email from Victoria and James to the Accommodation Manager, another member of the department, and the Public Advocate, 8 January 2017.

11. In email correspondence that followed between the Public Advocate, the department, Victoria and James, the parties appeared to accept that the injury had occurred when Mitchell kicked his fence while attempting to alert his support workers that he wanted them to return to his unit.

12. The department's Program Coordinator recognised Victoria and James' concerns about the notification and explained that, going forward, they would be notified on the day of the incident, or the day after, depending on its seriousness.[9]

13. The Public Advocate noted that a new system needed to be devised for Mitchell to alert support workers that he wished for them to return to his unit, and the Program Coordinator identified an intercom as a possible solution.

14. On 24 January 2017, the Accommodation Manager, Mitchell's psychologist at the time,[10] the Public Advocate and Victoria met to discuss the incident and other matters. Minutes of that meeting record the following:

> [Victoria] is to be notified regarding any hospital visits, as well as being updated every 2 weeks regarding Mitchell's activities.[11]

15. In response to my investigation, the department explained that, prior to 7 January 2017, it would notify the Public Advocate of medical incidents and hospitalisations. While the injury Mitchell sustained on 7 January 2017 was minor, and he had requested that staff not notify his family that day, the department's delay in notifying the Public Advocate does not appear to have been in line with this practice.

16. Nevertheless, I consider that the department took prompt and appropriate steps in response to the concerns of the Public Advocate, Victoria and James about the lack of notification to Mitchell's family. The department then meaningfully responded to the issue by identifying systems to avoid a similar injury occurring again.

Opinion

My final view is that the department did not act in a manner that was unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act when it responded to concerns about the failure to notify Mitchell's family of the incident.

In accordance with section 17(2)(d) of the Ombudsman Act and in light of the department's response to the concerns of the Public Advocate, Victoria and James, I do not consider it necessary or justifiable to investigate the department's failure to notify either party before Mitchell contacted Victoria the day after the incident.

Delay in the placement of a full care team at the Residence

17. Mitchell moved to his unit at the Residence on 23 December 2016 after an incident near his previous home. According to the department, remaining at that location was no longer viable because of risks to himself and members of the community.[12] The unit at the Residence was identified as the only suitable and available accommodation for Mitchell, given his complex needs and behaviours.

18. At the time, the Residence was a new facility comprised of eight units. I understand that the department had not yet determined how the facility would be used. Two other units

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9 Email from the Program Coordinator to the Public Advocate, Victoria and James, 12 January 2017.

10 In the period of time relevant to my investigation, Mitchell had two of psychologists. The first ended her role as Mitchell's psychologist in mid 2017, and the second commenced in the role shortly after. For the sake of clarity, I have referred to either as 'Mitchell's psychologist'.

11 Meeting minutes, 24 January 2017.

12 Letter from Mr Tony Harrison to my Office, 6 May 2019.

were occupied but the support workers responsible for the clients residing there did not have experience or capacity to support Mitchell. When Mitchell moved to the Residence, his support team increased from three to four fulltime support workers, and his team transferred with him. According to the department, the increased staffing allowed for two workers to support Mitchell on a 24 hour basis.[13]

19. However, supervisors responsible for Mitchell's support team were still required to supervise another site at [redacted], approximately 30 minutes away.[14] Between late December 2016 and May 2017, the supervisors started and finished their shifts each day at the Residence and were present during shift changeovers. The department described these as 'peak times' when Mitchell and staff were most at risk.[15] According to the department, this was not standard practice;

> In the majority of situations, shift supervisors are not present at handover times on site, generally supervisors work across multiple sites and handovers at these sites occur simultaneously therefore it is not possible to attend all handovers. It was identified that [Mitchell] found handover times difficult therefore the supervisor was required to attend at handover to support [Mitchell].[16]

20. In their submissions to my Office, Victoria and James noted that Mitchell experienced anxiety around shift changeover times and they understood this to be the case from as early as 2016.[17]

21. In the months after Mitchell's move to the Residence, the management team responsible for the facility, comprised of the Area Manager, Accommodation Manager and Program Coordinator, remained unchanged and were based approximately 3 kilometres away.

22. In March 2017, a site manager was appointed for the Residence. Two shift supervisors were later appointed in June 2017 and were based at the Residence, when the units reached capacity.

23. According to Victoria and James, in July 2017, they were advised that the supervisors responsible for both the Residence and [redacted] had been replaced by supervisors based at the Residence. As it appears that Victoria and James were not aware of the issue until after it had been addressed, it does not appear that the department could have failed to respond to concerns about the issue.

Opinion

In light of the above, my final view is that the department did not act in a manner that was unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act as it does not appear to have failed to respond to the concerns of Victoria and James.

In this instance, my consideration has been confined to how the department responded to concerns about the lack of a full care team for Mitchell. I have considered whether the delay in the placement of a full care team at the Residence amounted to error later in this report.

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13 Letter from Mr Tony Harrison to my Office, 10 January 2019.

14 Ibid. Ms Lois Boswell later advised my Office on 31 July 2020 that supervisors were based 3 kilometres away. This appears to have been confused with the location of the management team, based at [redacted] 3 kilometres away from the Residence. In any event, I am satisfied that on-site supervision was not present.

15 Above n 12.

16 Above n 13.

17 Above n 7.

Mitchell's visit to a topless restaurant

24. On 16 June 2017, Mitchell went on a lunchtime outing with the assistance of two support workers. During this outing, Mitchell visited a topless restaurant. He was assisted by one of the support workers (**A**). According to the summary of a meeting between A and the Area Manager for the Residence, A recalled that they stayed for approximately 30 minutes without incident and that the other support worker remained in the department vehicle outside. A noted that Mitchell had requested a visit to the restaurant on multiple occasions, to multiple support workers, over an extended period of time, but A had been able to dissuade Mitchell in the past. After returning home, Mitchell called Victoria and said that he had been to a strip club.[18]

25. According to the department, the visit had not been discussed with senior staff at the Residence or Accommodation Services management of the department ahead of time.[19] Planning or consultation with Victoria, James, or the Public Advocate had not occurred, nor had the visit been authorised. By email on the evening of 18 June 2017, Victoria queried whether the outing had been endorsed by senior staff and whether, in the opinion of Mitchell's psychologist, it had been in his best interest.[20]

26. Senior management, including the Director, Accommodation Services Operations, met with A on at least three occasions to discuss the visit. A was counselled on the inappropriateness of supporting the visit without speaking to senior staff, and that complex decisions around Mitchell's support required proactive consultation ahead of time.

27. According to the department, there is no record of any visits prior to 16 June 2017, and all support staff were advised that senior authorisation was required if Mitchell asked to visit the restaurant again.[21]

28. In response to Victoria and James' concerns, Mitchell's psychologist expressed the view that:
    - A should have consulted with management, rather than independently deciding that the visit was appropriate
    - it was not likely that one visit would have a lasting negative impact on Mitchell[22]
    - Mitchell's repeated requests to visit a topless restaurant may have indicated that 'there is a need that he wants support to address (whether it is helpful or not, the need exists)'
    - support staff would need a support plan to outline an agreed approach for a request of that nature
    - it was necessary for the department, the Public Advocate and Mitchell's family to work collaboratively to develop a plan through which Mitchell could be offered choices and alternatives for his expression of that need.[23]

29. From the department's records of its regular meetings with Victoria and James, it appears that the visit remained in discussion for a number of months.

30. Mitchell's visit to the topless restaurant was not preceded by any consultation with or authorisation by senior staff at the Residence, Mitchell's psychologist, the Public Advocate, or Victoria and James. The department has explained that, in the past, a sexologist provided recommendations in regard to Mitchell's needs and complex

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18 Unsigned letter from the Area Manager to A, June 2017.
19 Above n 12.
20 Email from Victoria and James to the Accommodation Manager, Mitchell's Psychologist, the Area Manager, and the Public Advocate, 18 June 2017.
21 Above n 12.
22 In response to my preliminary investigation, Victoria and James submitted that Mitchell's psychiatrist held a different view in this regard. I am not in a position to comment on either view, nor is it necessary to do so given the purpose of my investigation and the issues for consideration.
23 Email from Mitchell's psychologist to Victoria, 19 June 2017.

behaviours.[24] However, it does not appear that the department had planned for how to respond to requests of that nature.

31. Nevertheless, I am satisfied that the issue was promptly addressed by the department after Mitchell visited the restaurant. A was appropriately counselled. Senior staff responded to Victoria and James' concerns, encouraging a collaborative approach to develop a clear method for responding to similar requests from Mitchell in the future. I understand that such requests require approval from senior management, Victoria and James.

Opinion

In light of the above, my final view is that the department did not act in a manner that was unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act when it responded to Victoria and James' concerns about Mitchell's visit to a topless restaurant.

Diminished communication and underreporting

32. In December 2016, Mitchell's psychologist prepared a list of the key people involved in Mitchell's life and outlined the roles and responsibilities of each (**the role clarification list**). I understand that it was anticipated that, once finalised, the role clarification list would address concerns about consistent behaviour logging and communication between the groups involved in Mitchell's care. According to the department, the role clarification list remained in draft until December 2017 due to feedback and further changes requested by Victoria and James. That said, the department explained that staff were regularly updated with the new versions as changes were made.[25] In their submissions to my Office, Victoria and James noted that, at the time, they queried whether the role clarification list was necessary.[26]

33. The issue of reporting was also raised in a positive behaviour support plan prepared by Mitchell's psychologist in early December 2016.[27] The plan noted that, based on observations between September and November 2016, behaviours of concern involving verbal or physical aggression were occurring every day, and that Mitchell reacted negatively 'when staff attempted to do any form of reporting (which he has interpreted as "dobbing him in[")]'.[28]

34. Despite the development of the role clarification list and the recognition of difficulties around reporting, the department has acknowledged that, for a period of five months, communication between support workers and management at the Residence was not working well;

> Staff were not reporting incidents that were occurring out of fear of retribution from the family… Staff displayed a lack of clarity as to who they were reporting to, because they were routinely and regularly directed by the family themselves on how to support [Mitchell].
>
> …
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> At times arrangements were somewhat blurred for workers as to who to go to, because of the strong direction exercised by [Mitchell's family] over the support workers. For this reason, for a limited period of time, some serious behaviours were not reported on to management.[29]

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24 Above n 12. In response to my provisional report, Victoria and James made submissions about the advice.
25 Above n 12; above n 13. In response to my provisional report, Victoria and James explained that the role clarification list remained in draft because 'basic details were missing or incomplete.'
26 Above n 7.
27 'Positive Behaviour Support Plan for Mitchell', 8 December 2016.
28 Ibid.
29 Above n 12.

35. According to the department, in July and August 2017, management at the Residence detected that support workers were unsettled. There was increased sick leave and some support workers had expressed that they were experiencing greater stress and difficulty in safely supporting Mitchell.[30]

36. In response to my investigation, the department explained that, at the time, Mitchell had been regularly displaying significant agitation and threatening behaviour towards support workers and other staff. This appears to be consistent with the observations in the positive behaviour support plan of December 2016.

37. Despite this, I understand that there were fewer formal incident reports between December 2016 and July 2017 than the department would expect for that period of time. According to the department, 'there were 48 RiskMan reports made by staff working with Mitchell' compared to 77 reports for a similar period after the department identified and responded to the issue.[31]

38. RiskMan is the department's incident reporting system. It is used to record incidents, injuries and hazards that have impacted, or may impact, the health, safety or wellbeing of a staff member or client, so that the department may identify areas that are working well and those that require improvement. This includes near misses, and 'critical client incidences' that have caused or are likely to cause a significant impact on the health, safety or wellbeing of a client.

39. The RiskMan Incident Reporting Manual also notes that the system 'does not replace the need for workers to communicate incident details to their line supervisors.'[32] It appears that this form of communication had also diminished prior to August 2017.[33]

40. On 9 August 2017, the Director of Accommodation Services Operations notified Victoria and James of the increase in Mitchell's difficult behaviours and advised that this had only recently been detected by management at the Residence.[34] On 10 August 2017, Victoria contacted Mitchell's psychologist, raising the family's concerns and requesting 'a full review of best care method and holistic practice with Mitchell from your team.'[35]

41. In the week that followed, staff meetings included discussions around underreporting. Support workers explained their apprehension that a high number of RiskMan reports would negatively impact their employment, and that Mitchell would at times threaten support workers that he would have Victoria terminate their employment. Support workers were reassured that this was not the case.[36]

42. The Accommodation Services Manager, the Regional, Area and Site Managers, a supervisor at the Residence and Mitchell's psychologist then met with James to explain the situation further and detail the following actions to be undertaken:
    - support workers would be reassured of the security of their employment
    - the Public Advocate would be notified of future RiskMan reports
    - Mitchell's family would be provided with regular behaviour updates by his psychologist

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30 In response to my provisional determination, Victoria and James attributed underreporting and diminished communication to staffing changes at the management level and a lack of leadership. This is not consistent with contemporaneous documents provided to my Office, detailed at paragraph 41, and I am satisfied with the department's explanation for why underreporting occurred.

31 Letter from Mr Tony Harrison to my Office, 7 February 2020.

32 *RiskMan Incident Reporting Manual for Default Level Users with Disability Services and Disability SA*, June 2017.

33 House Meeting minutes, 15 August 2017.

34 The department advised my Office that no minutes were taken for this meeting. However, in a complaint on 31 August 2017 to the Minister at the time, Victoria and James provided a similar account of a meeting that day.

35 Email from James to Mitchell's psychologist, 10 August 2017.

36 Above n 31.

- the issue of underreporting would be raised with the Director, Accommodation Services Operations.[37]

43. In the weeks that followed, support workers were encouraged to report daily behaviours of concern to their supervisors. Having regard to records of the daily reports, this appears to have been an effective tool for re-engaging communication channels between support workers and management at the Residence.

44. Training was also provided to support workers by Mitchell's psychologist, providing a forum to discuss difficult behaviours and techniques for responding to those behaviours. In the eight months that followed, RiskMan reports increased by approximately 60% which, in the department's view, 'indicated that staff felt more supported and comfortable reporting all incidents.'[38]

45. The issues remained in discussion in meetings with Victoria and James in the months that followed. Meeting minutes included updates on Mitchell's behaviours of concern, areas of improvement, and factors that appeared to contribute to concerning behaviour. At present, Victoria and James are advised of incident reports on a monthly basis.[39]

46. In response to my provisional report, Victoria and James submitted that they had not received incident reports for 6 months prior to October 2020.[40] Following further enquiries by my Office, the department advised that incident reports had been provided between January and September 2020.[41] After that point, the introduction of a new incident reporting system had resulted in reporting gaps, but the issue was being investigated as a matter of priority. I am satisfied with this explanation.

47. In response to my provisional report, the department explained that staff wellbeing continues to be monitored through regular supervisory meetings, and that a reporting system for anonymous feedback is available for support workers and other staff.[42]

48. On the information available, it appears that once the department identified that support workers were unsettled and that there was an issue with reporting and communication, it notified Mitchell's family and took action to address the issue. I am therefore of the view that the department did not fail to respond to Victoria and James' concerns, once they were notified of the issue.

Opinion

In light of the above, my final view is that the department did not act in a manner that was unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act when it responded to Victoria and James' concerns.

In this instance, my consideration has been confined to how the department responded to Victoria and James' concerns about reporting and communication between Mitchell's support workers and management. I have considered whether levels of communication and reporting in itself amounted to error later in this report.

37 Meeting minutes, 15 August 2017.
38 Above n 31.
39 Letter from Ms Lois Boswell to my Office, 31 July 2020.
40 Email from Victoria and James to my Office, 20 October 2020.
41 Letter from Ms Lois Boswell to my Office, 4 December 2020.
42 Above n 5.

The SA Police protocol

49. On 25 August 2017, an internal memorandum was issued to Mitchell's support workers following a direction by the Director, Accommodation Services Operations. The memorandum included scripts for support workers to use before contacting SA Police (**SAPOL**) in situations where Mitchell's behaviour presented a risk to members of the public or support workers, or risked property damage.

50. According to the department, the memorandum was issued in the context of Mitchell's escalating behaviours at the time, which included threatened and alleged assault of support workers.

51. The Incident Management Guidelines that were used by the department at the time provided the following:

> **Reporting to SAPOL**
>
> An incident should be immediately reported to SAPOL by staff following consultation with their manager/supervisor, under the following circumstances,
>
> > The incident constituted an alleged offence, was not trivial in nature, and **any** of the following apply:
> > - The incident was serious in nature (ie rape, unlawful sexual intercourse, indecent assault).
> > - A party to the incident has an obvious injury or complains of being injured.
> > - There is a need to preserve physical evidence (medical examination, scene examination, seizure of exhibits such as clothing).
> > - Police attendance is necessary to ensure the safety of those involved in the incident or to restore order.

52. In response to my investigation, the department provided further explanation:

> Disability clients who exhibit significant behaviours of concern and are therefore at greater risk of causing harm to themselves or others may also have an explicit recommendation in their behaviour support plans that staff consider calling emergency services (SA Ambulance or SAPOL) if they judge that someone involved in the incident may be at direct risk of harm.
>
> This is often written into behaviour support plans so that it is clear to support staff that they have the option of calling SAPOL for assistance if they are unable to de-escalate an incident safely in order to maximise the safety of the client, staff, and others.[43]

53. I understand that, at the time, Mitchell's behaviour support plan did not include an explicit recommendation to that effect. The department explained that the memorandum was used as an interim measure until Mitchell's psychologist was able to conduct a formal assessment and prepare a new behaviour support plan that would include responses to high risk situations.[44]

54. The memorandum included clear, sensitively worded scripts[45] for support workers to use in two scenarios:
    - when a risk to staff or members of the public arose while in the community, the script explained that if Mitchell could not calm down, 'for your safety we will need to call the Police'
    - when a risk of property damage or a risk to a person arose at Mitchell's unit, staff would first try to deescalate the situation, then remove themselves from the unit

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43 Above n 12.
44 Above n 12.
45 The script began with the phrase, 'Mitchell, we care about you'.

before using the script. The script allowed for 10 to 15 minutes for Mitchell to consider the warning, before it was reiterated, if necessary.

55. The memorandum did not state that the scripts were only to be used as a last resort, and although it is reasonable to expect that it would be read in conjunction with the Incident Management Guidelines, it did not provide as much detail on the circumstances in which SAPOL could be contacted.

56. On 28 August 2017, the Regional Director advised James of the new approach for contacting SAPOL. James raised concerns about this approach and indicated that if the department contacted SAPOL, he and Victoria would 'contact the media regarding the long term gross negligence experienced by Mitchell and our family'.[46]

57. On 31 August 2017, an incident occurred in which Mitchell allegedly assaulted a support worker. Support workers were able to leave his unit and were then advised to contact SAPOL. According to a site manager who reported the incident to the Public Advocate the next morning, SAPOL officers spoke with Mitchell through his fence about why his behaviour had been unacceptable. I understand that the incident was deescalated and it had not been necessary for the officers to enter his unit.

58. Prior to 31 August 2017, the Public Advocate had expressed their concerns to the Director of Accommodation Services Operations about the memorandum and the department's approach, and their view that:
- Mitchell's psychologist could work with Mitchell and staff to 'devise strategies to help decrease the incidences of Mitchell becoming agitated, aggressive or assaulting staff'
- SAPOL should only be contacted as a last resort
- it would be appropriate for guidelines to be put in place 'as everyone would have a different view as what [sic] necessitates SAPOL's attendance.'[47]

59. In an email to James, the Public Advocate noted that their request had been declined but that they had been assured that Mitchell's safety was the first priority, followed by that of staff. However, I understand that the Director, Accommodation Services Operations later apologised to Victoria, James, and the Public Advocate for the way the protocol had been implemented.

60. According to the department, Mitchell's psychologist then prepared a new plan that aimed to address concerns raised by the Public Advocate, Victoria and James. The new plan provided that staff had discretion to call SAPOL in the following situations:
- when an incident occurred in the community and presented a risk of harm to Mitchell or another person, and staff had been unsuccessful in deescalating the situation
- when an incident occurred at Mitchell's unit where his behavior threatened the safety of staff, and staff had been unsuccessful in deescalating the situation and were unable or did not have time to exit the unit safely
    - where staff had been able to exit, the plan did not include steps for calling SAPOL.

61. The plan also noted that the department intended to organise positive engagement between SAPOL and Mitchell at a later date. Following the finalisation of the new plan, Mitchell's psychologist provided training to support workers on how to use it.

62. In September 2017, Victoria, James, and the Public Advocate were provided with a copy of the new plan. The plan was then discussed at a meeting between Mitchell's

46 Email from James to the Public Advocate and the Director of Accommodation Services Operations, 28 August 2017.
47 Email from the Public Advocate to James, 29 August 2017.

psychologist, the Director, Accommodation Services Operations and James on 18 September 2017, and the matter was removed from the agenda of future meetings.

63. In response to my investigation, the department explained that the behaviour plans of clients with high risk behaviours often allowed support workers to contact SAPOL in certain circumstances. Given Mitchell's history, it is unclear why a similar approach had not been taken prior to August 2017.

64. I recognise the concerns, particularly of the Public Advocate, that the memorandum did not specify that contacting SAPOL would only be used as a last resort. In my view, the memorandum provided limited detail on the circumstances that warranted such a response.

65. Nevertheless, I also consider that it was reasonably open to the department to implement a plan in order to manage its duel responsibilities; providing safe, respectful care for Mitchell, and ensuring a safe working environment for support workers. In that regard, I note that the new plan incorporated and responded to concerns about the memorandum, and provided clear advice on when support workers could consider contacting SAPOL.

Opinion

Although the department appears to have been initially resistant to concerns about the memorandum, in light of the above, my view is that its eventual response was not unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act.

The installation of an intercom with video capabilities

66. Between January and December 2017, a doorbell intercom was present in Mitchell's unit. It had been installed in January 2017, upon the advice of Mitchell's psychologist,[48] in order to improve communication and staff safety. The installation had been prompted by the incident in which Mitchell had injured himself while kicking a gate to regain staff attention.

67. The intercom model, shown below, included a transmitting device (below, left) installed inside Mitchell's unit, and a portable receiving device (below, right) for support workers. The transmitting device included a call button, microphone, speaker, and an infrared 'person in range' sensor, which detected movement within a 50 centimetre range. The receiving device had an 8.8 centimetre screen. The intercom had no capacity to record.[49]

Figure 1: the intercom model installed in Mitchell's unit

68. A set of instructions for support workers noted that the receiving device needed to be placed in the outer courtyard of Mitchell's unit to pick up a signal from the transmitting

48 In response to my provisional report, Victoria and James suggested that they had requested the intercom.
49 Above n 13.

device, and that staff needed to be within a safe distance to hear if the receiver sounded.

69. The transmitting device was located inside Mitchell's unit, allowing Mitchell and his support workers to communicate when the latter was not present.

70. While the video quality of the intercom appears to have been low, and the receiving unit screen was small,[50] I understand that support workers and other staff would use it to assess whether Mitchell was in his living room and how many chairs were present. According to the department, Mitchell would, at times, hold chairs over his head while waiting for support workers to re-enter his unit, with the apparent intention of hitting the person entering.[51]

71. That said, in response to my enquiries, the department explained that Mitchell enjoyed using the intercom and that it had been a positive tool for his independence and staff safety;

> [Mitchell] communicated really well through the intercom. [Mitchell] would push the button which was mounted on the wall in his lounge area which would ring like a doorbell in the staff office next to [Mitchell's] unit. Staff would answer the call and ask [Mitchell] if he was okay and ready for staff to return or if there was anything they could do for him. Staff would be able to see if [Mitchell] had any weapons in his hands, such as chairs, kitchen utensils etc, which could help them to assess if it was safe for them to return… [The intercom] had a great effect with [Mitchell] and reduced his banging to seek staff attention.[52]

72. The minutes from a meeting on 24 January 2017 between the department, Victoria, and the Public Advocate noted that Victoria was happy with the installation of the intercom. I understand that on occasions where it had been removed for maintenance, Victoria and James raised the issue with support workers and the department.

73. It appears, however, that Victoria and James were not aware of the intercom's video function. According to Victoria and James, during a visit to Mitchell's unit on 16 December 2017, a support worker 'mentioned in passing how she could sit in the office and observe Mitchell.' Victoria explained to my Office that she queried this later that evening, and the support worker advised her of the intercom's video capabilities, but noted that it was not used when Mitchell's family was present.[53]

74. Victoria and James' concerns about the video capabilities of the intercom were raised shortly after the visit, and the intercom was removed on 20 December 2017.

75. In an email to the Site Manager on 20 December 2017, the support worker also provided an account of her conversation with Victoria. According to the support worker, she had explained to Victoria that Mitchell's ability to be on his own had improved significantly as staff were able to check on how he was doing via the video intercom without needing to enter his unit. The support worker explained that when Victoria left, she queried the video capabilities of the intercom and expressed concern that her interactions with Mitchell were being monitored. In response, the support worker reassured Victoria that support workers were under strict instructions not to check on Mitchell when family were present and that video was only used when Mitchell needed staff attention or assistance.[54]

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50 Above n 13. In response to my provisional report, Victoria and James disputed whether the video quality of the intercom was low, referring to the product brochure for the intercom.

51 Above n 13. In response to my provisional report, Victoria and James disagreed with whether this was the case prior to the intercom's installation.

52 Above n 13.

53 Above n 7.

54 In response to my provisional report, Victoria and James queried whether evidence was available to support this account, and how the instructions were communicated to support workers. Although the instructions provided by the

76. In the weeks following and at a staff meeting on 28 December 2017, members of Mitchell's support team expressed their understanding that the family had been aware of the intercom's video function as they recalled Victoria using it to show support workers items while they were in the adjacent staff office.[55] Support workers also noted Mitchell's unhappiness with the intercom's removal, their opinions on how it had helped him, and their concerns about safety without the intercom available.

77. The minutes for the meeting also noted the effectiveness of alternatives since the intercom had been removed. At first, walkie-talkies had been used but these had been broken within the first few days of use. FaceTime on a mobile device was being used as an alternative but this was not considered to be as effective as Mitchell had difficulty using it independently and did not always answer.[56] Moreover, support workers noted that Mitchell had started to barricade the door to his unit, and hit the gates in order to gain their attention. The support workers considered this to be a return to older behaviours that the intercom had been installed to address. Support workers also reported feeling unsafe without the intercom as a means of deescalating heightened situations and assessing safety before returning to Mitchell's unit.[57]

78. In February 2018, Mitchell's psychologist presented a comprehensive summary of replacement options for Victoria and James to consider, including:
    - continuing use of the FaceTime system via Mitchell's iPad and a staff tablet in the adjacent office
    - a smart technology system using tablet to mobile communication and a separate camera device
    - walkie-talkies or phones
    - an intercom with only audio functions
    - an intercom with audio and video functions.[58]

79. Discussions continued first via email and then, it appears, at meetings between the department, Victoria and James. Nevertheless, I understand that FaceTime continued as the communication tool when support workers were not present in Mitchell's unit.

80. Despite improvements that the intercom appeared to have fostered in Mitchell's independence, and the lesser utility of other options such as walkie-talkies, the department responded quickly to Victoria and James' concerns when they realised that the intercom had a video function. In response to my provisional report, Victoria and James queried why the intercom had been removed if support workers considered that it had been a positive tool for Mitchell's independence and staff safety.[59] It is clear that the department removed the intercom after Victoria raised concerns about its video functions.

81. There is no information available to suggest that Victoria and James were monitored through the intercom without their knowledge. It appears that the intercom would not have functioned well for such a purpose, even if a support worker wished to do so.

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department do not include a direction in this regard, I am satisfied with the veracity of the support worker's account, given its contemporaneity and internal purpose.

55 In response to my provisional report, Victoria and James maintained that they had not been aware of the intercom's video functions.

56 In response to my provisional report, Victoria and James disputed this. I do not consider it necessary to examine the effectiveness of the intercom's replacements, and only note that the meeting minutes record these observations.

57 Meeting minutes, 28 December 2017.

58 Document titled 'Summary of Options for Communication between Mitchell's unit and the staff office at The Residence', provided by email from Mitchell's psychologist to Victoria and James on 8 February 2018.

59 Above n 40.

Opinion

In light of the above, my final view is that the department's response to Victoria and James' concerns about the intercom was not unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act.

Provisional view to decline further investigation

Allegations of excessive contact by Victoria

82. On or around 4 September 2017, a comment was allegedly made to the effect that Victoria had been contacting Mitchell's unit up to 15 times a day.

83. James emailed the Public Advocate and senior management of the department, raising a complaint about the comment and characterising it as a defamatory lie for the purpose of discrediting Victoria.[60] In a further email on 7 September 2017, James explained that he would not be satisfied with an apology and wanted to know who had made the comment, and that action be taken against that person.[61]

84. In response to the complaint, the department commenced an investigation. On 13 September 2017, the investigation was finalised and a memo to the Acting Executive Director concluded that:
    - the source of the comment was unclear, though it may have originated from a misunderstood comment by James at a meeting on 15 August 2017 to the effect that Victoria and Mitchell could be on the phone multiples times a day[62]
    - it was reasonable to conclude that there was frequent communication between Victoria and Mitchell but there was no evidence to support the conclusion that the comment had been made to discredit Victoria[63]
    - nevertheless, James had been advised that an apology would be made for the comment and resulting offence.

85. I understand that an apology was then given to Victoria and James. Minutes of a meeting on 18 September 2017 note that James acknowledged and accepted the apology.

86. Following James' complaint, the department promptly commenced an investigation into the alleged comment about Victoria's contact with Mitchell . Though it was not possible to form a conclusion as to the comment's source, the investigation was appropriately thorough and the department's conclusion appears reasonably open to it. In any event, an apology was given.

Opinion

In accordance with section 17(2)(d) of the Ombudsman Act and in light of the above, I do not consider that further investigation of this issue is necessary or justifiable as it is unlikely to result in a finding of administrative error or further meaningful outcomes.

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60 Email from James, 4 September 2017, cited in a memo prepared by the Director, Incident Management Unit, dated 13 September 2017.

61 Email from James, 7 September 2017, cited in a memo prepared by the Director, Incident Management Unit, dated 13 September 2017.

62 The meeting minutes do not document any comment to that effect, but the conclusion appears to have been based on recollections of multiple staff members present. In response to my provisional report, Victoria and James noted that 'It is therefore equally plausible that the 'multiple staff members' were supporting each other's story….'.

63 In response to my provisional report, Victoria and James maintained that this was the case.

Whether the delay in the placement of a full care team at the Residence between December 2016 and May 2017 was unreasonable or wrong

87. When Mitchell moved to the Residence in December 2017, the department's policy for client admissions and relocations specified:

> The minimum requirements to be met by Accommodation Services staff in ensuring that each person received safe, consistent and individualised support on admission… or when moving from one supported accommodation service to another.[64]

88. Emergency relocations, such as Mitchell's move to the Residence, required significant document creation and exchange between a client's new and former residence.

89. However, in response to my investigation, the department explained that as Mitchell relocated with his existing support arrangements, existing documentation remained. Moreover, in the department's view, 'support was provided over and above relocations standard and documentation was changed throughout the transition period [From Strathmont to [redacted] and then the Residence] as needed'.[65]

90. The development of one additional plan, a lifestyle review, was required within 6 weeks of Mitchell's relocation to the Residence, but was not completed until 13 June 2017. The department acknowledged that the lifestyle review was not completed within the required time, but has not offered an explanation for why this did not occur. That said, it is not clear whether the lifestyle review would have been relevant to the level of supervision at the Residence if it have been developed within the required time as it focussed on Mitchell's lifestyle goals and how these would be achieved.

91. The existing documentation that transferred with Mitchell to the Residence included support plans for:
    - community safety
    - health
    - supports and relationships
    - behaviour.

92. Each plan included proactive and reactive requirements for staff to seek support and advice from their supervisors.

93. Mitchell's positive behaviour support plan was relatively new when he moved to the Residence, and had been prepared by his psychologist, based on observations of Mitchell's concerning behaviours between September and November 2016. The plan identified that Mitchell reacted negatively when he observed support workers reporting to or communicating with their supervisors. According to the plan, at times Mitchell expressed his unhappiness by hiding support worker's mobile phones.[66]

94. In the interest of staff safety, the plan recommended that:
    - an extra staff member, such as a supervisor, visit during the early hours of the morning when Mitchell was more likely to experience stress or agitation
    - support staff have more than one way of contacting supervisors when they needed help.[67]

95. The plan also noted that although support workers felt they needed 'a backup staff member to support them', that person's presence was often not helpful for Mitchell.

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64 *Managing Client Admissions and Relocations within Accommodation Services Standard,* version 3.0.
65 Letter from Ms Lois Boswell to my Office, 9 September 2020.
66 Above n 27.
67 Above n 27.

Instead, the plan suggested a staffing model that provided for a backup staff member 'in the distance and only called up for help when the need arises'.[68]

96. It is not clear to me whether this recommendation referred to a support worker or a supervisor, though I am inclined to consider the latter is more likely. It is also unclear whether Mitchell's alleged history of hiding mobile phones had been taken into account when the department considered the ability of support workers to contact offsite supervisors for help when the need arose.

97. Nevertheless, in light of the positive behaviour support plan, the department appears to have recognised that greater care and attention was necessary for Mitchell's transition to the Residence. Staffing in his support team was increased following his move there to allow for two person support on a 24 hour basis. Moreover, the department has acknowledged that although supervision is not typically required during shift changes, and it cannot provide for all support worker shift changes to be supervised, this was considered necessary to safely support Mitchell and his team.

98. In response to my investigation, the department explained that onsite supervision was implemented at the Residence in May 2017 'due to client complexities'.[69] It is unclear what level of complexity prompted this change, but I understand that, by that stage, the Residence had reached capacity.

99. I recognise that the department needed to balance a number of factors during Mitchell's transition to the Residence, as:
- Mitchell's move was an emergency and occurred quickly
- although other clients were already residing at the Residence, the site was not fully operational given that staff levels, including on and offsite supervision, had yet to be reached
- staff presence, changeover and communication had been identified as stressors for Mitchell, and this needed to be carefully managed alongside staff safety.

100. I also accept that the additional measures implemented by the department after Mitchell's relocation, such as increased support worker presence on a 24 hour basis and supervisor support during changeovers, were in keeping with the recommendations of the support plan.

101. In response to my provisional report and as provided above on page three, the department has maintained that the level of supervision for the Residence and Mitchell between January and May 2017 was sufficient and in keeping with standard practice.

102. I recognise that it is easy for me to be critical of the department in hindsight, and my view of whether the delay in the placement of a full care team amounted to administrative error is finely balanced. On the one hand, it appears that:
- the relocation policy did not require the creation or exchange of additional documentation in the circumstances, except for Mitchell's lifestyle review which does not appear to consider or address support worker supervision
- the department took action that was consistent with the intention and recommendations of the positive behavior support plan
- the department provided a level of supervisory support for Mitchell's support workers that was in keeping with standard practice for a site such as the Residence at the time.

103. With this in mind, it may have been open for the department to take the approach that it did, and adapt that approach *if* it became necessary to do so.

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68 Above n 27.
69 Above n 13.

104. On the other hand:
    - in the same period, the department was aware of issues with reporting and communication, and supervision had been specifically identified as an important factor. In the circumstances, and having particular regard to the positive behavior support plan, I do not consider that offsite supervision based 30 minutes away was sufficient
    - I am uncertain of whether the department was best placed to identify whether supervision levels were appropriate, and respond as necessary, given that the level of communication between support workers and management was diminished during the same period
    - beyond reference to the Residence's client capacity and the department's standard practice, I do not consider that an adequate explanation for why onsite supervision was not needed prior to May 2017 has been provided, with particular reference to Mitchell's circumstances and the issues identified by his psychologist.

105. Given the department's understanding that greater care and supervision was needed for Mitchell and his support team during their transition to the Residence, it does not appear to me that the level of support and supervision between December 2016 and May 2017 was sufficient.

Opinion

In light of the above, my final view is that the delay in the presence of a full care team at the Residence was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act.

Whether the level of communication between Mitchell's support workers and management at the Residence in regard to incidents and behaviours of concern between December 2016 and August 2017 was unreasonable

106. As detailed above at paragraph 33, by December 2016, the department had recognised that:
    - Mitchell's behaviours of concern had increased, and this included verbal and physical aggression towards staff
    - Mitchell did not like it when support workers reported behaviours of concern and incidents, and his perception of why support workers contacted their supervisors appeared to contribute to his behaviours of concern at the time.[70]

107. Mitchell's positive behaviour support plan proposed a number of actions in response to increased behaviours of concern. This included the role clarification list, as well as:
    - the development of a welfare check-in process 'so that there is a common and transparent way of keeping family up to date on Mitchell's wellbeing'
    - additional staffing in the early hours of the morning
    - additional methods for support workers to contact their supervisors when they needed help
    - daily debriefing for staff 'to process feelings of threat'.[71]

108. However, information available suggests that, despite this recognition, underreporting and diminished communication between support workers and management at the Residence was only identified when management detected that Mitchell's support team was unsettled in August 2017. It is unclear:
    - why issues in staff wellbeing were not detected earlier, given that reporting and staff safety were identified as areas of concern in December 2016

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70 Above n 27.
71 Above n 27.

- why staff wellbeing was the factor that ultimately revealed underreporting, and why either issues had not been checked or monitored before August 2017.

109. In response to my investigation, the department acknowledged that:

> the level of communication and reporting of incidents between support workers and management [between December 2016 and July 2017] could and has been improved to ensure client wellbeing and work, health and safety of staff. This has also allowed for improved communication with the family.[72]

110. I recognise that the department had encountered difficulty in addressing concerns about underreporting, communication and role clarity, and this issue was and continues to be addressed by the department.[73] That said, I do not consider that these difficulties prevented the department from identifying and taking alternative proactive approaches to address the issues at an earlier stage or, at the very least, actively monitoring reporting and communication by Mitchell's support workers after December 2016. This appears to have been the intention of some of the recommendations included in Mitchell's positive behaviour support plan.

111. Further, in my view, the need for a proactive approach to reporting, communication and staff wellbeing increased after Mitchell's emergency relocation to the Residence, where onsite supervision was not permanently available for support workers until May 2017.

Opinion

In light of the above, my final view is that the level of communication between Mitchell's support workers and management staff at the Residence in regard to incidents and behaviours of concern was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act.

Whether the department failed to properly investigate a letter received by Victoria and James, detailing threats against Mitchell's safety and wellbeing (the letter), and whether this failure was unreasonable

112. On 3 March 2018, Victoria and James found a letter in the letterbox of a house they were preparing to sell. I understand that they had previously lived there. The letter, which was unsigned and undated, alleged that senior management had removed a site manager from the Residence, and staff at the Residence considered this to be unfair. The letter went on to describe that 60 staff had signed a petition against the action, but that management had put a stop to it and threatened staff employment. The letter continued:

> As you would imagine the staff involved are angry and pissed off which now puts your nephew at risk.
>
> *food…poison
> *medication…wrong
> *shampoo…what's in the bottle acid ?
> *bruises…how did that happen
> *other clients with violent behaviour .. eg dumb bells
> *going out…falling down stairs
> *how well does he swim
> *locked up

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72 Letter from Ms Lois Boswell to my Office, 31 July 2020. In response to this point in my provisional report, Victoria and James submitted that 'Communication has not improved.' It is unclear whether this refers to internal departmental communication or the department's communication with Victoria and James. There is no information available to me in support of the former and I consider the latter has been addressed, as detailed above a paragraphs 45 and 46.

73 See above at paragraph 47.

*food withheld
*going through the wind screen …seat unclipped

This little piglet is going to be abused with cruelty violence… regularly and repeatedly

113. That afternoon, James left a voicemail message for the Director, Accommodation Services Operations. Victoria and James then notified the Public Advocate and the Principal Community Visitor of the letter.

114. The department's Managing Misconduct Guideline provides:

> Not every failure to act with [the Code of Ethics for the South Australian Public Sector] will be dealt with by implementing misconduct procedures, noting that misconduct action is a part of a range of management practices that are available [to the department] to support high quality performance. However, in most instances the commencement of misconduct processes will be appropriate where the Chief Executive or delegate suspects on reasonable grounds misconduct has occurred.
>
> It is imperative that managers act with good faith when considering whether to initiate misconduct processes. Managers should address suspected employee misconduct in a timely manner. Inexplicable delays can lead to a perception that the employee's conduct in question has been condoned and/or is not serious.
>
> Accordingly, it is recommended that managers contact the Incident Management Unit for more detailed information…
>
> **4.2 How to use**
>
> **Investigation of suspected misconduct**
>
> An investigation of suspected misconduct is often necessary. Depending on the nature of the allegation, investigations can be conduct by local management, or where specialist skills are required, by the Incident Management Unit.
>
> Advice should be sought from the Incident Management Unit in respect of an investigation required.

115. The Guideline does not provide detail on how to conduct an investigation where the person responsible for the alleged misconduct has not been identified.

116. Further, it does not appear that the department's Management of Care Concerns Procedure or Incident Management Guidelines at the time included guidance on threats made against a client,[74] and I accept that it was not entirely clear whether the letter had been authored by a staff member of the department. If it had been established that a staff member was responsible for the letter, this may have amounted to a care concern within the procedure's definitions.

117. In the days following, I understand that the department took the following action in the interest of Mitchell's safety:
- hourly safety checks
- overnight supervision
- limiting staff to Mitchell's core team, and only replacing staff from Victoria and James' approved list.

118. Following discussions with the Director, Incident Management Unit (**the IMU**), the Director, Accommodation Services Operations enquired with relevant managers and supervisors as to whether:

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74 The Incident Management Guidelines define a critical client incident to include events that pose 'significant threat to the health and safety of clients', rather than threats made against clients.

- they suspected anybody of being the letter's author
- any staff had been noticeably upset or vocal about the site managers move away from the Residence
- any staff were known to refer to Mitchell as 'piglet'
- they knew about the petition referred to in the letter.

119. The Director also queried whether an audit could be conducted of the department's records to indicate whether the details of Victoria and James' previous address had been accessed.

120. In response, the Director, Accommodation Services Operations explained to the Director, IMU[75] that:
- the site manager had not been moved but had requested the change
- neither he nor Victoria and James could identify a possible author and did not believe that any of Mitchell's core support staff were the author/s
- management at the Residence did not suspect any staff of writing the letter and agreed that it was unlikely that the author was directly involved in Mitchell's care. Further, they could not identify any staff members who appeared to be particularly upset about the site manager's move
- management had explained that 'piglet' was an old nickname for Mitchell[76] and although some support workers knew of it, it had fallen out of common usage
- no one had come forward with any information about the source of the letter, and although management were aware of the rumours of the petition, they had not seen it and support workers had not provided any further information
- an audit to identify information access was not possible.

121. In response to my investigation,[77] the department explained that all staff members at the Residence were spoken to about the letter prior to commencement of the formal IMU investigation.[78]

122. On 5 March 2018, James and the Director, Accommodation Services Operations attended a SAPOL station to report the letter. I understand that SAPOL did not take a formal report but raised a street check for intelligence purposes as they did not consider that a criminal offence had been disclosed by the contents of the letter. According to the Director, James accepted this outcome. In response to my provisional report, Victoria and James explained that they felt 'there was no option but to accept the outcome.'[79]

123. On 11 March 2018, Victoria spent time with Mitchell. Upon returning to Mitchell's unit, Victoria presented a copy of the letter to the two support workers present. Without their knowledge, Victoria recorded the conversation, which lasted approximately 15 minutes. Mitchell was present throughout the conversation.

124. During the conversation, Victoria questioned whether there was a problem in 'our team' and whether the support workers knew anything about the petition. Though Victoria noted that she would like to think that the team was not responsible for the letter, she

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75 In response to my provisional report, Victoria and James disputed a number of points from the Director's email. While I have had regard to this difference of opinion, it does not alter my view of what was communicated between the Directors.

76 The IMU investigator later received submissions that the nickname was based on Mitchell's surname and was not intended to be derogatory. In response to my provisional report, Victoria and James explained that they did not agree with this characterisation of a 'clearly offensive and derogatory term that has been accepted as commonplace by the department, and moreover by the Residence management'. Although I am inclined to accept the information relayed by the department, it is not necessary for me to consider this issue in any further detail in this investigation.

77 Above n 5.

78 That is, by an IMU investigating officer. Records of this and the responses of the Residence were not provided to my Office.

79 Above n 40.

also explained that the support workers would be 'closely monitored', and that 'we watch you'.[80]

125. During the conversation, Victoria mentioned the letter's use of the name 'piglet'. Hearing this, Mitchell said the name of a support worker who was not present, stated that they 'write it' and used the nickname. Victoria queried whether the support worker hurt Mitchell. Mitchell replied that they had.

126. Towards the end of the recording, Mitchell asked for an ice-cream. Both support workers left the unit and the recording ended. The support workers, who I understand were visibly distressed by the conversation, spoke to supervisors present at the Residence and then to the Director, Accommodation Services Operations. The support workers allegedly explained that Victoria had made them read the letter out loud in Mitch's presence.[81] I understand that the Director then spoke with Victoria about the incident.

127. By email the next day, Victoria:
    - requested that the support worker named by Mitchell be moved to another site or Victoria and James would file a restraining order against them
    - requested that the allegation that Victoria had forced the support workers to read the letter be investigated, and outlined what action was required in order for the family to cooperate with the investigation
    - explained that if the support workers did not repeat their allegations, they expected an unreserved apology and disciplinary action.[82]

128. I understand that on 16 March 2018, the letter was referred to the IMU for investigation. In response to my provisional report, the department submitted that its investigation commenced around this time, when the Director, Accommodation Services contacted the Director, IMU. However, I note that the investigation diary accompanying the IMU investigation report commenced on 20 April 2020, after James's further complaint had been triaged.

129. On 4 April 2018, the Director, IMU met with James to discuss the letter and the allegation that Victoria had forced support workers to read it. The Director's notes of the meeting provide the following:
    - the Director explained his view that the author of the letter had intended to distress Mitchell's family, but not to reveal an intention to actually harm Mitchell as the effect of the letter was the immediate implementation of safety measures. According to the Director, James agreed with this assessment
    - the Director explained that the department did not investigate criminal offences and had limited investigative powers in comparison to SAPOL
    - investigating the source of the letter was difficult given its anonymity. Moreover, no suspects had been identified through enquiries with staff directly involved in Mitchell's care
    - the Director encouraged James to follow up on the family's disappointment at SAPOL's inaction and queried James' expectation of the department in relation to the letter
    - in response, James explained that he was not concerned about the letter or identifying its author. Rather, Mitchell's family were concerned with his ongoing wellbeing and wished to transition him to a private service provider as soon as possible. James went on to explain that he understood the difficulty in investigating the letter and reiterated that he was not concerned with identifying

80 Transcript of the conversation, 11 March 2018, prepared by the department.

81 In response to my provisional report, Victoria and James dispute whether Victoria had forced the support workers to read the letter and cast doubt about their apparent distress. This matter is not in issue in my investigation, but I accept the department's account of the workers' distress.

82 Email from James to the Director Accommodation Services Operations and others, 12 March 2018.

the author. Instead, James explained that Mitchell's family was concerned that support workers had, in their view, defamed Victoria, and that he wanted the two workers investigated and dismissed

- the Director advised that the department's investigation would consider alleged misconduct, and it was not likely to result in the termination of employment for the support workers who had read the letter with Victoria.[83]

130. In April 2018, the formal IMU investigation commenced. I understand that the Investigation Team of the IMU is responsible for investigating concerns about the standard of care provided by the department, as well as allegations of misconduct. Between April and December 2018, the investigating officer:
    - interviewed the two support workers who had read the letter with Victoria on 11 March 2018
    - interviewed the other support worker who allegedly used the term 'piglet' and had allegedly assaulted Mitchell on an unknown date
    - spoke with or obtained statements from at least six other staff members connected with Mitchell's care, including support workers, supervisors and managers. Formal interviews do not appear to have been conducted with each person[84]
    - did not interview or seek information from Mitchell as this was deemed to not be a viable option.

131. In each instance, the investigating officer queried whether the staff member had any knowledge or suspicion of who had written the letter, and whether they were aware of the petition referred to in the letter. Each responded that they did not know who had written the letter, and detailed their understanding of the petition and who had prepared it. The investigating officer also made enquiries about the nickname 'piglet', though this was largely in relation to the allegations that a support worker used it and had assaulted Mitchell.

132. In regard to the petition referred to in the letter, the investigation report noted that 'as the author of the threatening letter was aware of the staff petition, further investigation was undertaken to find the staff involved.' In the course of the investigation, one staff member was identified as having prepared a separate letter to management (**the petition letter**), expressing their unhappiness with the site manager's move from the Residence and the resulting loss of her experience and knowledge. Though not entirely clear on the information available, it appears that the petition letter and the petition are the same document. The IMU investigation concluded that a petition had not progressed or been formally submitted to management. The author of the petition letter denied having knowledge of who had authored the letter that threatened harm against Mitchell.

133. According to the investigation diary, the investigation report was completed within a week of the interview with the staff member identified as having prepared the petition letter. It does not appear that any further enquiries were made after that staff member provided their statement.

134. On 4 October 2018, while the investigation was underway, Mr Corcoran emailed the Director, IMU, querying whether an investigation of the letter had occurred. On 18 October 2018, the Director met with Mr Corcoran and, according to the Director's submissions to my Office, explained that a 'stand-alone' investigation had not been

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83 I note that Victoria and James have, in response to my provisional report, disputed a number of points in the summary above. In particular, they disagree with the Director's account that James was not concerned about the author of the letter. I have regard to this disagreement with the Director's account but it has not altered my final view of the issue for investigation.

84 I note that the investigating officer prepared to interview two staff members, but transcripts for those interviews are not available. Formal statements were provided, and the investigation diary notes that the meeting had occurred to take the staff members' statements.

undertaken in regard to the letter, but that it had been incorporated into the investigation of James' complaint about support workers allegedly defaming Victoria. According to the Director, he advised Mr Corcoran that initial investigation had been unable to identify the author and identification was now unlikely. In his submissions to my Office, the Director explained that:

> In my opinion and from my experience there were limited investigation opportunities open to the department.
>
> The letter was anonymously written so there was no identified suspect.
>
> The only successful outcome would occur if someone came forward with information on who was responsible for writing and sending the "letter" and the author had made an admission about writing and sending it.
>
> The matter was criminal and despite the matter being reported I believed we should give [Victoria and James] an opportunity to go back to SAPOL.
>
> In the interim I worked with Claude Bruno, Director of Accommodation Services to try and identify the author of the "letter"… All of those enquiries failed to identify a suspect.
>
> I meet [sic] with [James] on 4/4/18 and he made it very clear he was not concerned about identifying who wrote the letter and only wanted the complaint that two staff members "defamed/libelled" [sic] his wife investigated. He also advised he was not going back to SAPOL to complain about their lack of action.[85]

135. The investigation report, dated 28 November 2018, summarised the relevant allegations as follows:
    1. that an anonymous letter threatening Mitchell's safety was received by Victoria and James
    2. that two staff members had incorrectly reported that Victoria 'made them' read the anonymous letter out loud in the presence of Mitchell
    3. that another staff member called Mitchell 'piglet' and had pushed him onto the ground on an unknown date
    4. that staff had prepared a petition requesting the site manager's return to the Residence.

136. In regard to the letter, the investigation report concluded that:
    - SAPOL had declined to investigate the letter
    - all staff from whom the investigating officer had sought information denied having any knowledge of who authored the letter
    - when the report was finalised in November 2018, 'there had been no known incidents of harm that reflect the threats outlined within the anonymous letter'.[86]

137. The investigation report also formed conclusions about the allegations against the two support workers who read the letter with Victoria on 11 March 2018, and the support worker who allegedly called Mitchell 'piglet' and assaulted him on an unknown date. The conclusions did not concern who had authored or been responsible for the letter.

138. On 11 December 2018, the investigation report was submitted to the IMU Misconduct Team for consideration. However, the subsequent report from the Manager of the Misconduct Team to the Director of the IMU only considered the allegations against the two support workers arising from the incident with Victoria on 11 March 2018, and the allegation that another support worker had used the nickname 'piglet' and had assaulted Mitchell. The report noted that initial enquiries had been conducted into the source of the letter but did not detail a conclusion in this regard.

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85 Submissions by the Director Incident Management Unit to my Office, 10 January 2019.

86 Investigation Report, Incident Management Unit, 28 November 2018.

139. I acknowledge that an investigation to determine the author of an anonymous letter is a difficult task. I also recognise that the department's immediate response focussed on ensuring Mitchell's safety, while initial enquiries were made to determine whether there was any suspicion or knowledge at the local level as to who had written the letter.

140. However, I do not accept that the department's investigative options were limited to this initial enquiry. It appears that the author of the letter could reasonably have been narrowed to all staff at the Residence, and perhaps then further, to those who were aware that the site manager was preparing to leave.

141. Despite this, the IMU investigation focussed on the allegations against support workers that had arisen after the letter was received. For example, the IMU investigation diary notes that, on 8 May 2018, the Director, IMU brief the investigator to conduct interviews with the staff members who had read the letter with Victoria and that the 'purpose of interviews is to determine reason for staff members giving inaccurate account of incident (ie Aunty did not make them read the threat letter aloud).'[87]

142. Though each person with whom the investigating officer spoke was asked whether they were aware of the letter, in my view, the issue was not interrogated in any great detail in the course of the department's investigation. Moreover, less than a dozen people involved in Mitchell's care appear to have been interviewed in the course of the formal investigation.

143. It remains unclear to me why initial enquiries and the subsequent conclusion that the author could not be identified were, in the department's view, sufficient, given the very serious threats detailed in the letter. This also does not appear to be consistent with the department's Managing Misconduct Guideline, which notes that:

> An investigation of suspected misconduct is often necessary. Depending on the nature of the allegation, investigations can be conducted by local management, or where specialist investigation skills are required, by the Incident Management Unit.

144. Given the seriousness of the letter, I consider that specialist investigative skills were necessary. I am not satisfied that preliminary local enquiries and the subsequent contact with nine people were sufficient.

145. Moreover, in an atmosphere where support workers had expressed apprehension about incident reporting, the department's initial approach of 'telling staff about the letter and asking what they knew about who sent [it]'[88] was, in my view, insufficient and possibly counterproductive. I consider that the circumstances necessitated an independent and specialist investigative approach.

146. I do not consider that the preliminary conclusions by the Director, IMU – that the letter served to increase Mitchell's safety – were sufficient to dismiss the need for further and more thorough investigative efforts. At that stage, while the department's focus on Mitchell's safety was an understandable priority, it is concerning that this conclusion does not appear to consider possible serious misconduct by a staff member who may have been caring for vulnerable clients at the time.

147. I also do not accept that any alleged insistence by James about the investigation's focus should have been determinative. On the information available, the relationship between the department, Victoria and James appears to have been affected, at times, by mistrust and miscommunication. This appears to have contributed to a situation in which the department's focus arguably shifted to Victoria and James, diminishing its focus on Mitchell's care.

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87 Investigation Diary, Incident Management Unit, 8 May 2018.

88 Above n 5.

148. Ultimately, the department's responsibility was to ensure that no harm came to Mitchell or other clients. Determining whether a staff member was responsible for serious threats against his safety should have been a priority in the department's investigative efforts.

149. As detailed above at page three, the department maintained that it had conducted a sufficient investigation in 2018.

150. I accept that it is easy to be critical in hindsight. I also note that the department took some steps to establish who wrote the letter making initial enquiries at the local level and following up on the allegations raised by Mitchell.

151. That said, given that serious threats against a client's safety appear to have been made by a person employed by the department in the care of vulnerable people, I consider that the department should have taken all reasonable steps to establish who sent the letter. In particular, the department could have:
    - deployed an IMU investigating officer from the outset, rather than conducting local level enquiries, records of which have not been provided to my Office
    - interviewed more, if not all, staff at the Residence. If this was not reasonably practicable, all staff involved in Mitchell's care could have been formally interviewed
    - made further enquiries after the author of the petition letter had been identified, given its recognised relevance to the threats against Mitchell.

152. The department's response to my provisional report did not address these possible actions, and I have not been persuaded that the investigation actively or thoroughly considered the letter's source. I am particularly concerned by
    - the limited nature of formal interviews and inquiry, and their focus on separate allegations that had arisen after the letter had been received
    - that the investigation concluded shortly after a key piece of information – the source of the petition – had been revealed. It remains unclear why this point was not scrutinised or investigated further.

153. In my view, it was essential to ensure that the author of the letter was identified. It concerns me greatly that they may still be employed by the department and working with vulnerable people.

Opinion

In light of the above, my final view is that the department failed to properly investigate the letter, and that this was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act.

Summary and Recommendations

In conclusion, my view is that:

1. The department's handling of concerns expressed by Victoria and James in relation to:
    - Mitchell's injury and hospital attendance on 7 January 2017
    - the delay in the presence of a full care team at the Residence after Mitchell moved there in December 2016
    - Mitchell's visit to a topless restaurant on 16 June 2017
    - diminished communication and underreporting between Mitchell's support workers and management at the Residence for a period of five months
    - the implementation of a protocol allowing support workers to call SA Police where Mitchell's behaviour threatened his or another person's safety

- the installation of an intercom with a video function

was not unreasonable within the meaning of section 25(1)(b of the Ombudsman Act or wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

2. The delay in the placement of a full care team at the Residence between December 2016 and May 2017 was unreasonable within section 25(1)(b) of the Ombudsman Act.

3. The level of communication between Mitchell's support workers and management staff at the Residence in regard to incidents and Mitchell's behaviours of concern between December 2016 and August 2017 was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act

4. The department's failure to properly investigate a letter which threatened harm to Mitchell was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act.

To address these errors, I make the following recommendations under section 25(2) of the Ombudsman Act:

1. That the department provide a formal apology to Victoria and James in regard to the errors identified in my investigation.

2. That the department review and amend its policy, or develop and implement a policy to provide greater clarity on required supervision levels for the first 12 months of a new accommodation facility, including periodic reviews within that time.

3. That the department amend its relevant policies to require regular audits of incident reporting.

4. That the department amend its standard agenda for support worker meetings to include items on incident reporting, behaviours of concern, and staff wellbeing.

5. That the department review and amend the Managing Misconduct Guidelines, and any other guidelines or internal documents, to provide greater clarity on:
   - when misconduct investigations are to be undertaken
   - the responsibilities of the department where a complaint has not been made but there is good reason to commence an investigation
   - how to manage an investigation where external authorities, such as SA Police, are involved, and the scope of the department's investigation in such circumstances
   - the investigative process, particularly where it is initially unclear who is responsible for the alleged misconduct.

6. That the department conduct further enquiries to identify the author of the letter, including but not limited to:
   - interviewing the author of the petition referred to in the letter, if possible, to establish who else was aware of the petition
   - interviewing any other employees who worked at the Residence when the letter was received and who were aware of the petition

   and continue to an investigation where those enquiries indicate that the author of the letter might be identified.

   After doing so, if the department is unable to identify the author and no further enquiries can be made, I recommend that the department advise Victoria and James of the steps it has taken and their outcomes.

If the department is able to identify an author, and the author is still employed by the department, I recommend that the department consider disciplinary action.

Finally, in light of the department's response at the time, and in accordance with section 17(2)(d), I discontinue my investigation of whether the department failed to respond to allegations that Victoria contacted Mitchell 15 times a day. I also do not consider it necessary or justifiable to investigate the department's failure to notify Victoria and James or the Public Advocate of Mitchell's hospital attendance on 17 January 2017.

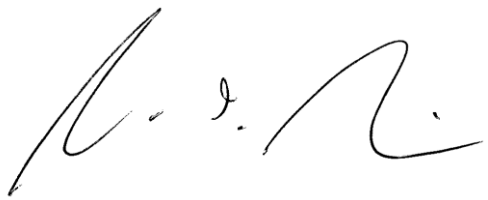
Final comment

In accordance with section 25(4) of the Ombudsman Act, the department should report to me by **21 April 2021** on what steps have been taken to give effect to the recommendations above; including:

- details of the actions that have been commenced or completed
- relevant dates of the actions taken to implement the recommendations.

In the event that no action has been taken, reasons for the inaction should be provided.

I have also sent a copy of my report to the Minister for Human Services as required by section 25(3) of the *Ombudsman Act 1972*.



Wayne Lines
SA OMBUDSMAN

27 January 2021