Commission for Children and Young People

# Annual report

## 2018–19

COMMISSION FOR CHILDREN AND YOUNG PEOPLE

The Commission respectfully acknowledges and celebrates the Traditional Owners of the lands throughout Victoria and pays its respects to their Elders, children and young people of past, current and future generations.



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COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

17 October 2019

The Hon. Luke Donnellan MLA
Minister for Child Protection
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

Dear Minister

In accordance with the *Financial Management Act 1994*, I am pleased to present the Commission for Children and Young People's Annual Report for the year ending 30 June 2019.

Yours sincerely

**Liana Buchanan**
*Principal Commissioner*

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# Definitions

## Language in this report

The term 'Aboriginal' used in this report refers to both Aboriginal and Torres Strait Islander Peoples.

## Case studies and thematic studies

Case studies and thematic studies have been included to illustrate the work of the Commission and key themes. Pseudonyms have been used and details have been altered to protect personal privacy. Stock photographs have also been used to protect children's identities.

## Abbreviations and acronyms

| | |
|---|---|
| ACCO | Aboriginal Community-Controlled Organisation |
| ACF | Aboriginal Children's Forum |
| CCYP Act | *Commission for Children and Young People Act 2012* |
| CIMS | Client Incident Management System |
| CRIS | Client Relationship Information System |
| CSO | Community sector organisation |
| DET | Department of Education and Training |
| DHHS | Department of Health and Human Services |
| DJCS | Department of Justice and Community Safety |
| FTE | Full Time Equivalent |
| IVP | Independent Visitor Program |
| NDIS | National Disability Insurance Scheme |
| OOHC | Out-of-home care |
| QARD | Quality Assessment and Regulation Division |
| SIDS | Sudden Infant Death Syndrome |
| SUDI | Sudden Unexpected Death in Infancy |
| VEOHRC | Victorian Equal Opportunity and Human Rights Commission |
| VRQA | Victorian Registration and Qualifications Authority |

From the

# Principal Commissioner

**Liana Buchanan**
*Principal Commissioner*

**We see ourselves as a community that cherishes and protects our young. In my role as Principal Commissioner for Children and Young People I see these values embodied daily in the hard work of individuals and organisations trying to improve the lives of children and young people.**

I also bear witness to how far we depart, in practice, from our collective commitment to protecting children and young people and their rights. In my work oversighting our child protection and youth justice systems, and in regulating organisations to prevent institutional child abuse, I see situations every single day where children and young people have been let down, their voices not heard, their safety compromised, and their basic needs not met.

This year has seen a continued focus in media and community conversation on the abuse of children in religious and other organisations. Also this year, here at the Commission, we entered our third year of administering the Child Safe Standards and the Reportable Conduct Scheme, two vital regulatory schemes intended to prevent institutional child abuse.

Victoria is the only jurisdiction to legislate to have both schemes in place, although the Royal Commission into Institutional Responses to Child Sexual Abuse has since recommended these schemes be rolled out nationally. I am proud to administer these schemes, and am confident they are driving much-needed change. That said, it is clear the path to keeping children safe in every organisation they encounter will be a long one.

This year we have seen more organisations embrace the task of developing a culture of child safety by implementing the Child Safe Standards. We have seen other organisations, including some we know to be high-risk organisations, prove slow to act.

In light of this, we continued to raise awareness of the Child Safe Standards and support organisations to comply through training, information sessions and dedicated resources. However, we have also increased our compliance and enforcement activity, and this will continue in the year ahead.

Meanwhile, the Reportable Conduct Scheme, which provides robust central oversight of how organisations respond to disclosures of abuse, expanded further. Between 4,000 and 5,000 additional organisations joined the Scheme when the early childhood sector and some other organisations of a public nature became covered from January 2019.

As with implementation of Child Safe Standards, I have seen many organisations, especially those that have been involved with the scheme since it began, dramatically improve their response to allegations. Unfortunately, I also see many problematic attitudes and practices, such as a tendency to minimise or disbelieve children's disclosures, disregard children's evidence, and poor investigations that compromise the quality of the response. Accordingly, we have increased guidance and training in conducting investigations and how to interview children.

The Reportable Conduct Scheme also reminds us that harm to children in our trusted organisations cannot be seen as a thing of the past; two years after the scheme began we have received 2,697 allegations and around one third of all allegations we receive are substantiated.

In our oversight of the child protection and other systems impacting vulnerable children, we conducted 32 child death inquiries to review services provided to children who died after being involved with Child Protection in the year before their death. These inquiries resulted in 19 recommendations for improvement. Common problems we identified include inadequate assessment of risk to a child, poor responses to family violence, a lack of access to cultural support for Aboriginal children, and ineffective referrals to other necessary services, meaning struggling children and their families receive no support or intervention.

The issues we see in our child death and other inquiries, and that we see in our work monitoring incidents in out-of-home care, are often related to a highly pressured child protection system with unrealistic workloads and inadequate early intervention services. In two major systemic inquiries due to be tabled later in 2019, we will put on the public record the often devastating implications for children whose safety and wellbeing is reliant on an overburdened system. I have commended the Victorian Government's recent investments in the child protection workforce; these inquiries will highlight that further reform is sorely needed to improve early intervention, strengthen child protection and develop a safe and stable out-of-home care system.

I am grateful to the many children and young people who have shaped and contributed to our work this year. Our inquiry into children and young people's experiences in out-of-home care, for example, was designed in partnership with young people with lived experience of the system and features input from more than 200 children and young people, who spoke to us about their lives in care. We cannot do our job as a Commission without hearing children and young people's voices and amplifying these voices throughout the community and government.

We also continue to closely monitor conditions in youth detention, which have been a source of concern since our 2017 inquiry into isolation, separation and lockdowns in *The same four walls*. While the Victorian Government has acknowledged the need for change and is progressing many positive initiatives, we continue to see children and young people affected by a challenged system. We have seen a tripling of lockdowns this year, generally due to inadequate staffing, which compromises children and young peoples' mental health, disrupts their education and rehabilitation, and contributes to unrest. We also continue to advocate for children's safety in the use of force and restraints, and the management of self-harm. I am grateful to our dedicated independent visitors, who are an invaluable conduit for information about children's day-to-day experiences in detention.

> **In my work oversighting our child protection and youth justice systems, and in regulating organisations to prevent institutional child abuse, I see situations every single day where children and young people have been let down, their voices not heard, their safety compromised, and their basic needs not met.**

I also appreciate the tireless work of our staff at the Commission. Our work is challenging and necessarily involves exposure to distressing information and experiences. Our team's passion, care and commitment to children's rights and safety is evident across all of our work. I feel privileged to work alongside my fellow Commissioner, Justin Mohamed, and all of our colleagues at the Commission.

The year ahead is shaping up as an ambitious one, in which we plan to push for significant system reform in the child protection and out-of-home care systems and in how we respond to Aboriginal and Torres Strait Islander children at risk of entering, or within, the youth justice system. As always, we will privilege the voices of the experts on these systems – children and young people – who bear the brunt of our system failures. At times, this role can be tough, but I am energised by the strength and resilience of so many children and young people who, quite frankly, deserve more from us.

From the

# Commissioner for Aboriginal Children and Young People

**Justin Mohamed**
*Commissioner for Aboriginal Children and Young People*

## In my first full year as Victoria's second Commissioner for Aboriginal Children and Young People, it is clear to me that promoting the wellbeing, cultural rights and self-determination of Aboriginal children and young people can never be seen as a finished project.

In carrying forward the profoundly important work of my predecessor, Andrew Jackomos, I can see that righting the wrongs of the past are central to creating a just future that will forever provide us with challenges we must continue to face with courage.

Together with the Commission, I pursue this work in a state that is seeing unprecedented progress towards a Treaty with Aboriginal people. Yet it is also a state where Aboriginal children and young people remain at risk in fundamental ways of being denied their cultural rights, their connection to community, and a future they can hold in their own hands.

It is this risk that we work to address, recognising it must be done through deep engagement with Aboriginal children and young people themselves.

The progress we make in reversing the stark over-representation of Aboriginal children and young people in Victoria's child protection and youth justice systems, in making them strong so they can build better lives, can only come from listening.

This year, I have listened to the young person denied his cultural rights and the care he deserved in secure welfare, and to the many children and young people too often living isolated and disconnected lives in out-of-home care and in youth justice detention, separated not only from their families, but from their culture, and from communities that are so much poorer without them.

Our work this year has sought to shift the balance back towards culture, connection, rights and wellbeing. In particular, our review of the Aboriginal Children's Forum aimed to support this vital forum to continue its work in holding government and agencies to account for the gap between the stated objectives of laws and policies, and their real impact in the lives of Aboriginal children and young people.

That includes addressing the unacceptable over-representation of Aboriginal children and young people in out-of-home care, but also increasing their guardianship by Aboriginal Community-Controlled Organisations, their placement with Aboriginal carers, and the critical provision of cultural support plans that nurture their Aboriginal identities.

> **Yet … Aboriginal children and young people remain at risk in fundamental ways of being denied their cultural rights, their connection to community, and a future they can hold in their own hands.**

While there is much work still to be done in these areas, I welcome this year's doubling of children case-managed by the Victorian Aboriginal Child Care Agency, and the guardianship authorisation of the Bendigo and District Aboriginal Co-operative under section 18 of the *Children, Youth and Families Act 2005*. It is also welcome to see two additional pilots underway at Njernda in Echuca and the Ballarat and District Aboriginal Co-operative.

Guardianship by Aboriginal organisations of Aboriginal children and young people in care is an essential step towards their connection to culture and community, and the ultimate self-determination that this supports.

Complementing this, we have also worked this year to increase the number of Aboriginal children and young people placed with Aboriginal carers.

In our efforts to stem the increasing rate at which our children and young people are being removed into care even after the National Apology of 2008, we must also do everything we can to ensure the care system in Victoria is a place that builds and strengthens lives, where children and young people experience connection and support, not harm and fragmentation.

As we work through the ACF towards these ends, we also recognise that the Commission's relationships with Aboriginal Community-Controlled Organisations will change, as these organisations themselves gain self-determination, and welcome additional responsibilities for the future of their communities.

To support this, the Commission this year began the development of specific communications for an Aboriginal audience, including videos to promote the Child Safe Standards and the Reportable Conduct Scheme. The benefits of the Standards and the Scheme in creating child-safe organisations that prevent and respond to abuse must be shared by all children and young people, especially those we know are over-represented in organisations that are supposed to keep them safe and respond to their vulnerability.

The importance of addressing this over-representation in out-of-home care is only heightened by the strong link we know to exist between this experience and involvement in the youth justice system, and, beyond that, adult prison.

We know the vulnerabilities that lead to care also pre-dispose Aboriginal children and young people to enter the justice system, in which they are again starkly over-represented. We know, too, that the impact particularly on younger Aboriginal children provides a compelling argument to raise the age of criminal responsibility to at least 14, in line with the latest recommendations of the United Nations Committee on the Rights of the Child.

This year, the Commission sought to tackle these challenges through our engagement with the Aboriginal Justice Forum, arguing for a greater youth focus so we intervene early in young Aboriginal lives. We also participated in work to progress independent, unannounced inspections of places of detention under the United Nations Optional Protocol to the Convention

Against Torture. Of four Commission staff who joined with the Victorian Ombudsman to pilot these inspections, two were Aboriginal.

More broadly, this year also saw significant work to build the foundations for the Koori Youth Justice Taskforce – a joint initiative of the Commission and the Department of Justice and Community Safety – and the Commission's related independent *Our youth, our way* inquiry, both of which seek to identify the factors leading to over-representation of Aboriginal children and young people, and provide solutions to reduce it.

Modelled on the *Taskforce 1000* approach to Aboriginal children and young people in out-of-home care, the Koori Youth Justice Taskforce this year began to examine the individual cases of Aboriginal children and young people in youth justice, intervening to improve individual outcomes, but also to identify positive practices that can be implemented across the state. Through this work, I have become acutely aware of the significant impact – for better or worse – that even a single decision can have in the life of an Aboriginal child or young person.

Coupled with the Taskforce, the *Our youth, our way* inquiry began engaging directly with Aboriginal children and young people, their families and communities about the impact of the youth justice system at many levels. Through this work, we began to broaden the perspective on youth justice beyond the fact of offending to the surrounding challenges that lead to it.

This work, which will continue through to the tabling of our report in Parliament in 2020, recognises that solutions to the challenges facing Aboriginal children and young people must be informed by their voices, and be led by Aboriginal people.

Finally, in just over a year as the Commissioner for Aboriginal Children and Young People, it has been heartening to see that significant reflection on and engagement with Aboriginal culture within the Commission itself.

Through the Commission's Aboriginal cultural events and our participation in continuous learning, we work from a place of fundamental respect for Aboriginal culture, led by our valued Aboriginal staff, but with the understanding that is our shared responsibility to reflect, learn and bring change.

As with so much vital change, the path to progress is deeply informed by culture, and we remain committed to bringing its benefits to the lives of Aboriginal children and young people across Victoria.

# About the Commission for Children and Young People

# About the Commission for Children and Young People

**We are an independent statutory body that promotes improvement in policies and practices for the safety and wellbeing of vulnerable children and young people in Victoria.**

## What we do

At the Commission we:

- provide independent scrutiny and oversight of services for children and young people, particularly those in the out-of-home care, child protection and youth justice systems
- advocate for best-practice policy, program and service responses to meet the needs of children and young people
- promote the rights, safety and wellbeing of children and young people
- promote the views and experience of children and young people to increase the awareness of government and the community
- support and regulate organisations that work with children and young people to prevent abuse and make sure these organisations have child-safe practices.

## Our vision

That the rights of all children and young people in Victoria are recognised, respected and defended.

## Our values

- We put the rights of children and young people at the centre of everything we do.
- We are strong, fearless and determined.
- We are transparent and accountable.
- We know diversity of people, experiences and perspectives makes our work stronger.
- We accomplish more as we are a united team.

## Legislation

Our main functions and powers are set out in the *Commission for Children and Young People Act 2012* (CCYP Act) and the *Child Wellbeing and Safety Act 2005*.

# Our priorities

## In 2018–19 we established seven key priorities:

1. Mobilise organisations and the broader community to prevent and respond to allegations of institutional child abuse
2. Establish a risk-informed, sustainable operating model for Child Safe Standards and the Reportable Conduct Scheme, targeting organisations to achieve the best outcomes for children and young people
3. Strengthen the participation and influence of children and young people across the Commission's work
4. Highlight the lived experience of children and young people in the out-of-home care and child protection systems to drive reform
5. Increase transparency of, and accountability for, government action on Commission recommendations and regulatory scheme obligations
6. Drive an effective and humane approach to children and young people involved with the criminal justice system
7. Continue to build a culturally rich, high-impact Commission for Children and Young People

# Highlights: our year in review

## Promoting children's safety in organisations

The Commission promotes children's safety in organisations in Victoria by administering legislated mandatory requirements under the Child Safe Standards and the Reportable Conduct Scheme. The Child Safe Standards drive a culture of child safety in organisations working with children, while the Reportable Conduct Scheme requires a range of conduct harmful to children to be promptly reported to the Commission and followed by action to investigate and respond to abuse.

This year the organisations covered by the Reportable Conduct Scheme expanded to include early years providers and other organisations of a public nature, adding between 4,000 and 5,000 additional organisations, and increasing total coverage to around 12,500 organisations. Under the Scheme a total of 805 mandatory notifications were made to the Commission this year, with the highest notifications recorded in the out-of-home care, education, and early childhood sectors (see page 82).

Complementing this work, the Commission this year took Child Safe Standards compliance action with 77 organisations, proactively targeting organisations where compliance concerns were identified.

In early 2019, the Commission also made a detailed submission to the Victorian Government's review of the Child Safe Standards. We hope the outcomes of the review will strengthen the Standards as Australia moves towards a nationally consistent approach to safeguarding children that reflects the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse.

A new risk-based regulatory approach also developed by the Commission this year will improve how we identify and respond to harm in order of priority within available resources.

In supporting compliance with the Standards and the Scheme, engagement with stakeholders is critical. This year, the Commission worked extensively with early years providers and religious organisations, in addition to its support across all organisations to promote compliance.

Together, the Child Safe Standards and the Reportable Conduct Scheme are providing a new level of protection for children and young people in Victoria.

## Making a difference for Aboriginal children and young people

With the stark over-representation of Victoria's Aboriginal children and young people in both the child protection and youth justice systems, the Commission this year worked across multiple fronts to protect their rights, and promote their wellbeing.

A review of the Aboriginal Children's Forum conducted by the Commission will support this forum's work as a vital means of progressing a range of significant issues. These include expanding the number of Aboriginal Community-Controlled Organisations with guardianship of Aboriginal children in the out-of-home care system, increasing the number of Aboriginal carers for these children and young people, and strengthening their connection to culture and community in support of self-determination (see page 59).

This year also saw extensive foundational work for the Koori Youth Justice Taskforce, and for the Commission's related, independent *Our youth, our way* inquiry, both of which are addressing the over-representation of Aboriginal children and young people in Victoria's youth justice system. The *Our youth, our way* inquiry will be tabled in the Parliament of Victoria next year (see page 60).

Complementing this, the Commission participated in the Aboriginal Justice Forum, working to ensure a greater youth focus.

## Effective oversight of youth justice

The Commission has a vital role ensuring robust oversight of Victoria's youth justice centres to protect the rights and wellbeing of children and young people, and to promote conditions of detention that enhance rehabilitation.

Children and young people from vulnerable groups – including those from out-of-home care and who are Aboriginal – are over-represented in Victoria's two youth justice centres, and it is essential that the level of oversight reflects and seeks to reduce their vulnerability.

This year the Commission maintained and expanded its oversight, increasing the diversity of volunteers in our Independent Visitor Program (see page 48), monitoring and following up serious incidents, tracking implementation of recommendations from our past inquiries, and advocating for systemic change to address persistent, serious problems such as the unacceptable rate of lockdowns, and poor responses to self-harm (see page 43).

We also participated in the Victorian Ombudsman's pilot of independent inspections of places of detention that followed Australia's ratification of the United Nations Optional Protocol to the Convention Against Torture (OPCAT). The Commission was pleased to contribute its expertise in the rights and needs of children and young people, and in the oversight of youth justice, as Victoria moves with other states and territories to establish National Preventative Mechanisms by December 2020 (see page 52).

Our oversight of youth justice was complemented by broader work to promote early intervention in the lives of children and young people to divert them from the too-frequent pathway through child protection into youth justice, and, ultimately, to the adult justice system.

## Safer, better care for children

The children and young people in Victoria's child protection and out-of-home care systems are among the most vulnerable in the state – victims of abuse and neglect who are too often disconnected from and denied the support of family, community and society, and the opportunities afforded to their peers.

The Commission has an important role maintaining oversight of these systems, and empowering the children and young people within them to participate in the decisions that affect them and to secure the life prospects they fully deserve.

This year we monitored and followed up on serious incidents in care such as self-harm and attempted suicide, physical and sexual abuse, and sexual exploitation (see page 36). We tracked the implementation of recommendations from our past inquiries, completed or began new inquiries, and advocated for systemic change.

An individual inquiry was completed this year for 'Jamie', a young Aboriginal person with an extensive background in care. The inquiry identified a range of serious systemic shortfalls in Jamie's care in the out-of-home care system, including treatment in residential care that exacerbated rather than responded to his mental health and other issues, a failure to connect him to culture, and poor coordination between health, mental health and child protection services.

Our oversight of residential care was this year expanded to include regular on-site inspections of residential care facilities to speak with children and young people directly, to identify individual and systemic issues they face, and discuss the extent to which residential care upholds their rights as set out in the Charter for children in out-of-home care.

This year we also made substantial progress towards *In our own words*, the Commission's systemic inquiry into out-of-home care, speaking in detail to more than 200 children and young people about their experiences of care. The report of the inquiry will be tabled in the Parliament of Victoria later in 2019.

## Learning from deaths to protect children

For every child or young person who dies within 12 months of their involvement with Child Protection, the Commission is required to undertake a child death inquiry to examine the services provided to them. The reviews recommend important systemic changes to improve future responses to children in the child protection system.

This year the Commission completed 32 child death inquiries and received 34 notifications of deaths of children and young people known to Child Protection (see page 20). This year, the themes from these inquiries included poor risk assessment, the excessive workload of Child Protection practitioners, inappropriate or failed referrals to support services, a failure to recognise the risk of family violence to children independently of adults, and a failure to engage fathers. We also noted, for the second year running, a higher number of infants dying from SIDS/SUDI.

The ongoing monitoring of child deaths also plays a critical role in informing the systemic inquiries of the Commission, where significant themes are examined on a broader level. This year the Commission began the *Lost, not forgotten* inquiry on the experiences of children who committed suicide after being known to Child Protection. The inquiry followed work completed last year on cumulative harm and suicide, and will be tabled in the Parliament of Victoria later in 2019.

## Engaging with children and young people

Our commissioners this year attended two Hour of Power events hosted by the CREATE Foundation to hear young people with a care experience speak about the issues important to them.

This year, the Commission built on our past engagement with children and young people to empower them to participate in and influence the work of the Commission. Children and young people were centrally involved in the *In our own words* inquiry, voicing their experiences of living in out-of-home care. Significant work was also done to put in place practices that build engagement throughout our work, including through the development of engagement tools, and an engagement framework based on how children and young people themselves thought we could better interact with them. We also focused on children's voices in youth justice through our Independent Visitor Program, and through our new on-site visits to children and young people living in residential care. Through this work, the Commission sought to reflect the requirement of the Convention on the Rights of the Child that children have a right to be heard and involved in all decisions that affect them.

# Out-of-home care and child protection

# Out-of-home care and child protection

## The Commission is responsible for monitoring and oversight of the child protection and out-of-home care systems.

We do this by:

- reviewing the death of every child who was involved with Child Protection in the year before they died
- monitoring all serious incidents in out-of-home care
- new on-site inspections of residential care services
- conducting inquiries into service responses to individual children
- initiating inquiries into systemic issues affecting children in child protection and the out-of-home care systems, and monitoring government action on past inquiries.

This year, in addition to child death inquiries, our inquiries have focused on young people's lived experiences of the out-of-home care system. We completed an inquiry into the experiences of an Aboriginal child in care and progressed two major systemic inquiries into the lived experiences of children and young people living in the out-of-home care system and those transitioning out of that system.

## Child death inquiries

Under the *Commission for Children and Young People Act 2012*, we must conduct an inquiry into the services provided to every child who dies and was known to Child Protection in the 12 months before their death. These inquiries aim to identify aspects of the service system that need to be improved to help children in the future. While the death of a child is a trigger for an inquiry, the Commission makes no findings as to the cause of death. Instead we focus on services provided to a child before they died.

### *Child deaths reported to the Commission 2018–19*

We were notified of the deaths of 34 children in 2018–19, including five Aboriginal children. The category of death identified in the following tables is based on information available to the Commission through Child Protection files. This is indicative, as only the Coroner can determine the formal cause of death.

***Table 1. Child death notifications received by the Commission by Aboriginal status and category of death 2018–19***[1]

| Category of death | Aboriginal | | Non-Aboriginal | | Total | |
|---|---|---|---|---|---|---|
| Accident | 1 | 2.9% | 7 | 20.6% | 8 | 23.5% |
| Illness | 2 | 5.9% | 5 | 14.7% | 7 | 20.6% |
| Non-Accidental Trauma | 1 | 2.9% | 2 | 5.9% | 3 | 8.8% |
| SIDS/SUDI[2] | 0 | 0 | 6 | 17.6% | 6 | 17.6% |
| Suicide | 0 | 0 | 3 | 8.8% | 3 | 8.8% |
| Pending determination/ unascertained/unclear from file | 1 | 2.9% | 6 | 17.6% | 7 | 20.6% |
| **Total** | **5** | **14.7%** | **29** | **85.3%** | **34** | **100.0%**[3] |

1 The category of death is indicative only and is based on information available to the Commission.

2 The sudden, unexpected death of a baby where there is no cause of death is called Sudden Unexpected Death in Infancy (SUDI). This category includes Sudden Infant Death Syndrome (SIDS).

3 Due to rounding, percentages may not add up to 100.

***Table 2. Child death notifications to the Commission by Aboriginal status and age 2018–19***

| Age | Aboriginal | | Non-Aboriginal | | Total | |
|---|---|---|---|---|---|---|
| 0–5 months | 0 | 0% | 11 | 37.9% | 11 | 32.4% |
| 6–11 months | 1 | 20.0% | 2 | 6.9% | 3 | 8.8% |
| 1–3 years | 2 | 40.0% | 3 | 6.9% | 5 | 11.8% |
| 4–12 years | 2 | 40.0% | 5 | 17.2% | 7 | 20.6% |
| 13–17 years | 0 | 0.0% | 9 | 31.0% | 9 | 26.5% |
| **Total** | **5** | **100.0%** | **29** | **100.0%** | **34** | **100.0%** |

***Table 3. Child death notifications received by the Commission 2014–19***

| Category of death | 2014–15 | 2015–16 | 2016–17 | 2017–18 | 2018–19 |
|---|---|---|---|---|---|
| Accident | 3 | 7 | 6 | 2 | 8 |
| Drug/substance-related | 0 | 0 | 3 | 0 | 0 |
| Illness | 15 | 13 | 13 | 11 | 7 |
| Non-accidental trauma | 1 | 6 | 3 | 1 | 3 |
| Pending determination/unascertained/unclear from file[4] | 1 | 3 | 4 | 4 | 7 |
| Sudden Unexpected Death in Infancy (SUDI) | 0 | 4 | 3 | 7 | 6 |
| Suicide/self-harm | 4 | 5 | 4 | 1 | 3 |
| **Total** | **24** | **38** | **36** | **26** | **34** |

As seen in previous years, the highest proportion of children who died was infants aged 0–5 months (n=11 or 32.4 per cent). The next largest group was made up of adolescents aged between 13–17 years (n=9 or 27 per cent), which is a slight increase in comparison to last year. The high rate of very young infants in scope for these inquiries remains a concern.

[4] 'Pending determination' refers to deaths where the likely cause of death is not yet clear. This includes cases for which there is an ongoing coronial investigation. 'Unascertained' refers to deaths in which a coroner could not determine the cause of death. This combined category includes matters where the coroner was unable to ascertain the cause of death or where the category of death was unclear at the time the inquiry was closed. 'Unclear from file' refers to cases where the Commission has been unable to determine a category of death from the available file information and there is no coronial process in train.

### *Child death inquiries completed*

In 2018–19, the Commission completed 32 child death inquiries and made 19 recommendations. These related to children who died from 2015–19.[5] Five of the inquiries related to Aboriginal children. As in previous years, almost all the children were living at home with their parent or parents at the time of death. For the completed inquiries, the largest category of death was SIDS, followed by illness.

The children whose lives we reviewed through our child death inquiries this year had been the subject of, on average, 2.5 reports to Child Protection, with 14 children (42.7 per cent) having only one Child Protection report recorded and 11 (34.3 per cent) having between two and four reports. One child had been the subject of 15 reports. In 15 (47 per cent) of the cases, the Child Protection case was still open when the child died.

***Table 4. Child death inquiries completed by the Commission by age, category of death and Aboriginal status by year 2018–19***

| | | Aboriginal | Non-Aboriginal | Grand Total |
|---|---|---|---|---|
| Accident | 0–5 months | 0 | 1 | 1 |
| | 1–3 years | 0 | 2 | 2 |
| | 13–17 years | 0 | 2 | 2 |
| | **Total** | **0** | **5** | **5** |
| Drug/substance-related | 13–17 years | 0 | 3 | 3 |
| | **Total** | **0** | **3** | **3** |
| Illness | 0–5 months | 1 | 1 | 2 |
| | 1–3 years | 1 | 2 | 3 |
| | 6–11 months | 0 | 1 | 1 |
| | 13–17 years | 1 | 1 | 2 |
| | **Total** | **3** | **5** | **8** |
| Non-accidental trauma | 6–11 months | 1 | 0 | 1 |
| | **Total** | **1** | **0** | **1** |
| SIDS/SUDI | 0–5 months | 1 | 8 | 9 |
| | 1–3 years | 0 | 1 | 1 |
| | 6–11 months | 0 | 1 | 1 |
| | **Total** | **1** | **10** | **11** |
| Suicide | 13–17 years | 0 | 1 | 1 |
| | **Total** | **0** | **1** | **1** |
| Unclear from file | 0–5 months | 0 | 1 | 1 |
| | 1–3 years | 0 | 1 | 1 |
| | 6–11 months | 0 | 1 | 1 |
| | **Total** | **0** | **3** | **3** |
| **Total** | | **5** | **27** | **32** |

[5] Sometimes the Commission is unable to complete an inquiry for a period due to a police investigation.

***Table 5. Child death inquiries completed by the Commission by living arrangements at death 2018–19***

| | Aboriginal | Non-Aboriginal | Total |
|---|---|---|---|
| At home with parent | 2 | 21 | 23 |
| Foster care | 0 | 1 | 1 |
| Homeless | 1 | 0 | 1 |
| Hospital | 2 | 2 | 4 |
| Kinship care | 0 | 2 | 2 |
| Residential care | 0 | 1 | 1 |
| **Total** | **5** | **27** | **32** |

### *Themes*

We identified a number of recurring themes in the inquiries we completed in 2018–19; some are the same or similar to last year's and some are new themes. These included:

- poor or inadequate assessment of risk faced by the child
- the impact of workload on Child Protection practice
- inappropriate or unsuccessful referrals to support services
- higher rates of SIDS/SUDI
- poor response to family violence
- failure to support Aboriginal children's right to culture
- failure to engage with fathers.

#### *Poor or inadequate assessment of risk faced by the child*

Poor practices around risk assessment continue to be a recurring issue in child death inquiries. Of the 32 inquiries completed, 19 found that Child Protection did not adequately assess the risks facing the child.

A failure to adequately consider risk factors such as family violence, substance abuse, parental capacity or cumulative harm was a common theme underpinning poor risk assessments. Examples of poor risk assessment included inadequate information-gathering, resulting in risk assessments that did not take proper account of relevant information. In other cases, we found that Child Protection's response to apparent risk was inadequate, either because it did not respond urgently or because it closed prematurely.

The Commission also found that Child Protection demonstrated some aspects of positive risk assessment practices in 12 inquiries. These inquiries found comprehensive and sensitive risk assessments, appropriate identification of high-risk indicators, and prompt and collaborative approaches to assessing risk. In these cases, Child Protection demonstrated sound decision-making as a result of appropriate information-gathering and assessment.

Over the past year, a new Child Information Sharing Scheme has been introduced with the commencement of the *Children Legislation Amendment (Information Sharing) Act 2018*. This is a welcome change, prompted by our repeated recommendations, and allows authorised organisations and professionals to share information relevant to children's wellbeing and safety. However, it is important to note that the failure to share or to gather information that we continue to see in our inquiries often does not arise due to legislative barriers, suggesting that significant improvement in practice and a shift in culture is also needed.

## Case study

### Inadequate risk assessment

Poppy died at age 12 years from a complex medical illness. Over her life, Poppy was the subject of three reports to Child Protection, with the second and third reports relating to her parents not ensuring she received the medical care she urgently required.

In the last year of her life, the school and support services both expressed concerns that Poppy's parents may have provided an unreliable account of the medical care she had received, and about the steps they had taken in relation to her medical care. Child Protection closed the second report at intake and the third at investigation without a proper understanding of the care Poppy received over the last year of her life, or the risks she faced if she did not get the medical help she needed.

The inquiry found that Child Protection ceased its involvement without an adequate understanding of these risks and therefore did not:

- take appropriate action to mitigate those risks
- provide guidance to services working with Poppy – whom Child Protection had requested to monitor her safety and wellbeing – about when future concerns about Poppy's health or wellbeing should trigger a 're-report' to Child Protection, or immediate emergency assistance.

***The impact of workload on child protection practice***

It is not common for the Child Protection files reviewed by the Commission for its inquiries to record detail of the resourcing context in which Child Protection practitioners are operating. This year, however, four inquiries found the Child Protection file explicitly noted the impact of under-resourcing on the Child Protection practitioners' ability to follow Child Protection procedure. The impact of workforce challenges included:

- issues relating to unallocated cases, including large numbers of unallocated cases, lengthy periods of awaiting allocation and a lack of information-gathering on unallocated cases to determine their priority level[6]
- a focus on immediate risk rather than cumulative risk indicators
- gaps in recording of information and superficial information being recorded
- multiple practitioners and team managers having responsibility for cases due to unplanned leave or staff relocation
- a lack of follow-up on serious incidents
- a 'first visit' being undertaken as a phone call, rather than 'face-to-face' in accordance with practice guidelines.

These cases point to broader systemic issues related to staff retention, capacity and excessive workloads, rather than individual practitioner competency, and echo findings made in the Commission's 2017 report, *'…safe and wanted…'*. This report found that, despite recent investment in the Child Protection workforce, the child protection system was under substantial stress with high levels of unallocated cases,[6] high caseloads and staff vacancies.

6 We note that DHHS refers to these cases as 'awaiting allocation'.

***Inappropriate or unsuccessful referrals to support services***

Seven inquiries found that Child Protection either did not make referrals to family support services or did not follow-up on the effectiveness of referrals made. This is a common theme, which has been noted in previous annual reports as well as in our 2018 *Inquiry into cumulative harm and suicide in child deaths*.

For example, we often see cases where the child's situation has not met the threshold for protective intervention, but referrals to Child FIRST are ineffective because services cannot engage the parents. These children 'fall through the cracks' between Child Protection and family services.

Despite Child Protection guidance that workers should ensure linkages and collaborative community plans have been developed and are operational before Child Protection closes a case, we continue to see cases being closed with no follow-up on referrals. Often, these cases demonstrated that Child Protection was overly optimistic about parental engagement with services, despite there being a history of poor or inconsistent engagement.

## Case study

### Ineffective referrals

David's death at the age of 14 was due to natural causes.

Child Protection received 15 reports about David over 14 years. Of these reports, 13 were closed at intake. These reports included concerns that related to parental substance misuse, family violence, environmental neglect, likelihood of significant physical harm and poor school attendance.

Many of the reports received by Child Protection were under-assessed, and despite David's exposure to risk, reports to Child Protection resulted in no effective intervention. David's school attendance was extremely poor, something that was raised in a number of reports to Child Protection. Child Protection did not recognise David's decreasing school attendance as an indicator of deteriorating mental health and as a consequence did not link him to appropriate services that could respond to his needs.

Child Protection repeatedly referred David and his family to Child FIRST. These referrals were ineffective due to the presence of other significant risks to David and because the family had not engaged on three previous occasions with this service. Child FIRST was unable to support the family on a voluntary basis given the mother's poor engagement and David did not receive the support he needed.

David's schools attempted to refer him to an educational support program. However, given these programs were voluntary and relied on his mother's support and engagement, the referrals were ineffective, and David could not access these programs. Similarly, the local health service worked with David and his family, but was limited in its ability to engage with the family without Child Protection's intervention. As a result, David did not receive the mental health support he required.

***Higher rates of SIDS/SUDI***[7]

Sudden Infant Death Syndrome, or 'SIDS', is the sudden and unexpected death of an apparently well infant during sleep. There has been an increase in children dying of SIDS/SUDI in the last two years. We reviewed 11 of these cases in 2018–19.

While there remains much that is unknown regarding SIDS-related deaths, there are a number of well-established risk factors including smoking in the household, co-sleeping, and overheating. Co-sleeping with a parent or carer who is alcohol or drug-affected is known to be particularly risky.

In five inquiries, the infant was noted to be co-sleeping with a parent and/or sibling at the time of death. In most cases co-sleeping occurred in spite of safe-sleeping information having been provided by either Child Protection, or the Maternal and Child Health Nurse, or both.

We also found a number of often co-existing risk factors in the cases involving children who had died from SIDS, including:

- family violence was a concern in eight of the 11 inquiries
- parental substance abuse featured in four inquiries
- concerns regarding parental capacity was present in four inquiries
- concerns for parental mental health were present in three inquiries.[8]

## Case study

### Safe-sleeping advice

Catherine died from what appeared to be SIDS when she was two months old. She was believed to be co-sleeping with her parents, who were substance-affected at the time. The family were from a non-English speaking background.

An earlier unborn Child Protection report related to her mother's past and current methamphetamine use. Catherine's mother acknowledged her drug use prior to and during pregnancy. An order made at birth placed Catherine in the care of her maternal grandfather. The order provided that Catherine's mother could reside with the grandfather, but her contact with Catherine must be supervised. Catherine's father lived separately. Catherine died while in the unsupervised care of her parents, in breach of the order.

The Commission found that Child Protection conducted aspects of the SIDS safe-sleeping assessment with Catherine's grandfather, as the primary carer, but did not provide him with safe-sleeping advice. Child Protection also did not provide Catherine's mother or father with safe-sleeping advice in case they had unsupervised contact with Catherine. The Commission also found the hospital where Catherine was born did not provide her parents with safe-sleeping advice. Catherine's parents and grandfather may therefore have been unaware of the risks of unsafe sleeping practices.

This inquiry recommended that Child Protection use Catherine's case in training to highlight the importance of understanding cultural co-sleeping practices in providing SIDS and safe-sleeping information, and also to highlight the need to ensure SIDS education for all family members who have significant involvement with an infant.

7 The sudden, unexpected death of a baby where there is no cause of death is called Sudden Unexpected Death in Infancy (SUDI). This category includes Sudden Infant Death Syndrome (SIDS).

8 In setting out these factors, we intend only to note the corresponding themes of note and are not suggesting that there is a causal connection between these factors and SIDS/SUDI.

In the cases we reviewed, Child Protection demonstrated poor practice in three cases and good practice in six cases in relation to the provision of safe-sleeping education and safe-sleeping assessments. For example, in some cases Child Protection reinforced safe-sleeping messages several times and liaised with Maternal and Child Health Services where there were concerns regarding the sleeping environment. The Commission acknowledges the introduction of new practice guidelines on infant responses, which include a requirement for regular monitoring of infants where an intensive response has been assessed as necessary. The Commission will continue to monitor service provision in relation to SIDS/SUDI deaths to identify any opportunities for improved or pre-emptive practice.

***Poor response to family violence***

Consistent with previous years and the Commission's *Neither seen nor heard* inquiry, family violence is a persistent and pervasive theme in child death inquiries. Of the 32 cases we reviewed, 21 children experienced family violence.

Poor practice by services was evident in the majority of these cases. Such poor practice included a failure to adequately consider the risk or impact of family violence on the child, a lack of engagement with parents about protective concerns (including with the perpetrator of family violence), a failure to evaluate support interventions, and premature case closure.

However, the Commission also identified several examples of good practice in relation to family violence. Evidence of good practice included the appropriate identification of family violence, the development of comprehensive safety plans, and the provision of appropriate supports.

The Commission notes the roll-out of three-day family violence training across the Child Protection workforce this year. We hope this training will equip Child Protection practitioners and managers to better engage families experiencing family violence, and facilitate better outcomes for child victims.

## Case study

### Poor response to family violence

Throughout his life, Tom had been exposed to trauma as a result of family violence inflicted by his father towards his mother. It was not until he was 12 years old that the incidents of family violence were reported to Child Protection and Tom's father left the family home. Although the support services were involved with the family, their focus remained predominantly with Tom's mother and did not show an understanding of the impact on Tom. Tom therefore did not receive a service response to address his experience of family violence.

This trauma became manifested in Tom's behaviours, which included absconding from home for extended periods and drug and alcohol abuse. In his adolescence, Tom's drug use escalated and there were increasing concerns for his safety and wellbeing. On two occasions, Tom was placed in secure welfare as a means of stabilising these behaviours, but this had minimal sustained impact and Tom continued with his drug use and disengagement from his family and support services. At 16 years of age, Tom died as a result of an accidental drug overdose.

The inquiry found that the service system did not take account of the impact of cumulative harm and the associated impact on Tom's psychological wellbeing and failed to provide a therapeutic response to meet his needs.

In addition to the role out of family violence training to the Child Protection workforce, DHHS has also developed a Family Violence Theoretical Model which is aimed at shifting from practice that is aware of family violence to practice that is effective in responding to family violence. The model integrates key elements of family violence practice with components of Child Protection's Best Interests Case Practice Model:

- tilting practice towards a focus on perpetrator accountability
- collaborating with the affected parent
- focusing on children's experience
- attending to practitioners' sense of safety at all times.

***Failure to support Aboriginal children's right to culture***

Five out of the 32 child death inquiries completed this year involved Aboriginal children. Three of the five Aboriginal children were infants. Only one infant and their family received input from a culturally specific service, with poor cultural support evident in three inquiries.

## Case study

### Good cultural support

Kylie died at the age of five months from pneumonia. Kylie was an Aboriginal infant born premature with complex medical needs. Kylie was never discharged from hospital.

Child Protection received a report about Kylie that related to concerns about her parents' ability to care for her outside of the hospital.

The inquiry found that Child Protection liaised extensively with the hospital during Kylie's hospital stay. The hospital was sensitive to Kylie and her family's cultural needs, having connected her family with the Aboriginal Liaison officer within the hospital and having referred Kylie and her family to an Aboriginal service for ongoing support pending Kylie's discharge from hospital.

In one inquiry, Child Protection did not record that the child was Aboriginal until there had been thirteen years' involvement. This indicated a repeated failure over the course of 14 reports to Child Protection to ask the child or their family whether they identified as Aboriginal. In another inquiry, the child's Aboriginality was not confirmed until after the child's death.

These cases demonstrate the need for Child Protection practitioners to be consistently mindful of a child's right to culture and to take this into account at all stages of Child Protection involvement.

***Failure to engage with fathers***

A lack of meaningful engagement with fathers was found in seven of the 32 cases we reviewed. In these cases, engagement with fathers was important both to ensure the safety of a child where there were concerns about a mother's parenting capacity and in cases where fathers were the perpetrators of family violence. Of the cases we reviewed, we found a failure to:

- involve the father (an alleged perpetrator of family violence) in three separate cases
- provide safe-sleeping advice to fathers in two separate cases
- determine a father's role in ensuring the safety of his child prior to case closure
- hold a father accountable for his poor parenting choices
- explore a father's responsibilities as a co-parent of a child with complex needs
- assess the illicit substance use of a father who had ongoing contact with his children.

In each of these cases, the child's mother was the focus of Child Protection's efforts to address safety concerns. The DHHS Best Interests Case Practice Model: *Working with families where an adult is violent*, developed in 2014, highlights the tendency of Child Protection practitioners to scrutinise women and fail to include men following a Child Protection report. The Commission is concerned that, after five years, the importance of engaging meaningfully with fathers continues to be overlooked.

## New on-site inspections and monitoring of residential care

The Commission initiated a new program of child-centred inspections of residential care properties, examining how the rights set out in the Charter for children in out-of-home care are being met.[9] The first inspection series examined children's right to have 'a home that feels like a home.' Commission staff sought to understand each child's definition of 'a home that feels like a home' and if they felt they were living in a home that felt like a home at the time of the visit.

Visiting four residential care homes across the state, each managed by a different service provider, the Commission spoke to almost all of the children in those homes. The final report will be provided to the Minister for Child Protection and the Secretary, Department of Health and Human Services.

Subsequent inspections will be delivered quarterly, each focusing on a different right, or group of rights, in the Charter. The Commission intends these inspections will complement DHHS audits by highlighting the lived experience of children and young people in Victoria's residential care system.

## Inquiries completed in 2018–19

### *Individual inquiry – 'Jamie'*

In 2019, the Commission finalised its inquiry into services delivered to 'Jamie', an Aboriginal child living in residential care who had a lengthy history of Child Protection involvement.[10]

Jamie came to the Commission's attention when he was injured in a restraint in secure welfare services. When the Commission reviewed Jamie's treatment, it found a context of Jamie displaying recurrent self-harm behaviours that had resulted (during a six-month period) in over forty hospital presentations, frequent police attendances and multiple admissions to secure welfare services. The inquiry examined the responsiveness of services provided to Jamie and the extent to which they successfully promoted Jamie's safety, mental wellbeing and Aboriginal identity.

The Commission found significant concerns about the delivery of a wide range of services that had been in contact with Jamie. It found, for example, that his experience of residential care had resulted in an exacerbation of Jamie's self-harming behaviours due to a placement with excessive staff turnover, poorly supported residential care staff, co-placement with other highly traumatised children and inadequate prioritisation of Jamie's medication regime. In addition, the use of police and emergency services by Jamie's placement in response to his presenting issues propelled Jamie unnecessarily into the criminal justice system.

On the intersection between the child protection and mental health systems' responses to Jamie, the Commission found there was a lack of shared understanding about Jamie's presenting issues, which were attributed to 'behavioural' causes, rather than being a result of 'mental health diagnoses'. This further contributed to inadequate responses to Jamie's pressing needs.

The Commission also found that Child Protection failed to prioritise Jamie's Aboriginal identity or promote connection to culture as an aspect of Jamie's right to safety, wellbeing and development. Similarly, almost all health and mental health services involved with Jamie had failed to demonstrate an understanding or awareness of cultural connection as inherently protective, stabilising and also, healing.

Finally, the Commission found that while regular care team meetings were held and information concerning Jamie was regularly shared, with some positive actions pursued, poor planning and co-ordination resulted in a generally

[9] Section 16(1)(f) of the *Children Youth and Families Act 2005* requires that the Secretary publish and promote a Charter for children in out-of-home care to provide a framework of principles to promote the wellbeing of those children.

[10] The inquiry was established under section 37(1)(a) of the *Commission for Children and Young People Act 2012*.

reactive case management approach that failed to promote Jamie's right to recovery. In addition, service systems failed to consistently hear and respond to Jamie's perspective on matters related to placement, self-harming, future planning and culture. Jamie's ability to influence and participate in decision-making processes was impeded by limited direct contact with Child Protection and no apparent attempts to involve him in case-planning processes.

The Commission gave a draft of its report into services provided to Jamie to DHHS before the usual adverse comments process. This led to positive early responses by DHHS, which immediately began addressing a number of the issues identified above.

Key recommendations made in Jamie's final inquiry include that:

- Jamie be placed in a clinically supported care placement, which minimises contact with high numbers of different staff members, creates structure and consistency and maximises Jamie's right to health
- opportunities be created to ensure that Jamie can be included in care team meetings and other decision-making processes
- DHHS develop a framework to identify in a timely way children like Jamie, who require a differentiated service response that is likely to involve multi-agency coordination, one-to-one care placement, consistent staffing arrangements and fewer staff members, attention to consistency and routine, and proactive involvement in decision-making.

Jamie's inquiry is an important example of the ways in which the Commission's individual inquiry power can help to raise and address issues for children and young people in the system, which may otherwise go unaddressed.

## Inquiries underway

This year, the Commission progressed two significant systemic inquiries related to young people's experiences of the out-of-home care system: the *In our own words* Inquiry and the *Inquiry concerning the services and supports provided to and outcomes for young people transitioning from out-of-home care* (leaving care inquiry). A core component of both of these inquiries has been listening to children and young people about their lived experience of the care system.

***In our own words***

The Commission initiated this inquiry under section 39 of the *Commission for Children and Young People Act 2012* to examine what it is like to be a child or young person in the out-of-home care system, by hearing directly from those living in out-of-home care or with recent lived experience in care.

The Commission spoke to over 200 children and young people across care types and across the state of Victoria and they gave us a very clear message that the system needs to change.

Children and young people told us that they are moved around too often and often with little or no notice or explanation. Those in residential care told us they often feel unsafe there.

Children and young people want more opportunities to participate in decisions that affect them, more consistent and caring relationships with the people who look after them, more opportunities to maintain connections to their friends, family and community, and to feel safe and secure where they live.

The Commission also consulted with carers and workers, both from DHHS and from community service organisations, to hear their perspectives on the pressures they face working in the out-of-home care system. The final report of this inquiry will be tabled later in 2019.

***Leaving care***

The Commission is also conducting an inquiry into the supports provided to young people at the end of their time in care. The inquiry has involved consultations with approximately 40 young people who have left care about their experiences exiting the system. We heard that young people often do not feel well prepared or that they have been provided with sufficient or appropriate supports to help them make their way as young adults. The report of this inquiry will be tabled in the 2019–20 financial year.

The Commission is extremely grateful to all the children and young people who participated in these inquiries to provide us with invaluable insights into what it's like to live in the out-of-home care system.

## Progress against past inquiries

During 2018–19, the Commission monitored the implementation of the previously tabled systemic inquiries, *'…as a good parent would…'* (2015), *Neither seen nor heard* (2016), *Always was, always will be* (2016), *In the child's best interests* (2016) and *'…safe and wanted…'* (2017), in addition to two group inquiries, which were provided to government in 2018 but not tabled.

***'…as a good parent would…'***

In 2015, the Commission tabled its first systemic inquiry report, *'…as a good parent would…'*, to examine ongoing sexual abuse and exploitation of children in residential care. The government accepted all of the inquiry's recommendations.

The most recent DHHS advice to the Commission identified that the following actions were completed during 2018–19:

- full implementation of a new incident management system (recommendation 3.3 – implement guidelines to ensure a consistent response to children who make quality of care allegations)
- the move from divisions to an area-based approach from June 2018 (recommendation 6.1 – review the departmental structure of divisions in relation to out-of-home care)
- by June 2019, 32 properties had been renewed or replaced, and maintenance and essential repairs had been delivered at approximately 230 residential care properties (recommendation 1.2 – Immediately improve the physical environment of residential care units to make them look and feel like homes)
- in August 2018, the publication of a Child Safe Standards monitoring framework for organisations funded and/or regulated by DHHS and the publication of standardised compliance assessment model (recommendation 9.1 – DHHS must monitor agencies' adherence to Child Safe Standards).

These activities, along with the appointment of dedicated Sexual Exploitation Practice Leaders and the operations of the 'Enhanced Response Model' at designated sites across the state, are important and positive initiatives.

During 2018–19, however, the Commission became concerned that the focus on identifying and addressing the sexual exploitation of children in care had waned. This concern was prompted by the largely unexplained, decreasing number of sexual exploitation incidents recorded across residential care. Though the number of children in residential care has remained largely stable, there were only 154 incidents of sexual exploitation recorded in 2018–19, compared to 394 incidents in 2016–17.

DHHS to date has been unable to provide firm advice about why there has been a reduction in the number of recorded sexual exploitation incidents, other than an indication that 'suspected' sexual exploitation matters are no longer recorded in the same way.

The Commission has also been disappointed to see several CIMS (Client Incident Management System) incidents categorised as 'dangerous actions' or 'absent client' where there are strong indications that children have been the subject of sexual exploitation. The Commission will continue to pursue this issue with DHHS and to advocate strongly for a sustained, proactive approach to the sexual exploitation of children in residential care.

***Neither seen nor heard***

*Neither seen nor heard* was tabled in the Victorian Parliament in December 2016. It examined a sample of child death inquiries where children had experienced family violence. The inquiry found that services commonly overlooked risks and underestimated the impact of family violence on children. Child victims were not recognised or given the support they needed. The report made 13 recommendations.

The inquiry recommended that the Victorian Government consider and address the findings arising from *Neither seen nor heard* in its implementation of recommendations made by the Royal Commission into Family Violence (Royal Commission). In 2018, the Commission raised concerns with the DHHS at the slow progress against several significant recommendations of *Neither seen nor heard*.

In 2018–19, the Commission met with DHHS and Family Safety Victoria several times to discuss implementation of recommendations made by *Neither seen nor heard* and progress against recommendations of the Royal Commission into Family Violence relating to children.

There is no question that the Victorian Government's unprecedented investment in, and reform of, responses to family violence will benefit children. The Commission acknowledges the significant progress made by DHHS to address practice-based issues, including via strengthened Child Protection practice guidance, advice, training and investment in specialist family violence workers and senior family violence practitioners.

However, the Commission remains disappointed by the limited visibility of action recommended by the Royal Commission to increase counselling and support for child victims and to improve refuges' capacity to meet children's needs. The Commission is also concerned by the lack of progress on recommendations to address adolescent family violence.

In addition, the Commission continues to advocate for improved identification of, and responses to, children who have experienced child sexual abuse in the context of family violence.

***'…safe and wanted…'***

In 2016, the then Minister for Families and Children recommended that the Commission conduct an inquiry to examine the first six months of the implementation of the *Children, Youth and Families Amendment (Permanent Care and Other Matters) Act 2014*.

In June 2017, we provided our report *'…safe and wanted…'* to the then Minister for Families and Children, and the Secretary of the Department of Health and Human Services. The Minister made the report public on 14 December 2017.

The final report made 40 recommendations to the Victorian Government to address the system-wide challenges about workforce capacity and resourcing, improve policies and practices and made further changes to the legislation to address the risk of negative outcomes for children.

The government advised legislative changes would not be progressed, but that other recommendations relating to additional resources, training and workforce, improving policy and practice were approved in full or in principle.

In June 2018, DHHS prepared an implementation schedule that had 30 June 2019 as a major milestone for the implementation of 17 recommendations.

In 2018–19, work commenced in response to one of our key recommendations through the establishment of a longitudinal study of children subject to Child Protection involvement. DHHS appointed a consortium led by the University of Melbourne to undertake the study, which will monitor and track outcomes and determine whether the permanency amendments are achieving their objectives.

The Commission is a member of the longitudinal study's stakeholder reference group, and the study is due to be completed by June 2020.

### *Always was, always will be* and *In the child's best interests*

In October 2016, the Commission tabled two systemic inquiries entitled *Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria* and *In the child's best interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria*.

These two inquiries stemmed from the *Taskforce 1000* project undertaken by the Commission in collaboration with DHHS in 2015 that looked at the individual issues and systemic failures for Aboriginal children and families within Victoria's child protection system.

The two reports made a total of 133 recommendations – 79 from *Always was, always will be* and 54 from *In the child's best interests* – to improve policy and practice within the child protection and out-of-home care systems for Aboriginal children and young people, improve compliance by DHHS and other agencies with the Aboriginal Child Placement Principle, and increase opportunities for greater Aboriginal self-determination within Child Protection decision-making.

Of the 133 recommendations, the Victorian Government accepted all those directed at it either in full, in part or in principle. The implementation of the recommendations has been monitored by a subcommittee of the Aboriginal Children's Forum (ACF) that meets to assess whether they believe the intent of the recommendation has been met in actions taken by the relevant lead agency. These assessed positions of the subcommittee are presented to the following ACF meeting for endorsement. The Commission sits on the ACF subcommittee.

As of June 2019, the ACF had endorsed that 76 of the 133 recommendations (57 per cent) were complete, 22 (16 per cent) were on track, 13 (10 per cent) were experiencing delays, five (4 per cent) had not commenced, seven (5 per cent) had not been pursued by agreement and 10 (8 per cent) were the responsibility of an agency outside of government.

For the 10 directed to an agency outside of government, the Commission will meet with relevant parties in 2019 to assess the implementation of these recommendations. In December 2019, the Commission plans to present to the ACF a report on the implementation of the 133 recommendations outlining the work still required to meet their intent.

### *Cumulative harm and suicide*

Last year, the Commission completed an inquiry into issues of cumulative harm and suicide in child deaths between 1 April 2007 and 22 December 2015. The inquiry examined services provided to 26 children who were involved with Child Protection and who died as a result of suicide.

The Commission made a number of recommendations for service improvements in relation to the identification of and early response to cases involving cumulative harm. We also made recommendations aimed at improving the availability of early supports from community-based child and family services, schools and specialist mental health services for children.

DHHS has implemented some recommendations – for example, it conducted an audit of children over 12 years old where there had been four or more reports closed at intake or investigation and the children remained in the care of their parents or in kinship care. The audit demonstrated a concerningly high rate of cases where there was no consideration of cumulative harm, confirming the Commission's concerns.

There remain a significant number of recommendations outstanding or for which the Commission is awaiting further information or confirmation of progress. These include:

- the development of a cumulative harm review policy and tool so that practitioners are clear on when to consider cumulative harm
- training for Child Protection and Child FIRST providers in cumulative harm and improving guidance for Child Protection practitioners on how and when cases should

be escalated, and when cumulative harm should be reviewed

- monitoring and reporting on the number of referrals to Child FIRST and integrated family services that do not result in engagement with the family
- improved processes to ensure that the voice and perspective of children and young people are taken into account in Child Protection investigations.

The Commission remains concerned about the issues identified in this inquiry and has initiated an expanded inquiry into the issues we see when we examine the experiences of children who have committed suicide after Child Protection involvement. The new inquiry report will be tabled later in 2019.

***Systemic inquiry into services provided to vulnerable children and young people with complex medical needs and/or disability***

This year, the Commission has continued to work with DHHS towards the implementation of the recommendations of our inquiry into services provided to vulnerable children and young people with complex medical needs and/or disability.

This inquiry, completed in June 2018, considered 72 child death inquiries finalised between 1 March 2013 and 28 February 2017 and determined the extent to which Victoria's service system currently upholds the rights of these children and young people to be safe and develop to reach their full potential.

In progressing these recommendations, DHHS amended CRIS to record a child's disability from December 2018. However, it is concerning that it remains impossible for DHHS to advise how many children in out-of-home care have a disability.

DHHS advises that further effort is underway to link CRIS and NDIS data to achieve a stronger understanding of the incidence of disability for children in care.

DHHS is also progressing guidance in Child Protection's new risk assessment framework, 'SAFER', on the unique needs of children with complex medical issues and disability, and is developing information-sharing processes with the NDIA in order to share vital information about the best interests of children and young people who are both known to Child Protection and have complex medical needs and/or disability.

In its discussions with DHHS, the Commission continues to emphasise the importance of:

- building the capacity of all Child Protection practitioners to assist vulnerable families to navigate the NDIS system
- the creation of independent advocates for particularly vulnerable children and young people in NDIS planning processes to ensure that plans reflect their voice and best interests and resolve their complaints about service delivery.

In April 2019, Berry Street and the Centre for Excellence in Child and Family Welfare raised concern regarding an increasing number of children with disabilities entering into the care system as a result of the introduction of the NDIS.

The Commission is concerned that many of the issues we foreshadowed in this inquiry appear now to be impacting children. Due to the poor data capture referred to above, it is impossible for DHHS to measure any increase in the number of children with disability who are in out-of-home care.[11] The Commission is continuing to monitor DHHS negotiations with the NDIA and efforts to make sure vulnerable children with disability are not left at heightened risk.

[11] In response to this issue, DHHS advised: 'DHHS data would indicate that the increase in numbers of children with complex disabilities in voluntary child care arrangements is commensurate with population growth and not statistically significant'.

## Out-of-home care incidents and incident monitoring

Section 60A of the *Commission for Children and Young People Act 2012* requires DHHS to provide the Commission with information about adverse incidents. The Commission receives incident reports for children in foster care, kinship care, residential care, lead-tenant settings and secure welfare services.

We review incident reports to identify concerns for the care provided to children or shortcomings in the response to incidents, seeking further information as required. Where necessary, incidents may be raised with DHHS, or the Commission may establish an inquiry under the *Commission for Children and Young People Act 2012*.

This year saw out-of-home-care incident reporting from two different sources:

- incidents that involved children case-managed by DHHS-funded organisations were reported via CIMS[12]
- incidents involving children case-managed by DHHS were reported against the CIR[13] until 1 October 2018, after which all incidents were reported via CIMS.

### *Out-of-home care incidents reported to the Commission 2018–19*

Due to the change in reporting frameworks, and the introduction of new incident report categories, it is not possible to compare this year's incidents in out-of-home care with last year's incidents.

As required by legislation,[14] DHHS provides the Commission with access to all endorsed CIMS incidents, major and non-major. For the financial year, there were over 6,500 endorsed CIMS incidents.[15]

The new reporting framework led to the Commission having increased access to incident reports. This year, the Commission received and reviewed 6,604 incident reports from CIMS and the CIR Framework – 70 per cent more than last year (3,896 reports).[16] Of those reports, the vast majority were CIMS incidents (6,583).[17]

DHHS use of 'major impact' and 'non-major impact' refers to the level of harm the incident causes to the client. Certain incident types are automatically 'major impact', such as the unanticipated death of a client, and sexual exploitation. A pattern of incidents that, taken together, meet the definition of a major impact incident should be categorised as major impact.[18]

12 Client Incident Management System.

13 Client Incident Register.

14 *Commission for Children and Young People Act 2012*, section 60(a).

15 CIMS data covers the period determined by DHHS endorsement date as falling within the period 1 July 2018–30 June 2019.

16 These figures were extracted from a live database on 26 August 2019 and may alter due to recategorisation or withdrawal of an incident report.

17 Twenty-one incidents were reported under the previous reporting framework as category one incidents.

18 https://providers.dhhs.vic.gov.au/client-incident-management-guide-cims-word, accessed 26 August 2019, page 25.

***Table 6. CIMS incidents by impact and incident type 2018–19***[19]

| Incident type | Major | Non-major | Total |
|---|---|---|---|
| Absent client | 118 | 1,386 | 1,504 |
| Dangerous actions – client | 162 | 1,112 | 1,274 |
| Self-harm/attempted suicide | 221 | 609 | 830 |
| Inappropriate physical treatment | 6 | 637 | 643 |
| Injury | 35 | 333 | 368 |
| Physical abuse | 349 | 10 | 359 |
| Emotional/psychological trauma | 56 | 245 | 301 |
| Sexual abuse | 266 | | 266 |
| Poor quality of care | 95 | 163 | 258 |
| Medication error | 18 | 238 | 256 |
| Emotional/psychological abuse | 55 | 135 | 190 |
| Inappropriate sexual behaviour | 8 | 154 | 162 |
| Sexual exploitation | 154 | | 154 |
| Death | 15 | 1 | 16 |
| Financial abuse | | 2 | 2 |
| **Total** | **1,558** | **5,025** | **6,583** |

'Physical abuse' incidents made up the largest proportion of major impact incidents in 2018–19. While not completely aligned, the similar category 'physical assault' was the second highest group of incidents in 2015–16 and 2016–17. 'Sexual abuse' incidents were the second largest group of 'major impact' incidents in 2018–19. In the previous incident framework, there were two sexual assault categories, which combined, also featured as a high-volume incident type.[20]

Further discussion on the comparatively low number of recorded sexual exploitation incidents is included earlier in this chapter, at (see page 31).

### *Incidents by care type*

Reflecting the previous three years' incident trends, most incidents reported to the Commission this year related to children in residential care. In 2018–19, residential care incidents accounted for a greater proportion than last year[21] – almost 75 per cent of CIMS incidents – despite the fact that this group of children make up approximately five per cent of the total out-of-home care population.

[19] CIMS data covers the period determined by DHHS endorsement date as falling within the period 1 July 2018–30 June 2019.

[20] In 2016–17, there were 222 'sexual assault – incident' incidents reported and 132 'sexual assault – rape' incidents reported, totalling 354 incidents which, as a combined amount, was the second highest incident group that year.

[21] In 2017–18, residential care incidents accounted for 68 per cent of CIR incidents and 64 per cent of CIMS incidents provided to the Commission.

***Table 7. CIMS incidents by care type (major and non-major impact)***[22]

| Care type | Major CIMS incidents | Non-Major CIMS incidents | Total number of CIMS incidents | Proportion of CIMS incidents (%) | Proportion of out-of-home care population (%) |
|---|---|---|---|---|---|
| Residential care, therapeutic care and secure welfare | 982 | 3,926 | 4,908 | 75 | 5 |
| Home-based care – foster | 239 | 653 | 892 | 14 | 20 |
| Home-based care – kinship | 267 | 381 | 648 | 10 | 75 |
| Home-based care – Lead tenant | 70 | 65 | 135 | 2 | 0 |
| **Grand Total** | **1,558** | **5,025** | **6,583** | **100** | **100** |

### *Commission's queries about out-of-home care incidents*

This year, the Commission asked for further information about 314 out-of-home care incidents. Information requests typically seek further information about the supports in place for the specific child, in the context of the incident.

A fifth of our information requests related to 'dangerous actions – client' incidents (18 per cent), followed by self-harm incidents (14 per cent). Reflecting the distribution of incidents reported, the Commission's incident inquiries related largely to residential care (64 per cent of matters), followed by kinship care (21 per cent). Forty per cent of our information requests involved Aboriginal children (127 matters) including over 100 requests for cultural support plans.[23]

Key themes arising from our monitoring of incidents include:

- there are no cultural support plans in place for many Aboriginal children in out-of-home care and those in place vary greatly in depth and relevance to the individual child
- some residential care co-placements create very difficult situations for particularly vulnerable children, who are often subject to physical and emotional abuse by other children
- there is little evidence that children experiencing mental health issues and often many episodes of self-harming are regularly engaged in quality, child-specific mental health services.

[22] CIMS data covers the period determined by DHHS endorsement date as falling within the period 1 July 2018–30 June 2019.

[23] *Children Youth and Families Act 2005*, section 176(1).

***Example of an incident query***

*In early 2019, the Commission asked for further information about the supports in place for a child, reported to have been the victim of a sexual assault by another client. The same child was subsequently identified by the Commission to have been involved in more than 10 incidents over the following two months – many identified as having had a 'major impact' on the child.*

*The Commission approached the relevant division to obtain further information about the supports in place. Due to a recent placement change, the consultation included operations managers from two different areas. This meeting provided the opportunity for the Commission to hear about the young person's circumstances and facilitated further dialogue between the area managers. The Commission kept the incident query open for a short period while monitoring the supports in place for the child and received regular updates via care team meeting minutes. The Commission is pleased to note that the number of 'major impact' incidents recorded for this child has dropped markedly.*

***Example of an incident query***

*During the year, the Commission received an incident report about an apparent assault by Victoria Police of a 10-year-old child in secure welfare services. The child was being interviewed as a victim of serious sexual offences at the time of the alleged assault. DHHS provided the Commission with relevant information including CCTV footage. The Commission's preliminary assessment identified a number of deeply concerning aspects to the incident and the Commission raised the matter formally with the Chief Commissioner of Victoria Police. The Commission is awaiting advice from Victoria Police about the investigation into the matter and any training gaps suggested by this incident.*

# Building the engagement and participation of children and young people

# Building the engagement and participation of children and young people

## The Convention on the Rights of the Child provides that children have a right to be heard and involved in all decisions that affect them.

In 2018–19, the Commission built on our past engagement with children to strengthen the various ways in which children and young people participate in and influence the work the Commission. For example, we:

- worked with young lived experience consultants to design our consultations for our out-of-home care inquiry, *In our own words*
- consulted with over 200 children and young people for the *In our own words* inquiry
- developed a set of Commission tools to guide our engagement with children and young people
- hired a youth consultant to work across the Commission and to provide us with advice on how to improve our child and youth participation practice across our functions
- convened an internal child and youth engagement working group to share resources and knowledge in youth participation across the Commission
- held a forum for young people and youth organisations who work with children and young people to share good practice and identify key ways the Commission might contribute to best practice in child and youth participation
- continued to engage with children and young people in Parkville and Malmsbury via our Independent Visitor Program, which ensures issues identified by children and young people in detention are raised and that the experience of children and young people directly informs the Commission's work
- planned a forum for Koori children and young people in out-of-home care

The Commission's *Our youth, our way* inquiry began statewide visits to engage with Aboriginal children and young people about youth justice. Commissioner for Aboriginal Children and Young People Justin Mohamed meets here with young people from Strong Brother, Strong Sister in Geelong.

- continued to meet and engage with individual Aboriginal children in youth justice and out-of-home care settings, to discuss with them any issues concerning their culture, care, safety or wellbeing
- undertook on-site monitoring visits to a small number of out-of-home care placements, during which we spoke directly to children and young people about their experiences of placement.

# Oversight and monitoring of youth justice

# Oversight and monitoring of youth justice

**Children and young people in youth justice are some of our community's most vulnerable members, with disproportionately high rates of poor mental health and experience of abuse and trauma and high levels of cognitive impairment.**[24]

The Commission monitors the safety and wellbeing of children and young people in the youth justice system using various mechanisms. We:

- operate a monthly Independent Visitor Program at each location and conduct exit interviews of children and young people leaving youth justice
- respond to systemic or significant concerns raised by members of the public about the operations of the system
- examine each serious youth justice incident and advocate to senior staff of the Department of Justice and Community Safety or the Minister when issues of significant risk are identified
- conduct on-site inspections and engage directly with children and young people on key issues.

This year we also:

- contributed to the Minister's Custodial Facilities Working Group, providing specialist advice on matters affecting children and young people
- initiated a joint Taskforce with the Department of Justice and Community Safety examining the over-representation of Aboriginal children and young people in the youth justice system, alongside the Commission's related *Our youth, our way* inquiry
- contributed four staff to support the Victorian Ombudsman's investigation into practices relating to solitary confinement of children and young people in contained environments
- monitored the care and wellbeing of a 17-year-old child sentenced to a term of imprisonment in adult corrections
- provided feedback to Youth Justice on policies and programs being developed, such as a new complaints process for children and young people and a new induction process.

These activities give the Commission a close view of the state of our youth justice system and its impact on the children and young people detained there. The Victorian Government has acknowledged the system is in need of reform and has embarked on that process. We will continue to work with government to inform change, and welcomed developments this year to introduce new rehabilitation programs, a case management framework, a new operational philosophy and the introduction of forensic youth mental health services in custody and the community.

[24] The Youth Parole Board's Annual Report 2017–18 reported that 53 per cent presented with mental health issues, 70 per cent were victims of abuse, trauma or neglect and 41 per cent presented with cognitive difficulties affecting their daily functioning.

## Our advocacy and impact

### *Lockdowns*

Some of the serious issues identified in our 2017 systemic inquiry *The same four walls* remain of concern. While there has been a steady decrease in the number of periods of isolation imposed due to an individual child or young person's behaviour,[25] groups of children and young people at both centres are being locked in their rooms at increasing and unacceptably high levels for operational reasons or due to insufficient staff.[26]

In 2018–19, there were 49,400 individual lockdown episodes, more than triple the number of lockdowns the previous year (15,725 lockdowns). At Parkville Youth Justice Centre, each child and young person was detained at a rate of 317 lockdowns in 2018–19, compared to a rate of 92 lockdowns per year the previous year.

***Table 8. Lockdowns at both Youth Justice locations 2017–19***[27]

| 2017–18 | | | |
|---|---|---|---|
| | **Malmsbury** | **Parkville** | **Total** |
| Number of lockdowns | 7,288 | 8,437 | 15,725 |
| Average population | 109 | 92 | 201 |
| Rate of lockdowns per child/young person | 67 | 92 | 78 |
| **2018–19** | | | |
| | **Malmsbury** | **Parkville** | **Total** |
| Number of lockdowns | 22,684 | 26,716 | 49,400 |
| Average population | 104 | 84 | 188 |
| Rate of lockdowns per child/young person | 218 | 317 | 262 |

The harmful impact of lockdowns on children and young people is well established. Being locked in their cells for hours, or sharing 'rotations' of lockdowns with other children through the day, disrupts access to important education and rehabilitation programs, and can exacerbate mental health and behavioural concerns. In some cases, the effect of lockdowns on children appears to have directly caused incidents of poor behaviour or precipitated self-harm attempts.

25 The *Children, Youth And Families Act 2005* – section 488(2) permits a child or young person to be placed in isolation if all other reasonable steps have been taken to prevent the person from harming himself or herself or any other person or from damaging property and the person's behaviour presents an immediate threat to his or her safety or the safety of any other person or to property.

26 The *Children, Youth And Families Act 2005* – section 488(7) allows the officer in charge of a remand centre, youth residential centre or youth justice centre to isolate a person in the interests of the security of the centre.

27 Isolations under section 488(7) of the *Children, Youth and Families Act 2005*. Data provided to the Commission by the Department of Justice and Community Safety.

### *Improving responses to self-harm in youth justice facilities*

In 2017–18, the Commission identified significant risks in Youth Justice responses to children and young people self-harming and/or attempting suicide. These risks included children self-harming while under staff observation without intervention by staff, in one instance resulting in a child appearing to lose consciousness while under staff observation. In response, Youth Justice reported that new policies had been introduced and training provided to all staff.

Since December 2018, Youth Justice has provided the Commission with all reports of incidents of suicide attempts and self-harm (not just the more serious incidents) to allow us to monitor the impact of new practice, policy and training. In 2019, the Commission identified further gaps in practice resulting in children being left at risk, including delayed intervention by staff when children were self-harming or when a child failed to respond verbally to staff.

The Commission raised these issues formally with the Department of Justice and Community Safety, asking for urgent action. In response, Youth Justice implemented a re-training requirement for all staff and strengthened induction training. Youth Justice also implemented an internal review process for self-harm incidents.

The Commission continues to closely monitor all incidents involving self-harm or suicidal behaviour in Youth Justice.

### *Children sleeping in isolation cells*

Following complaints raised by children and young people with the Commission's independent visitors, the Commission inspected isolation cells at youth justice centres to understand how they were being used for accommodation at times of overcrowding.

The Commission met with children and young people who had been placed in isolation cells as accommodation, and identified several issues. Some children had not accessed showers for five or more days, and had not accessed clean clothes or their personal belongings. Others raised concern that they were put into unclean cells or given soiled bed linen. As a result of this work, Youth Justice implemented new daily processes, including multiple checks during each day, to provide access to essential items for all children sleeping in an isolation cell.

### *Use of force and restraints*

This year, the Commission's monitoring function reviewed 27 incidents of alleged staff-to-client assaults,[28] and the Commission raised concerns about unreasonable use of force being applied to children and young people. These included concerns about the risks of a youth justice system adopting a punitive correctional approach to engaging with children and young people, the lack of individual assessment of risk posed by each child, and insufficient training for staff on how to work with children and young people to prevent and de-escalate conflict.

The Commission also raised concerns about the absence of risk assessments in the routine use of handcuffs to facilitate precinct movements across the Malmsbury Youth Justice Centre, and regarding the use of handcuffs for children and young people involved in self-harming incidents.

Youth Justice has advised the Commission that across both precincts, staff will receive further training in de-escalation to reinforce the importance of ensuring restraints and force are used only as a last resort. Work is also underway to re-establish risk-based decision-making for the use of mechanical restraint for precinct movements rather than as standard practice.

[28] For children under the age of 18, the oversight function complements the Reportable Conduct Scheme where allegations are made about use of physical violence against a child.

### *Impact of overcrowding on girls and young women*

At times during the year, the number of girls at Parkville Youth Justice Centre exceeded the capacity of the dedicated girls' unit, which was built to accommodate 15 children and young people. On some days in May 2019, for example, there were 24 girls and young women, requiring some to be placed elsewhere in the precinct.

Commission staff attended Parkville Youth Justice Centre and inspected the accommodation conditions of all girls at the location. The girls told Commission staff that due to staffing shortages, they had been locked in their rooms for 20 hours per day and had to eat their meals in their rooms. The girls reported extremely limited access to programs, education, meaningful activity and interaction with others during this time.

The Commission raised this situation with Youth Justice, who advised that the unit was experiencing tension after an attempted assault incident earlier in the week. Youth Justice subsequently made changes to the unit's placements and operations, and the unit was fully opened and returned to normal operations.

### *Cultural and religious awareness and service provision*

Through 2018–19, the Commission received several complaints from children and young people who reported that Youth Justice had prevented them from speaking in their first-born language. The Commission was also told that children and young people felt unsupported to practice their religion in Youth Justice custody, including their participation in Ramadan.

Youth Justice considered the issues raised by the Commission and advised that staff would be directed to permit children and young people to speak in their first-born language. In addition, each location developed strategies to increase opportunities for children and young people to participate in religious activities.

Youth Justice further advised that through the latter half of 2019, all Youth Justice staff would receive training in Victoria's Charter of Human Rights and Responsibilities.

## Incidents and incident monitoring

Since March 2016, section 60A of the *Commission for Children and Young People Act 2012* has required the Secretary to provide the Commission with information about adverse incidents occurring in youth justice centres, defined as category one incidents.

In addition to category one incidents, the Commission receives information about agreed category two incident types, including allegations of assault by Victoria Police reported to Youth Justice (44 incidents in the period) and incidents which require a child to be taken off-site for medical treatment (10 incidents in the year). This year, following a query from the Commission, Youth Justice amended the policy to ensure that admissions staff photograph all injuries reported upon reception to either Parkville or Malmsbury Youth Justice Centres, including injuries sustained as a result of alleged police misconduct.

### *Youth justice category one incidents 2018–19*

In 2018–19, Youth Justice (custody) recorded 128 category one incidents (see Table 9), a 47 per cent decrease on the financial year before. Each of the three categories of incidents (assault incidents/allegations, behaviour-related incidents and other incidents) decreased by approximately 45–60 per cent this financial year.

***Table 9. Category one incidents in Youth Justice 2017–19***

| | 2017–18 | 2018–19 |
|---|---|---|
| **Assault-related incidents/allegations** | **129** | **71** |
| Physical assault/client on client | 24 | 12 |
| Physical assault/client on staff | 31 | 15 |
| Physical assault/client on other | 1 | 0 |
| Physical assault/staff on client | 36 | 27 |
| Physical assault/other on client | 4 | 3 |
| Sexual assault/rape/client on client | 1 | 0 |
| Sexual assault/rape/client on other | 2 | 0 |
| Sexual assault/rape/staff on client | 1 | 0 |
| Sexual assault/rape/other on client | 3 | 0 |
| Sexual assault/indecent/client on client | 5 | 5 |
| Sexual assault/indecent/client on staff | 6 | 2 |
| Sexual assault/indecent/staff on client | 9 | 6 |
| Sexual assault/indecent/other on client | 6 | 1 |
| **Behaviour** | **34** | **14** |
| Behaviour – dangerous | 16 | 9 |
| Behaviour – sexual | 17 | 3 |
| Behaviour – sexual exploitation | 0 | 1 |
| Behaviour – disruptive | 1 | 1 |
| **Other** | **77** | **43** |
| Poor quality of care | 19 | 27 |
| Self-harm | 15 | 3 |
| Injury | 9 | 1 |
| Suicide attempted | 7 | 5 |
| Property damage/disruption | 7 | 1 |
| Possession | 5 | 0 |
| Community concern | 6 | 1 |
| Medical condition (known) – deterioration | 4 | 1 |
| Medication error – pharmacy | 0 | 1 |
| Medication error – other | 1 | 0 |

***Table 9. Category one incidents in Youth Justice 2017–19 (continued)***

| | 2017–18 | 2018–19 |
|---|---|---|
| Breach of privacy/confidentiality matters | 0 | 0 |
| Escape from centre | 0 | 0 |
| Escape – from temporary leave | 0 | 1 |
| Illness | 3 | 2 |
| Drug/alcohol | 1 | 0 |
| **Total** | **240** | **128** |

### *The Commission's queries about incidents in youth justice centres*

The Commission receives and reviews every incident report, with a focus on the treatment of the child or young person. If an incident raises concerns about the management of the child or the response to the incident, further information is requested from Youth Justice including, where appropriate, CCTV and body-worn video footage.

The Commission considers the information provided and, if the issues identified require further examination, the incident is escalated through formal correspondence to the Department of Justice and Community Safety.

This year, the Commission sought and reviewed additional information, including CCTV footage, in relation to 92 Youth Justice incidents. A quarter (25 per cent) of the Commission's queries related to allegations of physical assault by staff on a client, followed by self-harm/attempted suicide incidents (21 per cent), and allegations of poor quality of care (20 per cent).

The Commission categorises its incident queries in line with the rights set out in the United Nations Convention on the Rights of the Child. Most of the incidents we asked for further information about included concerns for the safety, health and wellbeing of children and young people (85 per cent) followed by 'rights and freedoms' (13 per cent), which largely relates to the right to be treated with respect and the right to be treated like a child.

***Table 10. Commission's Youth Justice incident queries by theme 2017–19***[29]

| Query theme | 2017–18 | | 2018–19 | |
|---|---|---|---|---|
| | Number | (%) | Number | (%) |
| Safety, health and wellbeing | 68 | 87 | 81 | 85 |
| Rights and freedoms | 8 | 10 | 12 | 13 |
| Family environment and people who matter to me | 1 | 1 | 2 | 2 |
| Reaching their full potential | 1 | 1 | | |
| **Total** | **78** | **100** | **95** | **100** |

[29] Some incident queries may involve multiple themes and therefore, a query may be counted more than once.

## Independent Visitor Program

Some of the independent visitors and Commission staff at Parkville Youth Justice Centre.

Our Independent Visitor Program (IVP) conducts regular visits to Victoria's youth justice centres at Parkville and Malmsbury. Our volunteer visitors go to each centre on a monthly basis, observe conditions and talk to children and staff about services and issues and report on their observations to the commissioners after each visit. The Commission seeks to resolve issues by raising them with senior Youth Justice managers. The main issues raised by children and young people this year included the frequency and impact of lockdowns and personal safety and health concerns.

The program has welcomed new volunteers from African and Aboriginal communities this year. Children and young people have responded positively to the new volunteers and the program has been strengthened by the increased diversity amongst the independent visitors.

## Progress against past inquiries

### *Individual inquiry into services provided to a child in youth justice*

In 2017, the Commission completed an individual inquiry into incidents of restraint that resulted in a child's limb being broken on two occasions in Youth Justice. The Commission recognises that through addressing the recommendations, Youth Justice has made several important improvements. In 2018–19, this included strengthening processes for capturing, recording and communicating to all staff critical information relating to children and young people.

In closing this inquiry in 2019, the Commission noted it will continue to monitor issues related to this inquiry, including de-escalation strategies used by Youth Justice staff and use of force as a last resort.

### *Group inquiry into events at Grevillea Youth Justice Precinct*

In March 2018, the Commission completed an inquiry in relation to a group of children in the Grevillea Youth Justice Precinct, prior to, during and following a series of incidents in the unit on 13 February 2017. The Commission made 11 recommendations to improve Youth Justice policy and practice that were accepted by the Department of Justice and Community Safety.

During 2018–19, DJCS delivered ongoing training to Corrections Victoria staff working in a Youth Justice facility, focusing on legislative and human rights obligations, information about the complexity of young people in Youth Justice custody and the importance of trauma-informed responses.

Youth Justice has also updated Director's Instructions to clarify expectations for the management of information regarding children and young people among staff. During this period, procedures were also updated to guide staff on the decontamination process following the deployment of oleoresin capsicum (OC) spray. Procedures were also amended to specify that staff may only remove property

from children and young people's cells or bedrooms in the event that they are considered a risk to themselves or others, or impact on the security of the location.

### *The same four walls*

*The same four walls* inquiry into the use of isolation, separation and lockdowns in the Victorian youth justice system was tabled in the Victorian Parliament in March 2017. The inquiry found that children and young people in Victoria's youth justice centres were subjected to unacceptable levels of isolation and routinely 'locked down' or isolated due to staffing issues. Youth Justice acted on many of our 21 recommendations in the year after this inquiry.

The number of isolations used in response to a child's behaviour has significantly decreased in the last two years. However, we are extremely concerned that the number of lockdowns, largely due to staff shortages, has tripled (see page 43).

In 2018–19, in response to the inquiry's recommendation, Youth Justice undertook work in conjunction with health services to clarify responsibilities for decision-making regarding observations. As at 30 June 2019, the Commission considers that 15 of the 21 recommendations have been completed. The Department of Justice and Community Safety will be addressing two key recommendations through the proposed establishment of a dedicated Youth Justice Act.[30] The Commission will monitor the ongoing implementation of the remaining recommendations and any action on the Victorian Ombudsman's investigation into solitary confinement (see page 52).

[30] The inquiry recommended that the Victorian Government amend legislation to clarify the purpose of isolation and the circumstances under which a young person can be isolated, and to provide that all young people in youth justice centres are provided at least one hour of fresh air each day.

# Influencing policy, services and the law

## The Commission's role includes promoting the rights and interests of children and young people, and advising government on necessary improvements to policy, services and the law.

This year, the Commission made formal submissions to government, parliamentary inquiries and statutory bodies. Our commissioners also provided advice to government through direct contact with ministers and senior officers, as well as through ministerial and other government advisory bodies across a range of policy areas central to children's lives.

We also sought to raise broader awareness of the need for policy, system and legal improvements for children and young people through the media and by talking directly to the community and to stakeholders at forums, conferences and other events.

Our advocacy and advice this year covered many issues impacting on the rights of children and young people. Areas we focused on included:

- reforms to ensure children who experience family violence benefit adequately from current family violence reforms
- conditions in places of detention, including changes to Victoria's Corrections Regulations and planning for the 2020 implementation of the Optional Protocol to the Convention Against Torture (OPCAT)
- criminal justice responses to children and young people, including the government's introduction of intimidation and unlawful association offences
- inclusive education, including policies relating to the use of restraint and seclusion in Victorian schools
- the mental health system's accessibility to and impact on vulnerable children, through submissions to the Productivity Commission's Mental Health Inquiry, and on the terms of reference of the Royal Commission into Victoria's Mental Health System.

## Children and young people in closed environments

### *Preventative detention*

In October 2018, the Commission received a new set of powers to monitor the safety and wellbeing of children held in preventative detention in Victoria. From the same date, the *Terrorism (Community Protection) Act 2003* permits police to take a child aged 14 or older into custody ('preventative police detention') for up to 36 hours without a court order, in certain circumstances. Police can also apply to the Supreme Court for a preventative detention order, which will enable a child age 14 or older to be detained for up to 14 days.

The Commission's powers include monitoring the treatment of a child detained in the above circumstances, promoting the interests of the child, accessing any document or information relating to the child, and providing advice to the Attorney-General, other relevant ministers or the Chief Commissioner of Victoria Police about the child's treatment while in detention.

To deliver these new functions, the Commission now has a 24-hour operational response model, focused on ensuring zero physical harm and minimal emotional harm to the children in question, and the protection of their human rights. Further work will take place in 2019–20 to strengthen internal operational processes and develop further agreements with other relevant stakeholders including Youth Justice and the Victorian Ombudsman.

Since October 2018, the Commission has been legislatively required to report the number of times the Commission has performed its monitoring function as per the *Terrorism (Community Protection) Act 2003* in the relevant financial year and any general observations or conclusions the Commission may want to include in the report in relation to performance of its function.[31]

Since we assumed these functions, we have not been notified of any preventative detention decisions and therefore have not exercised this function.

[31] *Commission for Children and Young People Act 2012*, s23A.

### *Monitoring places of detention under OPCAT*

The Optional Protocol to the Convention Against Torture (OPCAT) was ratified by the Commonwealth Government in 2017 and will be implemented in each state by 2020. OPCAT requires independent inspection of all places of detention in Australia. Inspections will be undertaken by a network of inspection bodies, which together constitute a National Preventative Mechanism (NPM). The agencies appointed as NPMs will undertake regular, unannounced visits to places of detention and will be able to identify problematic issues in detention before they escalate. The NPM work aims to proactively identify and address problems through regular dialogue with detention authorities.

The Commission has continued to state its interest in becoming an NPM for places of detention involving children and young people in Victoria, acknowledging that this is a decision for the Victorian Government.

This year, the Commission made submissions to consultations held by the Australian Human Rights Commission and the Commonwealth Ombudsman to provide information about its existing monitoring functions and powers with respect to places of detention where children are held, including youth justice and secure welfare services. The Australian and New Zealand Children's Commissioners and Guardians have agreed that, 'as a matter of principle, the oversight bodies charged under the OPCAT with inspecting and visiting facilities detaining children and young people should have a specialist focus on children's rights and be appropriately resourced', emphasising the importance of child-centred expertise and the application of a child rights framework.[32]

### *The Victorian Ombudsman's investigation into the use of 'solitary confinement'*

In March and April 2019, the Commission contributed four staff to a multi-agency inspection team led by the Victorian Ombudsman. The team carried out thematic inspections in line with the OPCAT approach as part of an Ombudsman's investigation, looking at practices relating to solitary confinement of children and young people across three facilities. The team inspected Port Phillip Prison, Victoria's largest maximum-security prison with a dedicated youth unit; Malmsbury Youth Justice Centre, and secure welfare service facilities where children under Child Protection orders who are at substantial and immediate risk of harm can be held.

### *Children and young people in immigration detention*

Concerned members of the public contacted the Commission on numerous occasions during 2018–19, worried about the health and wellbeing of children held in immigration detention in the Melbourne Immigration Transit Accommodation (MITA) and the Broadmeadows Residential Precinct (BRP) nearby.

In March 2019, the Principal Commissioner wrote to the Hon. Peter Dutton MP seeking information about the children and their welfare.

By agreement of the Australian Government's Department of Home Affairs, the Principal Commissioner subsequently visited MITA and BRP and met with four children. With the consent of each child, or their parent, Home Affairs has subsequently shared information with the Commission about the children's care and treatment.

As a result of the visits and information provided, the Commission raised a number of significant issues with Home Affairs, Border Force and Serco, who share responsibility for the care of children in immigration detention. These concerns included the children's access to the outside world and contact with their peers that is critical for development; limited access to outdoor space and schooling for one child; and access to health and dental care.

[32] https://www.humanrights.gov.au/our-work/childrens-rights/publications/australian-and-new-zealand-childrens-commissioners-and-0

The Commission welcomed Home Affairs' co-operation and willingness to consider improvements but has yet to see significant improvements in the conditions for these children. The Commission continues to request information about the children's healthcare, access to education, fresh air, sunlight and critical developmental opportunities.

The Commission strongly endorses the position held by the Australian Children's Commissioners and Guardians that no child or young person should be held in detention or separated from their family as a result of their immigration status.[33]

## Criminal justice responses to children and young people

This year, the Commission continued to advocate for broader systemic changes to reduce the rate of incarceration of some of the state's most vulnerable children. The commissioners contributed to the growing calls for the age of criminal responsibility to be raised, including through the May 2019 Communique of the Australian and New Zealand Children's Commissioners and Guardians.

The Commission advocated to government on several pieces of legislation introduced in the last year.

This advocacy resulted in stronger protections in the Corrections Regulations 2019 for young people under the age of 18 detained in Victoria's adult prisons. The Commission is fundamentally opposed to the detention of children under 18 in adult correctional facilities, but as long as this is possible under Victorian law it is essential that adequate safeguards are in place to protect children's safety, wellbeing and rights. Through its submission on the Corrections Regulations, the Commission was able to secure additional protections, including requirements that a child's age, vulnerability and best interests be considered in certain situations, such as before an instrument of restraint is applied or a separation order is made.

The Commission also raised concerns with government about a new offence applying to children and young people in youth justice centres who intimidate Youth Justice workers, carrying a maximum penalty of 10 years' imprisonment. The Commission's concerns about this offence were based on its view that the offence is unlikely to improve safety and security in youth justice centres and may have unintended counterproductive effects on vulnerable children and young people and their prospects of rehabilitation. The Commission also advanced the view that a poorly functioning youth justice system increases the prospect of violence in youth justice centres. The Commission will monitor the implementation of these laws.

The Commission raised concerns about legislation enabling police to take DNA samples from children aged 15 to 17 years; proposed legislation that would have criminalised unlawful association of children as young as 14 but was not ultimately enacted; and changes to the *Children, Youth and Families Act 2005* relating to the publication of details that enable identification of children charged or convicted of offences.

## Mental health

The Commission's work has given us visibility of the mental health issues for Victoria's most vulnerable children, including children who are known to Child Protection, in out-of-home care and in Youth Justice custody. The Commission made a submission on the terms of reference for the Royal Commission into Victoria's Mental Health System, emphasising the need for the Royal Commission to focus on mental health services for children and young people, particularly those involved in the child protection, out-of-home care and youth justice systems, including the cultural appropriateness of services.

The Commission also made a submission to the Productivity Commission's Inquiry into Mental Health in 2019, providing the Commission's evidence-informed view of the mental health vulnerabilities of children in different parts of the child protection and out-of-home care

[33] https://www.humanrights.gov.au/our-work/childrens-rights/publications/australian-and-new-zealand-childrens-commissioners-and-0

systems; an overview of barriers to accessing appropriate mental health services for children and young people in out-of-home care; and highlighting the over-representation of children and young people with mental health needs in the youth justice system. This submission also emphasised the importance of addressing the mental health needs of children and young people in the youth justice system to support their rehabilitation. It noted issues and gaps identified in recent youth justice reviews in Victoria, and relevant recommendations of the Royal Commission into the Protection and Detention of Children in the Northern Territory.

## Children, young people and family violence

The Commission continued to work to make sure the impact of family violence on children and young people is recognised and addressed in current family violence reforms in the wake of the Royal Commission into Family Violence. Both commissioners contributed to the Victorian Government's Family Violence Steering Committee and other advisory groups guiding aspects of the reforms.

The Royal Commission identified the propensity of the system to cast child victims of family violence as mere bystanders or witnesses. Through our work, we often see cases where the interests of the child, including the child's safety and wellbeing, are not considered separately from those of their protective parent, and where the impact of family violence on children is underestimated and not addressed. The Commission has advocated for the needs of children as victims of family violence to be considered in the reforms and addressed in service responses to family violence.

One aspect of this is ensuring that family violence services undertake individual risk assessments of children living in situations of family violence. The Commission this year provided feedback on the practice guidance that is being developed for workers undertaking family violence risk assessment under the new multi-agency risk assessment and management (MARAM) framework, to ensure the needs of children are properly considered when workers are developing risk assessment and management plans. The Commission acknowledges the work that Family Safety Victoria is undertaking to develop revised risk assessment tools for children. The Commission also acknowledges a welcome shift, including in Child Protection practice, to increase the system's focus on perpetrators' behaviours and responsibilities. The Commission will continue to support development and use of new tools and promote cultural change to ensure the safety and protection of children.

The Royal Commission also found that the service system overwhelmingly lacks the specialised supports children need to heal and recover from family violence. Despite key recommendations calling on the government to address the needs of children who are victims of family violence, progress on these reforms has been slow. As noted on page 32, the Commission has continued to monitor the government's action on recommendations relevant to children and advocates strongly to ensure implementation does not stall or falter.

## Inclusive education

Our child death inquiries and systemic inquiries have frequently shown that continued engagement in education is a protective factor for vulnerable children. The Commission continues to advocate for children who are vulnerable and disadvantaged to be able to access education. As part of this advocacy, the Commission made a submission to the Department of Education and Training on the need for policy and regulation to enable independent oversight of the use of restraint and seclusion by Victorian schools. The Commission has also requested data on the use of suspension and expulsion in Victorian schools.

In 2018–19, the Commission became a supporting partner in an academic study led by the University of Adelaide that aims to investigate the extent to which suspensions and exclusions are used by schools in Victoria and other states to discipline students and manage diverse student populations. The study is also supported by UNICEF and the South Australian and Western Australian Children's Commissioners.

The Commission also contributed to continuous improvement in the provision of education in youth justice centres through involvement in a reference group for a research project conducted by Victoria University, the University of Tasmania and Deakin University, focused on improving educational connection for young people in Youth Justice custody. The study concluded that 'the reduction of recidivism requires a strengthened partnership between Parkville College and DJCS to offer [children and young people] structured support, hope and the confidence to learn and to plan for more learning'. The Principal Commissioner spoke at the report launch, commending the report to inform reform of policies and practices. The Commissioner emphasised that education is the right of all children and young people and critical to their rehabilitation. She highlighted the remarkable role played by Parkville College, but also how more needs to be done to provide children and young people in custody with an environment conducive to learning – including improving cultural supports, strengthening support for children with health and disability needs, and addressing operational issues such as lockdowns, which currently stop children and young people going to school.

## Media


In April, Commissioner Justin Mohamed spoke to ABC TV news about the concerning rates of Aboriginal children and young people removed into out-of-home care.

The Commission continued to be active across state and national media this year, with our Principal Commissioner and Commissioner for Aboriginal Children and Young People taking part in more than 60 media engagements to speak out about issues and reforms central to safeguarding the rights and wellbeing of children and young people across Victoria.

Youth justice issues (54 per cent) again led our media, including coverage of self-harm and mistreatment in youth justice centres, together with Aboriginal cultural rights, and the Commission's work on the Koori Youth Justice Taskforce and the *Our youth, our way* inquiry, both of which are addressing the stark and unacceptable over-representation of Aboriginal children and young people in Victoria's youth justice system.

Broader issues relating to Aboriginal children and young people also accounted for around a third of our media, with out-of-home care and child deaths also featuring.

This year, as part of its advocacy described above, the Commission was involved in significant coverage of children held in the Melbourne Immigration Transit Accommodation at Broadmeadows.

Our Commissioner for Aboriginal Children and Young People continued regular appearances on ABC *The Drum*, with our Principal Commissioner receiving national radio coverage on the importance of listening to victims of child abuse, the role of the Child Safe Standards and Reportable Conduct Scheme, solitary confinement in youth detention, and the concerning link between children in Child Protection and Youth Justice involvement.

Our Principal Commissioner also published opinion pieces on the National Apology to victims of child abuse perpetrated by institutions and the factors underlying continuing unrest at the Parkville Youth Justice Centre.

## Public appearances

Liana Buchanan with Anne Longfield, Children's Commissioner for England and Wales.

Complementing their media engagements, the commissioners this year also carried out an extensive program of public engagements across the range of the Commission's work, speaking together and individually to highlight vital issues for children and young people in Victoria, often with national, or international relevance.

Together, our commissioners progressed the national agenda of the Australia and New Zealand Children's Commissioners and Guardians (ANZCCG). They engaged with the Victorian Children's Council, and took part in a panel with children and young people in out-of-home care at two Hour of Power events hosted by the CREATE Foundation.

Our Principal Commissioner spoke on a broad range of issues in more than 50 public speeches, including at Monash University on adolescent family violence and its impact on children, and on the impact of trauma at a Monash University and Turning Point oration. On International Women's Day, the Principal Commissioner spoke at the Burnet Institute about young women who are most at risk, sharing insights from our oversight of Child Protection and out-of-home care. In December she gave a keynote presentation at the STOP domestic violence conference on the invisibility of children as victims of family violence. She also spoke in October about the impact of family violence on children and young people at McAuley Community Services' launch of the Court Support for Kids evaluation report.

A further important theme of the Principal Commissioner's public speeches was the need to avoid complacency and to act on the lessons from the Royal Commission into Institutional Responses to Child Sexual Abuse.

A highlight of the Principal Commissioner's public engagement this year was her presentation to the United Kingdom's Independent Inquiry into Child Sexual Abuse, taking Victoria's insights on mandatory reporting and the Reportable Conduct Scheme to an international stage, and meeting with Anne Longfield, Children's Commissioner for England and Wales. The seminar was live-streamed via the Internet to an international audience.

Our Commissioner for Aboriginal Children and Young People this year engaged extensively with Aboriginal community organisations and stakeholders, and was involved with the Aboriginal Justice Forum and the Aboriginal Children's Forum.

In March the Commissioner presented our review of the Aboriginal Children's Forum, highlighting the way forward for this vital and effective forum. He also attended the launch of the Aboriginal-led family violence strategy, *Dhelk Dja: Safe our way*, and of the Victorian Aboriginal Affairs Framework 2018–23 in October.

The year had a significant focus on Aboriginal children and young people in Victoria's youth justice system – particularly their denial of Aboriginal cultural rights, and their stark over-representation in the system. The Commissioner engaged with the Koori Court, attended the launch of the Koori Youth Council's *Ngaga-Dji* (Hear me) report, and led the Commission's extensive public engagements for the Koori Youth Justice Taskforce and the Commission's independent *Our youth, our way* inquiry.

# Improving outcomes for Aboriginal children

**Throughout 2018–19, the Commission has continued to advocate for and promote the rights, needs and best interests of Aboriginal children, young people and families across Victoria. The Commission achieved this through the leadership of the Commissioner for Aboriginal Children and Young People.**

This year the Commission:

- worked with government departments, community sector organisations (CSOs) and Aboriginal Community-Controlled Organisations (ACCOs) to respond to specific concerns raised with the Commission regarding the welfare, cultural safety and service provision of vulnerable Aboriginal children and young people
- provided strategic policy advice to government on legislation and policy proposals that impact Aboriginal children, young people and families
- initiated individual and systemic own-motion inquiries to examine the structural impediments that adversely impact on the emotional and social wellbeing and safety of Aboriginal children and young people
- continued to monitor and report back on the implementation progress of previous inquiry recommendations
- undertook direct engagement with Aboriginal organisations, community, children and young people to ensure that the voice of the Victorian Aboriginal community informs the Commission's work and strategic planning.

## Aboriginal Children's Forum review

At the Aboriginal Children's Forum (ACF) meeting in Port Fairy in September 2018, the members of the ACF resolved that the Commissioner for Aboriginal Children and Young People undertake a review of the ACF, with specific focus on the ACF's achievements, membership, structure and purpose, and the Commissioner make any recommendations that would strengthen and ensure sustainability of the forum.

The Commission, in collaboration with consultant Keren Murray, undertook the review from October to December 2018. The review comprised a reflection on the history of the ACF and the actions that have come from it, interviews with various stakeholders from government, ACCOs and CSOs who are involved with the ACF, and an evaluation of how ACF aligns with relevant overarching government strategies such as *Wungurilwil Gapgapduir*, transitioning Aboriginal children to Aboriginal care and the Victorian Aboriginal Affairs Framework 2018–23. The review report was completed in January 2019 and the report and recommendations were presented to the Minister for Child Protection, the Secretary of DHHS, and members of the ACF.

The ACF meetings in March and June 2019 accepted the recommendations and developed processes to incorporate them into the structure and agenda of the ACF.

## Koori Youth Justice Taskforce and *Our youth, our way* inquiry

As discussed in last year's annual report, the Commission has been resourced by the Victorian Government to undertake the Koori Youth Justice Taskforce (Taskforce) to examine over-representation of Aboriginal children and young people in the state's youth justice system. The Taskforce is a collaboration between the Commission and the Department of Justice and Community Safety.

In 2018–19, the Taskforce began auditing the client files of all Aboriginal children and young people who were involved in the youth justice system from October 2018 to March 2019. The audits identify areas of concern and good practice to inform the thirteen regional forums being held across Victoria from June to November 2019.

Youth justice stakeholders will be meeting at the regional forums to identify systemic issues in their region that negatively impact on Aboriginal children and young people and contribute to over-representation within the system. Each region will develop and commit to a regional action plan that addresses the identified issues and provides a template for systemic change.

In addition to the regional forums, private sessions will occur across the thirteen regions which will allow an in-depth case plan review for specific Aboriginal children and young people identified as having high levels of risk and/or complexity. An individual action plan will be developed for each young person to address the risks and complexities.

The regional and individual action plans will be monitored and reported on by the Commission and DJCS.

The first regional forum and private sessions were held in Ballarat on 27–28 June 2019. The Taskforce is due to be completed and report back to the Minister for Youth Justice by May 2020.

At the same time as the Taskforce is operating, the Commission is undertaking a related own-motion systemic inquiry into the over-representation of Aboriginal children and young people in the youth justice system. The *Our youth, our way* inquiry will build upon previous youth justice reports such as the Commission's *The same four walls* inquiry, the *Aboriginal cultural rights in youth justice centres* report completed by the Commission in partnership with the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) and the *Ngaga-dji* (Hear me) report by the Koori Youth Council.

*Our youth, our way* is due to be presented to the relevant ministers and tabled in Parliament in 2020.

## Aboriginal cultural rights in youth justice centres

The *Aboriginal cultural rights in youth justice centres* report was a joint initiative of the Commission and VEOHRC and examined how cultural rights for Aboriginal children and young people are understood, protected and actioned within Victoria's youth justice centres. The report made eight recommendations to DJCS to promote and strengthen the cultural rights of Aboriginal children and young people within the Malmsbury and Parkville youth justice centres. The Department of Justice and Community Safety accepted all eight recommendations and is currently implementing the recommendations.

## Wungurilwil Gapgapduir

*Wungurilwil Gapgapduir* is a tripartite agreement between the Victorian Government, the Aboriginal community and CSOs to commit to better outcomes for Aboriginal children and young people. From the Agreement a three-year strategic action plan was developed that details the steps the sector needs to take to address over-representation of Aboriginal children and young people in the child protection and out-of-home care sectors.

For the 2018–19 financial year, the Commission had responsibility for two actions under the agreement. These were to:

- evaluate and audit cultural support plans to determine the extent to which plans support Aboriginal children and young people to connect with Aboriginal community and culture, and
- convene an annual forum with Aboriginal children and young people in out-of-home care, supported by a series of regional forums.

In responding to the first action, the Commission commenced discussions and planning with the 18 senior cultural advisers who are based within ACCOs and DHHS, to develop a framework to assess the quality of cultural support plans. When the framework is developed and tested, the Commission will assess a random sample of current cultural support plans to ascertain their quality and ability to achieve effective connection to community and culture. A report on this will be provided to members of the ACF in 2020.

In response to the second action, the Commission developed a forum agenda and program for the first annual out-of-home care forum and worked with Child Protection practitioners and ACCOs to identify and support Aboriginal children and young people aged 14–17 years in out-of-home care to attend. The forum was held in July 2019 at the Aborigines Advancement League in Thornbury. This forum will be evaluated and the learnings used to develop the regional forum plan for the remainder of 2019–20.

# Supporting and regulating child-safe organisations

## The Commission as regulator

As a relatively new regulator, this year the Commission made significant progress in developing frameworks to help it make best use of limited resources to improve the safety of children in Victoria through the Child Safe Standards and Reportable Conduct Scheme.

The Commission remains the only agency nationally to administer both of these important new schemes, as recommended by the Royal Commission into Institutional Responses to Child Sexual Abuse.

### *Statement of Expectations*

We are guided in this work by a Ministerial Statement of Expectations. In 2018–19, the then Minister for Families and Children asked the Commission to deliver initiatives in relation to timeliness, risk-based strategies, data to inform a risk-based approach and compliance-related assistance and advice. Reflecting this, the Commission this year:

- published a document articulating the Commission's regulatory approach including its risk-based strategy
- developed an operational performance framework containing key performance indicators relating to the operation of its regulatory functions
- strengthened data collection to support the operational performance framework
- prepared and delivered a strategy to raise awareness among relevant sectors about the commencement of phase 3 of the Reportable Conduct Scheme
- prepared and implemented strategies to provide compliance-related assistance and advice to sectors identified using a risk-based approach including the faith-based and early-years sectors.

In June 2019, the Minister for Child Protection issued a new Statement of Expectations for the 2019–21 period, with key expectations of continuing development of a risk-based approach to regulation, along with a focus on driving cooperation amongst other child safety regulators. The Ministerial Statement of Expectations and the Commission's response and action plan are available on the Commission's website.

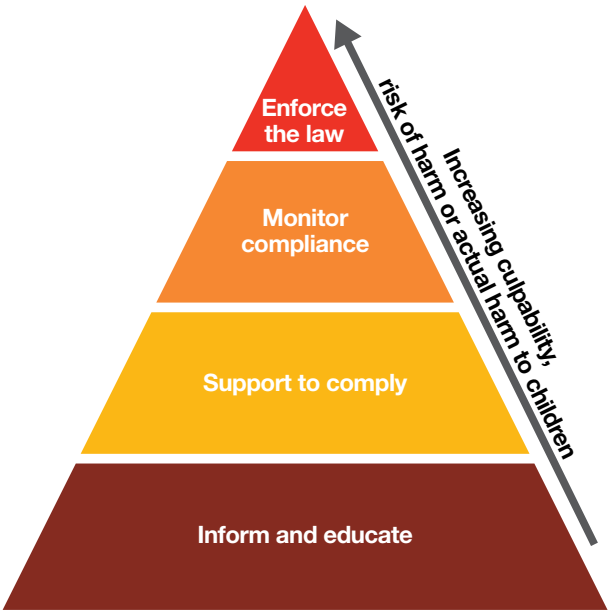
### *New regulatory approach*

As part of this work, the Commission published a new regulatory approach setting out our strategy to regulate organisations that must comply with the Child Safe Standards and the Reportable Conduct Scheme.

The approach provides organisations, the public, other regulators, government and Commission staff with a clear statement of how the Commission aims to perform its role and what Victorians can expect from the Commission.

The approach sets out new regulatory principles, our approach to co-regulation and information-sharing, as well as the Commission's graduated approach to compliance and enforcement. The regulatory approach document is available on the Commission's website.

***Figure 1. The Commission's regulatory approach***




### *Risk-based regulatory framework*

The Commission regulates to develop improved child-safe culture and practices in more than 50,000 organisations to better prevent and respond to child abuse. The Commission this year progressed the development of a risk-based regulatory framework including a range of tools to understand and analyse risk. The risk factors underpinning these tools are based on research prepared

for the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission).

Our framework considers the following:

- the risk of child abuse occurring within sectors or an individual organisation
- the risk of an organisation not properly investigating a reportable allegation
- the risk individual workers or volunteers pose to children.

The tools being developed for the framework will enable the Commission to undertake:

- high-level assessments of organisational risk
- detailed assessments of organisational risk
- classification of sectors on the basis of risk
- assessments of an organisation's ability to conduct an appropriate reportable conduct investigation.

This year, the Commission consulted widely on the development of the tools and engaged with key relevant authorities and co-regulators to progress the development of the framework.

Following the development and testing of the tools, in 2019–20, the Commission will focus on fine-tuning the framework and beginning implementation.

### *Review of Child Safe Standards*

This year, the Commission provided a detailed submission and ongoing assistance to a DHHS Review of Victoria's Child Safe Standards.

The Commission welcomed the review as a timely opportunity to consider the final report of the Royal Commission, together with early insights from the operation of the Victorian Child Safe Standards.

In the review submission, the Commission highlighted the importance of legislated, mandatory child safe standards to improve safety outcomes for Victorian children. The submission also highlighted the need to clarify the role of the Commission and relevant authorities, along with the need for modern compliance and enforcement tools to enable a graduated approach to regulation.

A key focus of the review has been the implementation of the National Principles for Child Safe Organisations (National Principles) endorsed on 19 February 2019 by the Council of Australian Governments (COAG). There are some differences between the Victorian Child Safe Standards and the National Principles. However, the Commission considers that in practice there is a great deal of commonality between the two. Harmonisation would be beneficial provided this does not result in a reduction in safety outcomes for Victorian children.

The Commission looks forward to the conclusion of the review.

### *Specialist training for Commission staff*

This year, we increased specialist training for Commission staff to assist them to better deliver their role educating, guiding and providing advice to organisations subject to the Reportable Conduct Scheme and Child Safe Standards. Throughout 2018–19, staff were provided with training in relation to:

- investigative interviewing techniques for children and young people
- the impact of trauma on children
- trauma-informed practice and how to respond to and support victim/survivors of trauma.

## Supporting compliance

The Commission's new regulatory approach published in June 2019 now sets out in detail our strategy to support organisations to comply with the Scheme.

The Commission's approach to regulation is to assist individual organisations and sectors to develop an understanding of compliance requirements and ways to keep children safe. Our priority is to build the capacity, knowledge and skills of organisations to develop their own systems and culture to prevent child abuse in a way that best suits the nature of their organisation.

### *Information sessions and conferences*

Demand for information sessions on the Child Safe Standards and Reportable Conduct Scheme increased this year. With staff turnover in the organisations the Commission regulates, as well as a dynamic market in services to children meaning that new organisations are constantly coming into scope for compliance with the two regulatory regimes, information sessions are likely to remain a valuable feature of the Commission's education toolkit.

This year, the Commission delivered 33 information sessions on the Child Safe Standards to 1,053 participants from sectors including education, health, community services, sport and recreation. Sessions encouraged organisations to take ownership of the safety of children in their organisations, provided an overview of the Standards and outlined practical strategies to embed them into everyday practice. A doubling of session and participant numbers from 2017–18 reflects the Commission's increasing focus this year on Child Safe Standards, which are critical to preventing child abuse.

The Commission also delivered 48 information sessions to 1,332[34] participants about the Reportable Conduct Scheme.

Feedback from information sessions indicated that some organisations that have been subject to the Standards and Scheme for some time are now seeking more detailed training on specific aspects of the two regulatory regimes. The Commission has started developing new sessions that will extend organisations' understanding of these aspects of the Standards and Scheme.

Presenting at conferences enables the Commission to reach targeted audiences. The Commission this year participated in eight conferences – seven that focused on the early years, sporting and faith sectors, and one that had a more general audience. Highlights included:

- a workshop presentation on how Child Safe Standards and the Reportable Conduct Scheme empower children, to around 250 early childhood educators as part of the Early Childhood Matters conference hosted by Wyndham City Council
- presentations to service providers and educators at the Family Day Care Australia Forum to approximately 140 participants
- the Early Learning Association Australia (ELAA) Conference 2019 where the Principal Commissioner delivered a keynote address to an audience of approximately 500 people.

> *"Being nominated to be Child Safety Officer for my sports club was a scary thought until I attended today's session. It's made me more confident and comfortable in what my role is and what I need to implement for all [our organisation]."*
>
> *"It was a good balance of theoretical and practical information. It reinforced the areas that we are on track with, as well as highlighting some areas which need further improvement/work."*
>
> *"I won't hesitate to contact the CCYP if I have any questions or concerns – it was made clear to us that the CCYP is here to help."*
>
> *"Thanks to CCYP for following through in this way from the implementation of the Standards. It is a collaborative and proactive approach to child safeguarding in organisations. It helped many participants feel less alone in their work to strengthen practices and culture in their organisations."*

[34] This excludes additional information sessions dedicated to the early years sector delivered as part of the Commission's implementation of Phase 3 of the Reportable Conduct Scheme.

### *Supporting faith-based organisations and early years services*

The Commission focused significant effort in 2018–19 on educating and guiding faith-based organisations and early years providers.

The Commission launched the new *A guide for faith communities on the Reportable Conduct Scheme*, which was developed together with the Faith Communities Council of Victoria and the Victorian Council of Churches. The guide is available on the Commission's website and has been widely distributed through the faith communities' network. This resource is being translated into fifteen community languages to increase its reach across the diverse faith-based sector. Over the course of the year, the Commission has also held meetings with different faith-based organisations, faith communities and support groups, providing advice and guidance about regulatory obligations, and delivered an information session at the Victorian Interfaith Networks Conference 2018.

As of 1 January 2019, the Reportable Conduct Scheme applied to all education and care services and children's services, collectively referred to as the early years sector. The sector comprises between 4,000 and 5,000 organisations, a significant increase in the coverage of the Reportable Conduct Scheme.

To support these new organisations to learn about their obligations under the Reportable Conduct Scheme, the Commission delivered an extensive awareness raising campaign engaging face to face with an estimated 1,100 individuals. Activities included:

- writing to over 4,000 education and care services and licensees of children's services
- delivering 30 dedicated early years information sessions to approximately 600 participants
- presenting at numerous early years sector conferences
- meeting with peak bodies and large approved providers
- publishing guidance material developed specifically for the early years sector
- disseminating information on social media and through electronic mailout
- working with co-regulators, including the Quality Assessment and Regulation Division of the Department of Education and Training, to design and disseminate guidance.

### *Child Safe Standards community of practice*

This year the Commission started a Child Safe Standards community of practice in response to organisations required to comply with the Standards requesting opportunities to gather and share practice amongst themselves and to trouble-shoot practical problems and solutions.

The first meeting of the Community had 78 attendees from 67 organisations drawn from sectors including education, early years, faith-based organisations, out-of-home care, local government, disability, health, housing, sport and youth recreation. The Commission will facilitate the Community of Practice in the short term, with the aim of increasing ownership and responsibility by organisations over time.

### *Resources to support compliance*

This year our commissioners appeared in new videos to promote the Child Safe Standards and the Reportable Conduct Scheme.

The Commission uses multimedia to educate and guide organisations about the Standards and the Scheme. Commission videos were this year viewed 13,152 times, and our information sheets were downloaded 46,532 times. *A guide for creating a child safe organisation* continued to be well-received, being downloaded over 2,300 times with a further 5,600 hardcopies distributed. This year we also updated existing videos on the Standards and the Scheme.

# Child Safe Standards

# Child Safe Standards

## Overview

- The Commission initiated action in relation to 77 organisations over identified concerns of potential non-compliance with Child Safe Standards.
- This included direct action by the Commission regarding 52 organisations.
- This year there was an increase in proactive targeting of organisations and the identification of Standards non-compliance concerns through the Reportable Conduct Scheme.

## Observations on the operation of the Standards in 2018–19

The Child Safe Standards are a set of mandatory requirements that must be implemented by certain organisations that provide services or facilities for children, or engage children. They promote children's safety by requiring organisations to implement policies and practices to prevent, respond to and report allegations of child abuse. The Commission has the following functions in relation to the oversight and enforcement of compliance with the Standards:

- educating and guiding co-regulators and relevant organisations
- overseeing and enforcing organisations' compliance with the Standards.

This year the Commission further increased its responses to potential non-compliance with the Standards, initiating compliance action with 33 per cent more organisations than last year.

The Commission started action in respect of 17 organisations as a result of information gathered through the Reportable Conduct Scheme. Increasingly the Commission's role overseeing reportable conduct investigations is providing valuable information about potential systems issues or critical child safety risks within organisations.

There has also been an increase from last year in activity by relevant authorities in response to potential non-compliance with the Standards by individual organisations, as well as action to educate, raise awareness and promote compliance with the Standards.

The Commission continues to encounter organisations that are not aware of their obligations to comply with the Standards. However, in taking action about concerns of non-compliance with the Standards, the Commission increasingly finds organisations that have taken some steps to implement the Standards but need advice and guidance to complete the task. We generally see a willingness from most organisations to comply with the Standards, but some have higher support needs.

## Action by the Commission about non-compliance concerns

In 2018–19, the Commission started compliance action, either directly or by referring to a co-regulator, in relation to 77 organisations. Twenty-five of these were referred to relevant authorities for action with the remaining 52 matters (68 per cent) initiated directly by the Commission.

Compliance action was concluded by the Commission in respect of 30 organisations in 2018–19.[35] As at 30 June

[35] Compliance action may have been commenced in previous financial years. Compliance action is concluded when no further Commission action is required. The Commission may continue monitoring an organisation after action has been taken to assess whether cultural change or improved practices have been properly embedded. These cases will be counted as concluded, and should additional action be required, a new compliance action will be commenced.

2019, the Commission had 96 open matters[36] where the Commission had commenced action in relation to an organisation due to concerns about non-compliance with the Standards.

***Table 11. Organisations where the Commission started action about concerns of non-compliance with the Standards by sector 2018–19***

| Sector[37] | Number of organisations[38] |
|---|---|
| Education and training[39] | 22 |
| Religious bodies (excluding schools) | 5 |
| Sport and recreation[40] | 33 |
| Tourism and events | 3 |
| Out-of-home care | 2 |
| Government departments or authorities | 3 |
| Early childhood | 2 |
| Other[41] | 7 |
| **Total** | **77** |

Some common themes identified by the Commission in addressing concerns about potential non-compliance include:

- Organisations paying insufficient attention to promoting the three principles – cultural safety of Aboriginal children and children from culturally and/or linguistically diverse backgrounds, and the safety of children with disability. The Commission has seen a particular trend in 2018–19 of concerns about the safety of children with disability.
- Inadequate child abuse reporting procedures, including a lack of guidance to staff to help them respond appropriately to a disclosure of potential abuse, procedures that do not give clear guidance that all allegations about criminal conduct should be reported to the police, and procedures lacking in guidance to staff to help them to identify and manage risks to children after an allegation of abuse is disclosed.
- Poor screening practices, meaning organisations have taken on new volunteers or staff without being aware that they have engaged in inappropriate behaviour towards children at previous organisations.
- Organisations using template policies, procedures and codes of conduct sourced from peak bodies or other organisations without tailoring them to the specific child safety risks and issues in their organisation.
- Organisations with multiple geographically dispersed sites and diffuse networks finding it challenging to build a cohesive child-safe culture, ensure appropriate oversight of the implementation of the organisation's child-safe framework and identify and manage the risks to children in all areas of the organisation's activities.
- In some religious organisations, the Commission has seen a reluctance to prioritise child safety over religious practices or traditions that create risks of child abuse, or to consider change to mitigate risks.
- Organisations lacking strategies to support the participation and empowerment of children, and who advise they are uncomfortable talking to children about safety.

Many of the Commission's compliance actions this year involved providing support and guidance to organisations to improve their understanding of the drivers for risks of child abuse, and how to identify and manage these risks in their organisation. This process then supports the

36 Compliance action may have been commenced in previous financial years.

37 Organisations have been grouped into sectors, or included in the 'other' category, to assist with de-identification given low numbers for some organisation types.

38 This captures action commenced in 2018–19 in respect of organisations not already the subject of Commission action commenced in previous years.

39 Includes Victorian Government, independent and Catholic primary and secondary schools, training organisations such as Group Training Organisations and Registered Training Organisations.

40 Includes sporting clubs, sporting peak bodies and other recreational clubs and associations.

41 Includes disability services, tutoring services, entertainment services, charities, and interpreting services.

organisation to implement the Standards in a way that directly addresses the risks of child abuse specific to the organisation. Using research from the Royal Commission into Institutional Responses to Child Sexual Abuse, the Commission is developing a tool for organisations to assist them to undertake more effective risk identification and management.

Since the Commission started administering the Standards on 1 January 2017, it has commenced action about concerns of non-compliance with the Standards in respect of 146 organisations.

Some of the positive changes the Commission has noted after our engagement with organisations about their non-compliance with the Standards include:

- where alleged inappropriate behaviour with children has been investigated by police, but with charges not being laid for a range of reasons, the Commission has been able to work with organisations to generate improvements in child safety
- senior leaders in some organisations have taken greater responsibility for ensuring the organisation complies with child safety obligations
- some organisations that were resistant to engaging with children and young people, or unaware of the benefits of doing so, have consulted with children, created opportunities for their participation in decision-making and communicated with them about the importance of their safety and their right to feel safe and to be heard
- some sporting organisations have achieved a greater understanding of the vulnerability of children and young people in elite sports and the importance of measures to counteract this vulnerability
- a change in some organisations' approaches away from a more simplistic view, overly focused on Working with Children Checks, to one more driven by a holistic approach to the safety of children, appreciating all elements that contribute to risks of child abuse.

Often action by the Commission will involve providing guidance material and recommendations on actions an organisation could take to improve compliance with the Standards. The organisation's response is monitored and escalated action can be taken if necessary, including enforcement action. The Commission did not need to commence enforcement action in 2018–19 due to organisations generally being receptive and responsive to the Commission's 'support to comply' approach.

***Table 12. Commission's enforcement activities concerning the Standards 2018–19***

| Enforcement action | Number |
|---|---|
| Section 30 – notice to produce issued by the Commission | 0 |
| Section 33 – court declaration that a relevant entity has failed to comply with a notice to produce | 0 |
| Section 33 – civil penalty for failure to comply with notice to produce | 0 |
| Section 31 – notices to comply issued by the Commission | 0 |
| Section 33 – court declaration that a relevant entity has failed to comply with a notice to comply | 0 |
| Section 33 – civil penalty for failure to comply with notice to comply | 0 |

### *Relevant authorities and co-regulation*

The *Child Wellbeing and Safety Act 2005* establishes a regulatory regime where the Commission shares responsibility for supporting compliance with the Standards with Victorian government departments and the Victorian Registration and Qualifications Authority (VRQA).

Where a department or authority regulates or funds an organisation required to comply with the Standards, it is considered a relevant authority for that organisation.

The Commission works with relevant authorities where there are concerns about compliance, and relevant authorities also have a role in raising awareness about the Standards and supporting organisations to comply. Where a relevant authority is identified, the Commission will usually refer potential non-compliance to the relevant authority for action, or consult with that relevant authority in action taken by the Commission.

In 2018–19, the Commission referred 25 organisations to co-regulators where the Commission had identified a concern about non-compliance with the Standards.

Each organisation can have multiple relevant authorities. Where more than one is identified, the Commission will consult with the relevant authorities to allocate a lead for the compliance action with an organisation. The Commission took the lead on one compliance action involving multiple relevant authorities in 2018–19.[42]

***Table 13. Relevant authorities where the Commission referred a concern of non-compliance with the Standards or consulted on compliance action as at 30 June 2019***[43]

| Relevant authority | Number of referrals made by the Commission[44] |
|---|---|
| Victorian Registration and Qualifications Authority | 20 |
| Department of Health and Human Services | 2 |
| Department of Education and Training | 2 |
| Department of Environment, Land, Water and Planning | 1 |
| **Total** | **25** |

This year, the Commission established a Government Department Senior Executive Group to bring together senior representatives of departments to discuss issues concerning child safety, the Standards and the Reportable Conduct Scheme. The Commission also continued its support of the officer-level Government Department Child Safe Standards Working Group.

Further work by the Commission in 2018–19 will help refine the Standards co-regulatory model.

## Action by relevant authorities about non-compliance concerns

Relevant authorities also take their own action to address concerns about non-compliance without a referral from the Commission.

***Table 14. Actions by relevant authorities to assess and address concerns of potential non-compliance with the Standards as at 30 June 2019***[45]

| Relevant authority | Number of organisations |
|---|---|
| Department of Premier and Cabinet[46] | 1 |
| Department of Health and Human Services | 74[47] |
| Department of Education and Training[48] | 1 |
| Department of Environment, Land, Water and Planning | 1 |
| **Total** | **77** |

In addition to acting on non-compliance concerns under the Standards, DHHS has undertaken other relevant compliance activities in relation to section 120 of the *Children, Youth and Families Act 2005* and the Human

42 This matter has not been counted as a referral as no compliance activity was required or requested of the relevant authorities.

43 Number of referrals may be recognised differently between different agencies and the Commission due to different counting rules being applied.

44 An organisation may have more than one relevant authority. If this is the case, a referral will be counted against each relevant authority.

45 This table incorporates all actions taken by the departments, including those referred by the Commission and those commenced by the departments on the basis of other information.

46 Includes child employment entertainment industry.

47 This includes compliance assessments or activities specifically under the Standards, as well as activities under the *Children, Youth and Families Act 2005* and Human Services Standards that overlap with the scope of the Standards. Sectors include housing and homelessness, out-of-home care and disability.

48 This excludes organisations where the VRQA is the relevant authority such as primary and secondary schools. It includes early childhood organisations, community language schools and other organisations that DET funds or regulates.

Services Standards. These portfolios impose responsibilities on organisations that align with obligations under the Standards, such as suitability screening processes for employees in sectors including out-of-home care, disability services and housing and homelessness services.

The VRQA also undertakes a large number of relevant compliance activities annually, consistent with its role as the key regulator of schools and other educational institutions. Further information about the VRQA's activities, including its considerable activity to support the Standards in schools, can be found in its annual report.

***Table 15. Victorian Registration and Qualifications Authority action to assess and address concerns about potential non-compliance with the Standards as at 30 June 2019***

| Activity type | Number of activities[49] |
|---|---|
| School reviews | 793 |
| Non-review investigations | 2 |
| OSSEO reviews[50] | 22 |
| Registration activity including assessment of compliance against the Standards | 44 |
| Complaints investigations | 15 |

## Action by relevant authorities to educate and promote compliance

This year, relevant authorities advised the Commission of a range of activities they have undertaken to proactively educate, raise awareness and promote compliance with the Standards in 2018–19.

### *Victorian Registration and Qualifications Authority*

In 2018–19, the Victorian Registration and Qualifications Authority continued its Child Safe Standards Specialist Schools project to examine implementation of the Standards in specialist schools. The project is examining the support needs of schools and opportunities to develop additional support and resources for these organisations.

The VRQA also continued its review of school boarding facilities to better understand the work of schools in managing the risk of child abuse within the boarding facility environment. The VRQA is working with stakeholders to consider project findings and identify opportunities to develop sector-specific resources to support compliance in these areas.

In 2018–19, the VRQA launched a further project to gather insights into how schools exhibiting best practice have embedded a culture of child safety in their schools. Findings will be used to develop resources and case studies to support all schools to comply with the Standards.

On 20 June 2019, the Victorian Auditor-General's Office tabled the report *School Compliance with Victoria's Child Safe Standards*. VRQA has commenced actions to implement a number of improvement opportunities following the report, and this work will continue into the next financial year.

### *Department of Education and Training*

The Department of Education and Training this year released resources providing practical assistance to schools to identify, report and respond to child abuse, updating its guidance document *Identifying and responding to all forms of abuse in Victorian schools*. DET published *Four critical actions for schools: Responding to incidents, disclosures and suspicions of child abuse* and templates to support schools to develop local policies and procedures and appropriately document actions in response to suspected abuse.

Compliance with the Standards has been included as a condition of funding and accreditation in the common funding agreement for all Community Language Schools and reflected in the *Community language schools funding program – Accreditation and funding guide 2019–2021*.

[49] This includes referrals made by the Commission.

[50] Overseas Secondary Student Exchange Organisations.

DET has also prepared sector-specific resources to support Community Language Schools to understand their responsibilities in relation to the Standards and reporting requirements. A new funding agreement with the Ethnic Schools Association of Victoria includes the specific requirement that an officer is employed to ensure all community language schools comply with the Standards.

In 2018–19, DET updated guidance and published a new resource on the Department's PROJECT website to support schools to identify, report and respond to child abuse. DET updated the *Identifying and responding to all forms of abuse in Victorian schools* guidance and *Four critical actions for schools: Responding to incidents, disclosures and suspicions of child abuse*, and published a *Child safety responding and reporting obligations policy and procedures* template to support government schools to develop local policies and procedures to identify and respond to suspected abuse.

DET's Quality Assessment and Regulation Division (QARD) regularly communicates with early childhood education and care services to support their compliance with the Standards.

QARD's monitoring of early childhood education and care services includes measures to check that services are aware of and have taken steps to implement the Standards. Where services do not ensure the safety, health or wellbeing of children, or fail to address the Standards, action is taken to ensure services address these issues.

### *Department of Health and Human Services*

DHHS this year promoted the Standards by publishing new and updated resources to support organisations that it funds and regulates to comply. This included updating fact sheets on the Standards and publishing new resources on indicators of abuse, risk management strategies and strategies to promote the participation and empowerment of children on its website. In addition, DHHS used a quarterly news bulletin and presentations at stakeholder meetings to provide targeted communications on specific standards where data indicated patterns of non-compliance.

During National Children's Week, DHHS led a campaign to promote the Standards through newsletters, social media posts and the release of a Child Safe Standards children's poster aimed at encouraging children to speak up if they feel unsafe. DHHS wrote individually to each of its funded and/or regulated in-scope organisations to promote its updated resources and remind organisations of their legal obligation to comply with the Standards.

DHHS funded peak bodies and other organisations to develop sector-specific resources on the Standards, including working with National Disability Services to develop disability-specific resources and working with the Victorian Aboriginal Child Care Agency on a video *Keeping Aboriginal children safe in a mainstream organisation*.

In 2018–19, DHHS continued its dedicated enquiry line and email inbox for organisations seeking information and advice about the Standards and the Reportable Conduct Scheme.

### *Department of Jobs, Precincts and Regions (existed for part of the reporting year)*

The Department of Jobs, Precincts and Regions this year sent communications to entities funded under the Youth Employment Program and to relevant sports associations, reminding them of their responsibilities under the Standards. The department also worked with its creative agencies that entered the Reportable Conduct Scheme on 1 January 2019 to ensure appropriate mechanisms are in place to report and respond to suspected child abuse.

### *Department of Transport (existed for part of the reporting year)*

The Department of Transport this year worked with bus operators to educate them on their obligations under the Standards as part of its process to recontract the 1,450 free school buses that operate in regional Victoria. This included ensuring that future contractors are prepared to comply with the Victorian Funding Guideline for Services to Children, which specifically embeds a requirement to comply with the Standards.

### *Department of Treasury and Finance*

In recognition that implementing reporting processes required by the Reportable Conduct Scheme supports compliance with aspects of the Standards, the Department of Treasury and Finance this year shared its own reportable conduct policy with its agencies and requested that relevant agencies prepare and implement their own policies.

### *Department of Environment, Land, Water and Planning*

The Department of Environment, Land, Water and Planning provided information on the Standards to relevant organisations it funds and regulates, including:

- wildlife licence holders employing or conducting activities with children
- agencies that the department supports and oversees, such as relevant boards of management for nature parks, gardens and zoos.

### *Department of Premier and Cabinet*

The Department of Premier and Cabinet's Wage Inspectorate Victoria (the Inspectorate) this year incorporated information about the requirements of the Standards into its communication to organisations employing children under the child employment permit system. Information about the Standards was sent with every child employment permit issued and included in briefings with all new entrants to the permit system. The Inspectorate also used its Entertainment Industry Working Party as a forum to raise awareness of the Standards.

# Reportable Conduct Scheme

# Reportable Conduct Scheme

## Overview

- Since the Scheme commenced on 1 July 2017, the Commission has received 1,611 mandatory notifications relating to 2,697 allegations of reportable conduct. In 2018–19, 805 mandatory notifications were received relating to 1,271 allegations. Thirty-one percent of all allegations received since the start of the Scheme were substantiated as at 30 June 2019.
- The early childhood sector came into the Reportable Conduct Scheme on 1 January 2019. Commensurate with the size of the sector and the frequent contact with children inherent in its activities, 27 per cent of all notifications received by the Commission since 1 January 2019 have been from this sector.[51]
- Since the start of the Scheme, 221 individuals found to have engaged in substantiated reportable conduct have been referred to the Department of Justice and Community Safety for the purpose of a reassessment of their appropriateness to retain a Working with Children Check.
- Numbers of public notifications have increased with 117 received in 2018–19.

## Observations on the Scheme's operation in 2018–19

While the Scheme has only been operating for two years, the Commission is pleased to note that in these two years, there have been positive improvements in how organisations respond to allegations of reportable conduct.

Where possible, observations on the data are included in the report, but they should be viewed as preliminary in nature given that, after only two years, there is limited ability to identify trends.

### *Expanding the Scheme's reach*

The Reportable Conduct Scheme expanded its coverage in 2018–19. From 1 January 2019, the following new organisations were brought into the Scheme:

- the early childhood sector comprising approved education and care services and children's services – for example, long day care centres, outside school hours care, kindergarten services, family day care and occasional care providers
- some organisations that have functions of a public nature such as certain art centres, libraries, museums, zoos, parks and gardens.

The increase in the number of organisations covered by the Scheme was significant, with between 4,000 and 5,000 additional organisations bringing the total number of organisations required to comply to approximately 12,500. As expected, this has resulted in large numbers of mandatory notifications now being received from the early childhood sector. Over the six months from 1 January 2019, mandatory notifications from the early childhood sector comprised 27 per cent of total mandatory notifications for the period. Out-of-home care, education and early childhood organisations are now typically the three largest mandatory notifying sectors.

In general, this sector this year responded positively to its new responsibilities under the Scheme. As co-regulators, the Commission and the Department of Education and Training have worked together to support the sector with these changes.

[51] A small number of early childhood organisations came into scope of the Scheme prior to 1 January 2019 due to other functions of their organisation, for example providing disability services, that were brought in on an earlier date. As a result, some early childhood cases are observable in the 2017–18 results.

### *Investigative practice*

In 2018–19, the Commission noted many organisations' investigative practice continued to mature, particularly those organisations subject to the Scheme since it began on 1 July 2017.

Many organisations the Commission has contact with have changed their management of investigations since the Scheme first began, putting in place improved systems so that allegations of reportable conduct are promptly identified and appropriately responded to. For some, this has included appointing dedicated investigators, upskilling staff and in some cases using external investigators. Improvements the Commission noted in some organisations include:

- organisations increasingly taking steps to manage risks to the alleged victim and other children during an investigation
- improvements in the quality and appropriateness of the evidence being collected and relied upon by organisations and the application of appropriate weighting practices in assessing that evidence
- increased application of the thresholds specific to reportable conduct and the Commission's guidance material
- organisations increasingly documenting where disciplinary or other action is or is not taken following an investigation and the organisation's justification for this.

## Case study

### Department of Justice and Community Safety

The Department has made a number of improvements to its investigative processes based on the feedback provided by the Commission throughout the year. The investigation process now involves a full investigation for all reportable conduct allegations reported to the Commission. This includes employees being notified of the allegation once it has been reported to the Commission and advising employees of the impact a substantiated allegation has on their Working with Children Check. Employees are given the opportunity to respond to all allegations, and all relevant witnesses, including alleged child victims and witnesses, are interviewed unless there is a good reason not to. Senior investigators undertook training with the Commission on interviewing children and young people to address their concerns about not being experienced in interviewing children and young people, especially those with a traumatic background.

The policy *Investigating allegations of reportable conduct* has been updated and expanded to include information on the reporting processes and the elements of what constitutes reportable conduct, and how the relevant thresholds of reportable conduct should be applied when considering the investigation. Detailed investigation reports are prepared for all investigations, and where the allegation is also the subject of a misconduct investigation, separate findings are made and a specific reportable conduct report prepared for the Commission.

The Commission also noted improvements in many organisations' attention to procedural fairness for subjects of allegation. Improvements include an increase in organisations providing the subject of allegation details of the alleged conduct prior to interview, and making the subject of allegation aware that the Commission has been notified of the allegation and the potential consequences of a substantiated finding. Increasingly, organisations are also routinely making subjects of allegation aware of the outcome of investigations and findings made. These improvements are not uniform, and the Commission will continue to guide organisations that need to improve procedural fairness.

Many areas for improvement remain if the community is to have full confidence that all allegations of child abuse are receiving proper attention. Issues for attention by organisations include:

- the proper identification and management of conflicts of interest. Concerningly, the Commission continues to see organisations without robust practices, policies and procedures to manage allegations and investigations concerning the head of an organisation or people occupying key governance roles.
- ensuring organisations make findings based on the evidence collected. The Commission still sees organisations reluctant to substantiate allegations due to concern for the subject of allegation's reputation, employment or feelings, despite the existence of solid evidence supporting reportable conduct perpetrated against a child or young person.
- all appropriate witnesses being interviewed. As part of its oversight function, the Commission continues to see some organisations choosing not to interview relevant witnesses including the alleged victim, the subject of allegation and other witnesses.

The Commission delivered a range of dedicated specialist forums and training in 2018–19 to support organisations to improve their investigative practices. In June 2019, the Commission hosted three full-day forums for individuals within organisations who have a role in reportable conduct investigations. Over 200 participants attended forums held in Sunshine, Bendigo and Traralgon. The interactive forums provided the opportunity for attendees to work through case studies of investigations in small groups, complete mock investigation plans, and make mock findings. These forums will be repeated in 2019–20.

### *Interviewing children as alleged victims or witnesses*

The Commission considers that alleged child victims and relevant child witnesses should generally be interviewed unless there is a good reason not to. Where it is not appropriate to conduct an interview, organisations are asked to provide a reason for this decision.

Excluding children from investigations without good reason can deprive investigators of valuable evidence relevant to deciding whether an adult has engaged in child-related misconduct or abuse. It can also send a damaging message to children that their voice is not valued, and can contribute to them not feeling listened to or heard.

Supporting children to participate in investigations relevant to them is consistent with Child Safe Standard 7, which requires organisations to have strategies in place to promote the participation and empowerment of children and aligns with obligations under the *United Nations Convention on the Rights of the Child*.

The Commission has observed a number of organisations choosing not to interview children when their evidence would have been relevant. Some organisations have a specific policy never to interview children. We have also observed numerous incidents of investigators not giving appropriate weight to children's evidence and unjustifiably preferring the evidence of adults over children.

Some of the reasons provided by organisations for their practice show genuine concern for children. In some cases, organisations have simply not provided their staff with the appropriate training to support them in their roles. Commission staff often hear organisations with a key role in delivering services to children state that they don't know how to speak to children. Myths around the lack of reliability of children's evidence also still pervade some reportable conduct investigations.

The Commission continues to guide organisations to improve practice in this area and has partnered with Griffith University to develop a program of work to assist organisations in upskilling their staff in the interviewing of children and young people as part of reportable conduct investigations.

In July 2018 the Commission hosted a one-day forum in Melbourne for individuals who conduct reportable conduct investigations. Professor Martine Powell from the Centre for Investigative Interviewing at Griffith University focused on practical interviewing techniques to use with children.

Dr Jenny Dwyer delivered a session to assist organisations to understand the impact of trauma on children. The forum was attended by 77 participants from a broad range of sectors including faith-based organisations, disability services and government.

In April 2019, 114 participants attended further training delivered by Professor Martine Powell that will also contribute to research commissioned from Griffith University to inform options to take further action on this issue.

### *Sexual misconduct*

In 2018–19, the Commission received 178 reportable allegations relating to sexual misconduct. The Commission provided significant written guidance to organisations in this area, and also routinely provided advice on individual sexual misconduct investigations.

Investigations into alleged sexual misconduct as a type of reportable conduct can challenge organisations. Part of the assessment of whether conduct is sexual misconduct involves a consideration of whether conduct:

- was of a sexual nature or for sexual arousal or gratification
- was overly personal or intimate, or
- involved grooming behaviour.

Grooming does not only involve a child and can include a focus on a range of individuals to gain access to a child's life and can include seemingly innocuous actions such as initiating opportunities for unsupervised contact, spending inappropriate 'special time' with a child or inappropriately showing special favours to a child. Grooming behaviour can be difficult to confidently detect.

The Commission will continue efforts to support and guide organisations in making decisions about whether conduct amounts to sexual misconduct.

## Notifications of reportable allegations

The Scheme requires heads of organisations to notify the Commission of allegations of reportable conduct. Notifications are required within three business days of the head becoming aware that any person has formed a reasonable belief that reportable conduct or misconduct that may be reportable conduct has occurred. The head is required to submit a notification, whether or not they themselves share that reasonable belief. Since the Scheme commenced on 1 July 2017, the Commission has received 1,611 mandatory notifications.

The *Child Wellbeing and Safety Act 2005* also allows any person – for example, members of the public – to disclose allegations to the Commission. Where the Commission receives a public notification, it assesses whether it is covered by the Scheme. Usually, contact will be made with the relevant organisation to disclose the information so that a mandatory notification can be made and investigation commenced. In the two years of the Scheme's operation, the Commission has received 190 public notifications.

***Table 16. Reportable conduct matters received by notification type 2017–19***

| Type | 2017–18[52] | 2018–19 | Since start of the Scheme[53] |
|---|---|---|---|
| Mandatory notification | 806[54] | 805 | 1,611 |
| Public notification[55] | 73 | 117 | 190 |

## Mandatory notifications

The following sections contain information about notifications of reportable allegations received by the Commission from heads of organisations. This data details allegations. For many of these, the facts have not yet been established and findings have not yet been made about whether the alleged conduct occurred.

For the period 1 July 2018 to 30 June 2019, the Commission received 805 notifications of reportable allegations from heads of organisations, which is similar to the number received in the 2017–18 year (806).[56] It will take some years for numbers of notifications to settle into a predictable trend given the commencement of the Scheme in three phases over two years.

The Commission remains concerned that there is under-reporting in some sectors and will continue to work in 2019–20 to increase awareness and support effective reporting practices in these sectors.

### *Notifications received*

Since the Scheme commenced, the Commission has received an average of 67 notifications per month. After a low in late 2018, notifications have continued to build to a two-year high in the final quarter of 2018–19.

The Commission expects the number of notifications will continue to increase in future years as organisations strengthen their processes to ensure all reportable allegations are appropriately notified to the Commission and awareness of the Scheme's requirements grows.

We also expect public notifications will continue to increase, as they have in the 2018–19 year, as community awareness of the Scheme grows.

52 In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 annual report. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified as one notification.

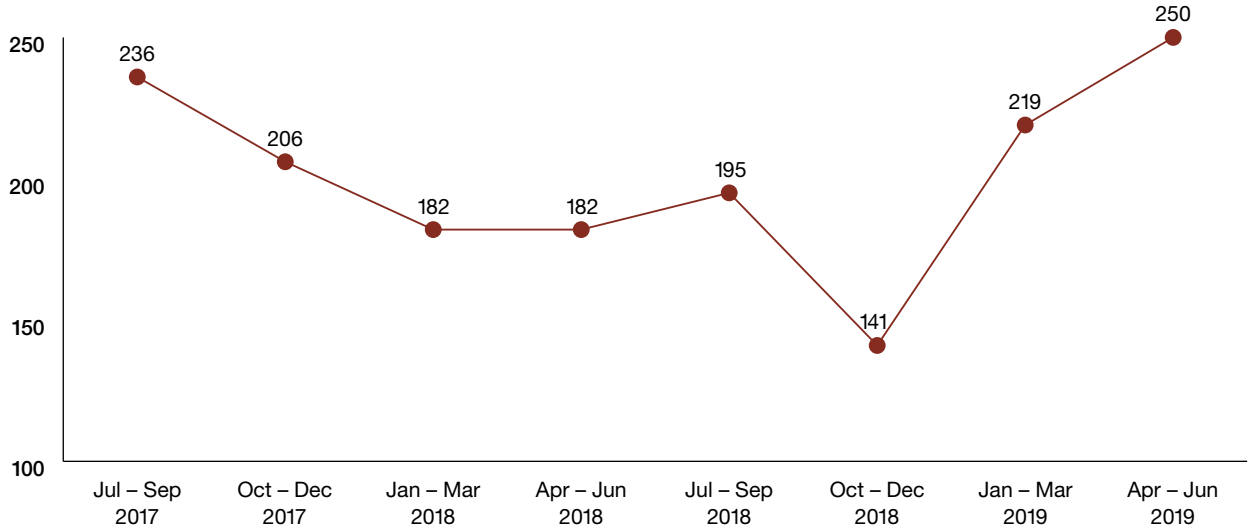
53 This refers to the period 1 July 2017 to 30 June 2019.

54 This figure is less than that stated in the Commission's 2017–18 annual report as it excludes 44 mandatory notifications that, on receipt of further information, were determined to be out of scope of the Scheme and should not have been reported to the Commission, and includes one mandatory notification that was originally incorrectly classified as a public notification.

55 Many public notifications will subsequently result in the head of an organisation submitting a mandatory notification. Others will be assessed as being outside the jurisdiction of the Scheme due to not meeting legislative requirements.

56 This includes notifications made on behalf of heads of organisations by their delegates, agents or other person authorised to act on their behalf. Each mandatory notification submitted by the head of an organisation can have multiple alleged victims and contain multiple allegations. Each notification will have only one subject of allegation who is alleged to have committed the reportable conduct. Where there are multiple subjects of allegation, these are counted as separate notifications.

***Figure 2. Number of mandatory notifications received by the Commission by quarter 2017–19***




### *Mandatory notifications by sector*

Since the Scheme's commencement, the out-of-home care and education[57] sectors have consistently represented the highest proportion of notifications (40 per cent and 28 per cent respectively). Workers and volunteers in these sectors have frequent contact with children when compared with some other sectors covered by the Scheme and entered the Scheme with comparatively well-developed processes for reporting child abuse when compared with other sectors.

The early childhood sector has provided a high proportion of notifications since 1 January 2019 (27 per cent).[58] This proportion of notifications is commensurate with the size of the sector and the frequent contact with children inherent in its activities. The notification rate appears to show a positive and rapid grasp of the notification requirements of the Scheme.

There was an increase in notifications from religious bodies in 2018–19. However, numbers remain concerningly low and seem inconsistent with the large numbers of religious bodies in Victoria and data on sexual abuse presented by the Royal Commission into Institutional Responses to Child Sexual Abuse.

The number of notifications from the health and disability sectors also remains low given the size of these sectors and the nature of the contact between adults and children in these types of organisations. The Royal Commission noted children with disability are particularly vulnerable to abuse so low reporting by that sector is of concern.

The Commission will continue its targeted engagement and communication activities in these sectors and others, and will work with other regulators where they exist, to build awareness of the Scheme and strengthen accountability.

57 Mainly schools.

58 A small number of early childhood organisations came into scope of the Scheme prior to 1 January 2019 due to other functions of their organisation – for example, providing disability services – that were brought in on an earlier date. As a result, some early childhood cases are observable in the 2017–18 results.

***Table 17. Notifications of reportable allegations received by sector 2017–19***

| Sector | 2017–18[59] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| **Out-of-home care**[60] | **361** | **45** | **286** | **36** | **647** | **40** |
| Residential care | 127 | | 87 | | 214 | |
| Foster care | 113 | | 92 | | 205 | |
| Kinship care | 105 | | 92 | | 197 | |
| Other (includes permanent care, respite and contingency care, lead tenant and where the subject of allegation's role is not the direct care of children such as administrative staff of an out-of-home care organisation) | 16 | | 15 | | 31 | |
| **Child protection**[61] | **16** | **2** | **2** | **<1** | **18** | **1** |
| **Education** | **262** | **33** | **185** | **23** | **447** | **28** |
| Non-government school – Independent[62] | 84 | | 65 | | 149 | |
| Non-government school – Catholic[63] | 84 | | 62 | | 146 | |
| Victorian Government school[64] | 90 | | 49 | | 139 | |
| Other (includes other senior secondary courses and qualifications, international student courses, student exchange programs and other administrative employees) | 4 | | 9 | | 13 | |
| **Early childhood**[65] | **22** | **3** | **152** | **19** | **174** | **11** |
| Long day care | 10 | | 89 | | 99 | |
| Preschool/kindergarten | 5 | | 21 | | 26 | |
| Outside school hours care | 4 | | 21 | | 25 | |
| Family day care | 0 | | 11 | | 11 | |
| Childcare (4 or more children) | 3 | | 9 | | 12 | |
| Employee – other/administration | 0 | | 1 | | 1 | |

59 In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 Annual Report. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified as one notification.

60 Includes services provided by DHHS, community services organisations and other organisation types.

61 Includes Child Protection services provided by DHHS, Child Protection services provided by organisations pursuant to a DHHS contract and DHHS secure welfare.

62 Includes primary and secondary school.

63 Includes primary and secondary school.

64 Includes primary and secondary school.

65 Includes preschool, kindergarten, long day care, and other childcare. While early childhood providers were required to comply with the Scheme from 1 January 2019, some were covered in 2017–18. This was due to other functions within the organisation being covered, meaning the organisation as a whole was required to comply including where early childhood services are provided.

***Table 17. Notifications of reportable allegations received by sector 2017–19 (continued)***

| Sector | 2017–18[59] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| **Religious body**[66] | **17** | **2** | **71** | **9** | **88** | **5** |
| **Youth justice**[67] | **47** | **6** | **51** | **6** | **98** | **6** |
| **Disability services**[68] | **40** | **5** | **26** | **3** | **66** | **4** |
| Residential disability service | 17 | | 12 | | 29 | |
| Respite disability care provider | 7 | | 5 | | 12 | |
| Other disability service (includes non-residential disability services, unknown sub-service types and other administrative employees) | 16 | | 9 | | 25 | |
| **Health**[69] | **5** | **<1** | **7** | **<1** | **12** | **<1** |
| **Victorian Government department**[70] | **4** | **<1** | **2** | **<1** | **6** | **<1** |
| **Accommodation**[71] | **4** | **<1** | **1** | **<1** | **5** | **<1** |
| **Other**[72] | **28** | **3** | **22** | **3** | **50** | **3** |
| **Total** | **806** | **100** | **805** | **100** | **1,611** | **100** |

### *Reportable allegations by type of reportable conduct*

Each mandatory notification can contain multiple reportable allegations and multiple alleged victims. The 1,611 notifications received in the first two years of the Scheme contained 2,697 allegations.[73]

There are five types of 'reportable conduct' listed in the *Child Wellbeing and Safety Act 2005*:

- sexual offences (against, with, or in the presence of a child)
- sexual misconduct (against, with, or in the presence of a child)
- physical violence (against, with, or in the presence of a child)
- behaviour that causes significant emotional or psychological harm
- significant neglect.

In 2018–19 the highest number of allegations (54 per cent) related to physical violence.[74]

66 Excludes notifications in relation to services provided by religious bodies in other sectors.

67 Youth justice functions provided by the Department of Justice and Community Safety.

68 Includes registered and non-registered disability services providers, residential services for children with a disability and DHHS disability support services.

69 Includes hospitals (public and private), mental health services with inpatient beds and inpatient drug and alcohol services.

70 Excludes notifications in relation to state government workers or volunteers contained in other sectors.

71 Includes overnight camps and homelessness service providers with overnight beds.

72 In this category, four notifications were from organisations subsequently deemed outside the scope of the Scheme. One related to an organisation that was not yet identified. Of those notifications within the scope of the scheme, these related to employees not otherwise captured in other sectors – for example, aquatic and leisure centre workers and council workers.

73 It is too early in the life of the Scheme to robustly identify trends and drivers underpinning this data. The phased implementation of the Scheme means the organisations subject to the Scheme in 2018–19 are different to the previous year, making year-on-year analysis difficult.

74 This covers a range of conduct including actual physical violence and threats of physical violence. Where physical contact is made with a child, it must be capable of causing injury or harm to the child. It is, however, not necessary that this injury or harm actually happened.

***Table 18. Reportable allegations from mandatory notifications received 2017–19***

| Conduct type | 2017–18[75] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| **Physical violence** | **630** | **44** | **683** | **54** | **1,313** | **49** |
| Physical violence committed against a child | 532 | 37 | 568 | 45 | 1,100 | 41 |
| Physical violence committed in the presence of a child | 96 | 7 | 106 | 8 | 202 | 7 |
| Physical violence committed with a child | 2 | <1 | 9 | <1 | 11 | <1 |
| **Sexual misconduct** | **286** | **20** | **178** | **14** | **464** | **17** |
| Sexual misconduct committed against a child | 249 | 17 | 151 | 12 | 400 | 15 |
| Sexual misconduct committed in the presence of a child | 25 | 2 | 22 | 2 | 47 | 2 |
| Sexual misconduct committed with a child | 12 | <1 | 5 | <1 | 17 | <1 |
| **Behaviour that causes significant emotional or psychological harm to a child to a child** | **260** | **18** | **164** | **13** | **424** | **16** |
| **Significant neglect of a child** | **156** | **11** | **137** | **11** | **293** | **11** |
| **Sexual offences** | **94** | **7** | **109** | **9** | **203** | **8** |
| Sexual offence committed against a child | 93 | 7 | 101 | 8 | 194 | 7 |
| Sexual offence committed in the presence of a child | 0 | – | 4 | <1 | 4 | <1 |
| Sexual offence committed with a child | 1 | <1 | 4 | <1 | 5 | <1 |
| **Total** | **1,426** | **100** | **1,271** | **100** | **2,697** | **100** |

Different types of allegations appear more prevalent in some sectors. For example, there is a higher proportion of sexual offence allegations in religious bodies than any other sector, and a higher proportion of physical violence allegations in the early childhood sector.

[75] In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 annual report. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified as one notification.

***Table 19. Reportable allegations by sector and type of reportable conduct 2017–19***[76]

| Sector[77] | 2017–18[78] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%)[79] | No. | Prop. (%) | No. | Prop. (%) |
| **Out-of-home care** | **669** | **100** | **507** | **100** | **1,176** | **100**[80] |
| Physical violence | 340 | 51 | 282 | 56 | 622 | 53 |
| Significant neglect of a child | 132 | 20 | 95 | 19 | 227 | 19 |
| Behaviour that causes significant emotional or psychological harm to a child | 123 | 18 | 72 | 14 | 195 | 17 |
| Sexual offences | 36 | 5 | 29 | 6 | 65 | 6 |
| Sexual misconduct | 38 | 6 | 29 | 6 | 67 | 6 |
| **Education**[81] | **548** | **100** | **343** | **100** | **891** | **100** |
| Physical violence | 186 | 34 | 147 | 43 | 333 | 37 |
| Sexual misconduct | 201 | 37 | 116 | 34 | 317 | 36 |
| Behaviour that causes significant emotional or psychological harm to a child | 117 | 21 | 57 | 17 | 174 | 20 |
| Sexual offences | 33 | 6 | 19 | 6 | 52 | 6 |
| Significant neglect of a child | 11 | 2 | 4 | 1 | 15 | 2 |
| **Early childhood** | **24** | **100** | **199** | **100** | **223** | **100** |
| Physical violence | 18 | 75 | 156 | 78 | 174 | 78 |
| Significant neglect of a child | 1 | 4 | 18 | 9 | 19 | 9 |
| Behaviour that causes significant emotional or psychological harm to a child | 5 | 21 | 17 | 9 | 22 | 10 |
| Sexual offences | 0 | – | 4 | 2 | 4 | 2 |
| Sexual misconduct | 0 | – | 4 | 2 | 4 | 2 |

76 Analysis of reportable allegations by sector type and type of reportable conduct needs to be viewed in the context of the Scheme being in its early stages. In particular, it is too early to identify trends for sectors or in types of reportable conduct. Further, some sectors including out-of-home care and education have been subject to the Scheme for 24 months, whereas other sectors have only been subject to the Scheme for six months. Additionally, this analysis is of reportable allegations, not substantiated incidents of reportable conduct.

77 If a reportable conduct type does not appear under a sector, this is because no allegations of that reportable conduct type have been received for that sector. Reportable conduct types have been grouped in this table. Physical violence, sexual misconduct and sexual offences includes against, with, or in the presence of a child.

78 In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 annual report. Variations are attributable to the fact that Scheme data is live and includes open matters, causing some movement of data over time. This is due to new information coming to light that alters previous classifications or results in matters being excluded because they are discovered to be out of the scope of the Scheme.

79 Rounding may result in percentages not adding up to 100.

80 Rounding may result in percentages not adding up to 100.

81 Education includes Victorian Government, independent and Catholic schools, and other education institutions.

***Table 19. Reportable allegations by sector and type of reportable conduct 2017–19 (continued)***

| Sector[77] | 2017–18[78] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%)[79] | No. | Prop. (%) | No. | Prop. (%) |
| **Youth justice** | **57** | **100** | **65** | **100** | **122** | **100** |
| Physical violence | 35 | 61 | 58 | 89 | 93 | 76 |
| Sexual misconduct | 13 | 23 | 1 | 2 | 14 | 11 |
| Significant neglect of a child | 5 | 9 | 3 | 5 | 8 | 7 |
| Sexual offences | 3 | 5 | 1 | 2 | 4 | 3 |
| Behaviour that causes significant emotional or psychological harm to a child | 1 | 2 | 2 | 3 | 3 | 2 |
| **Religious body** | **24** | **100** | **88** | **100** | **112** | **100** |
| Sexual offences | 8 | 33 | 47 | 53 | 55 | 49 |
| Sexual misconduct | 10 | 42 | 13 | 15 | 23 | 21 |
| Physical violence | 3 | 13 | 9 | 10 | 12 | 11 |
| Significant neglect of a child | 0 | – | 11 | 13 | 11 | 10 |
| Behaviour that causes significant emotional or psychological harm to a child | 3 | 13 | 8 | 9 | 11 | 10 |
| **Disability services** | **45** | **100** | **28** | **100** | **73** | **100** |
| Physical violence | 26 | 58 | 20 | 71 | 46 | 63 |
| Sexual misconduct | 10 | 22 | 5 | 18 | 15 | 21 |
| Significant neglect of a child | 5 | 11 | 1 | 4 | 6 | 8 |
| Sexual offences | 3 | 7 | 1 | 4 | 4 | 5 |
| Behaviour that causes significant emotional or psychological harm to a child | 1 | 2 | 1 | 4 | 2 | 3 |
| **Other** | **21** | **100** | **22** | **100** | **43** | **100** |
| Physical violence | 6 | 29 | 7 | 32 | 13 | 30 |
| Sexual misconduct | 10 | 48 | 2 | 9 | 12 | 28 |
| Behaviour that causes significant emotional or psychological harm to a child | 4 | 19 | 4 | 18 | 8 | 19 |
| Sexual offences | 1 | 5 | 5 | 23 | 6 | 14 |
| Significant neglect of a child | 0 | – | 4 | 18 | 4 | 9 |
| **Child protection** | **23** | **100** | **2** | **100** | **25** | **100** |
| Physical violence | 12 | 52 | 0 | – | 12 | 48 |
| Sexual offences | 5 | 22 | 1 | 50 | 6 | 24 |

***Table 19. Reportable allegations by sector and type of reportable conduct 2017–19 (continued)***

| Sector[77] | 2017–18[78] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%)[79] | No. | Prop. (%) | No. | Prop. (%) |
| Sexual misconduct | 4 | 17 | 0 | – | 4 | 16 |
| Significant neglect of a child | 1 | 4 | 1 | 50 | 2 | 8 |
| Behaviour that causes significant emotional or psychological harm to a child | 1 | 4 | 0 | – | 1 | 4 |
| **Health** | **4** | **100** | **15** | **100** | **19** | **100** |
| Sexual misconduct | 0 | – | 8 | 53 | 8 | 42 |
| Behaviour that causes significant emotional or psychological harm to a child | 2 | 50 | 3 | 20 | 5 | 26 |
| Sexual offences | 2 | 50 | 2 | 13 | 4 | 21 |
| Physical violence | 0 | – | 2 | 13 | 2 | 11 |
| **Victorian Government departments** | **6** | **100** | **2** | **100** | **8** | **100** |
| Physical violence | 4 | 67 | 2 | 100 | 6 | 75 |
| Sexual offences | 1 | 17 | 0 | – | 1 | 13 |
| Behaviour that causes significant emotional or psychological harm to a child | 1 | 17 | 0 | – | 1 | 13 |
| **Accommodation** | **5** | **100** | **0** | **–** | **5** | **100** |
| Sexual offences | 2 | 40 | 0 | – | 2 | 40 |
| Behaviour that causes significant emotional or psychological harm to a child | 2 | 40 | 0 | – | 2 | 40 |
| Significant neglect of a child | 1 | 20 | 0 | – | 1 | 20 |
| **Total** | **1,426** | **100** | **1,271** | **100** | **2,697** | **100** |

## Alleged victims

This analysis relates to notifications of reportable allegations, not substantiated incidents of reportable conduct. The term alleged victim has been used in this section to reflect this.

There were 768 unique alleged victims related to the 805 mandatory notifications received between July 2018 and June 2019.[82] There have been 1,502 unique alleged victims since the start of the Scheme. Alleged victims[83] must be aged under 18 years at the time of the alleged conduct for the conduct to be covered by the Scheme.

Sixty-two per cent of unique alleged victims[84] of an allegation of reportable conduct in 2018–19 were male and 37 per cent were female.[85]

Since the start of the Scheme, 58 per cent of unique alleged victims have been male and 42 per cent have been female.

The majority of unique alleged victims in 2018–19 were involved in one notification (88 per cent), however, a small proportion were involved in multiple notifications. In 2018–19, 18 per cent of mandatory notifications involved more than one alleged victim.

Sixty-seven per cent of allegations of physical violence involved a male alleged victim.

In 2018–19, alleged victims in a reportable allegation of sexual misconduct were more likely to be female than male. This type of conduct accounted for 21 per cent of all allegations involving a female alleged victim and seven per cent of all allegations involving a male alleged victim.

In last year's annual report, a typographical error was made in Figure 1 on page 82. Blue should represent female alleged victims and orange should represent male alleged victims.

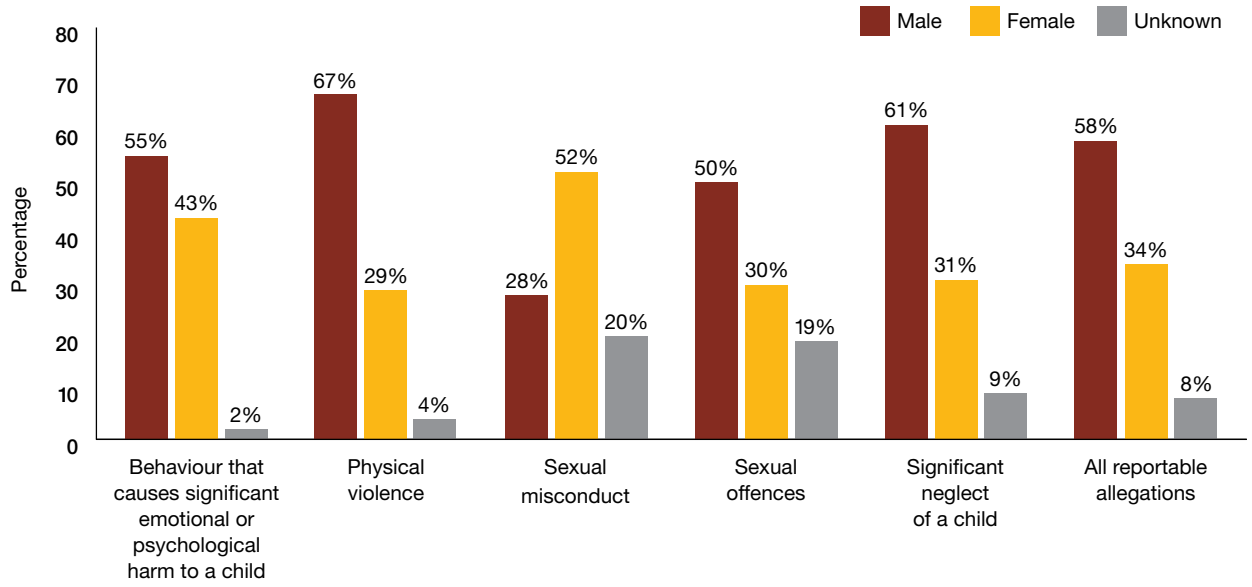
82 Unique alleged victims refer to an individual child or young person who has been the victim of a reportable allegation at least once during the Scheme. Where the unique alleged victims are referred to in terms of the financial year, then this refers to the number of individuals who were the victim of a reportable allegation within the financial year referenced. Where a child or young person has been the victim of multiple allegations over multiple years, they will be counted once for each financial year. Totals since the start of the Scheme only count each unique alleged victim once for the two-year period.

83 Alleged victims can be the subject of multiple notifications to the Commission and multiple reportable allegations. These allegations could involve conduct by one or more workers or volunteers.

84 The following analysis is related to unique individuals who have been the alleged victim of one or more allegation of reportable conduct within the reporting period. It should be noted that the Commission is not always provided with identifying information regarding the alleged victim of a reportable conduct allegation and therefore, data relating to allegations without an identified alleged victim has been excluded from the following analysis. There were 96 allegations of reportable conduct reported to the Commission with no identified alleged victim.

85 Alleged victims can be involved in more than one allegation, which can be related to multiple types of reportable conduct. In order to provide analysis related to unique alleged victims, the type of conduct reported at each individual's first allegation has been used.

***Figure 3. Reportable allegations by type of reportable conduct and gender of alleged victims 2018–19***




### *Aboriginal and/or Torres Strait Islander status, cultural background and disability status of alleged victims*

In 2018–19, organisations subject to the Scheme identified:

- 11 per cent of unique alleged victims as being Aboriginal and/or Torres Strait Islander
- 13 per cent of unique alleged victims as being from a culturally and/or linguistically diverse (CALD) background
- seven per cent of unique alleged victims as having disability.

The Commission was not provided with details of characteristics of the alleged victim in a high number of matters. We continue to emphasise the importance of organisations providing cultural safety to participants in reportable conduct investigations, and ensuring those with disability are supported to participate in investigations. In the next financial year, the Commission will further increase efforts to require organisations to turn their minds to these characteristics.

### *Age of alleged victims at the time of reportable conduct*

The average age of alleged victims at the time of the first reportable conduct was ten years of age. The majority of alleged victims reported in 2018–19 were in the 10–14 years age group (26 per cent).

The significant increase in 2018–19 in alleged victims aged zero to four years reflects the full entry of the early childhood sector into the Scheme in this year.

***Table 20. Age of unique alleged victim at date of first alleged reportable conduct 2017–19***

| Age | 2017–18 | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| 0–4 years | 73 | 9 | 165 | 21 | 235 | 16 |
| 5–9 years | 136 | 17 | 164 | 21 | 292 | 19 |
| 10–14 years | 232 | 30 | 201 | 26 | 417 | 28 |
| 15–17 years | 184 | 23 | 167 | 22 | 334 | 22 |
| 18 years | 3 | <1 | 0 | – | 3 | <1 |
| Not identified | 150 | 19 | 71 | 9 | 221 | 15 |
| **Total** | **778** | **100** | **768** | **100** | **1,502** | **100** |

### *Age of alleged victim and alleged reportable conduct type*[86]

Across all age groups, alleged victims were most likely to be exposed to physical violence. Just under a third of all physical violence allegations were reported in respect of children aged 10 to 14 years (29 per cent) and the majority of all sexual misconduct allegations were reported in respect of children aged 15 to 17 years (39 per cent).

## Subjects of allegation

A worker or volunteer who is alleged to have committed reportable conduct is known as the subject of allegation. A subject of allegation must be aged 18 years or over at the time of the alleged reportable conduct.

A person can be the subject of allegation for more than one notification with multiple reportable allegations involving more than one alleged victim.

There were 713 unique individuals[87] who were subjects of allegation across the 805 notifications and 1,271 reportable allegations in 2018–19. The majority of individuals were subject to only one allegation (64 per cent). A small proportion (five per cent) were the subject of five or more allegations. There was an average of five reportable allegations per subject of allegation.

Since the start of the Scheme, there have been 1,373 unique subjects of allegation.

### *Employment status of subjects of allegation*

The Commission has five categories for the employment status of subjects of allegation. These are based on their relationship to the organisation that is subject to the Scheme and has submitted the mandatory notification about their alleged conduct. Sixty-eight per cent of subjects of allegation were identified as employees of an organisation and 23 per cent were identified as foster or kinship carers in 2018–19, which is consistent with 2017–18.

86 Data in this section is based on total number of allegations and not unique alleged victims.

87 Unique subjects of allegation refers to an individual who has been the subject of a reportable allegation at least once during the Scheme. Where the unique subjects of allegation are referred to in terms of the financial year, then this refers to the number of individuals who were the subject of a reportable allegation within the financial year referenced. Where an individual has been the subject of multiple allegations over multiple years, they will be counted once for each financial year. Totals since the start of the Scheme only count each unique subject of allegation once for the two-year period.

***Table 21. Employment type of unique subjects of allegation 2017–19***[88]

| Employment type | 2017–18[89] | | 2018–19 | | Since start of Scheme[90] | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| Employee | 487 | 70 | 485 | 68 | 949 | 69 |
| Foster or kinship carer | 185 | 27 | 167 | 23 | 339 | 25 |
| Minister of religion or religious leader | 6 | <1 | 35 | 5 | 41 | 3 |
| Volunteer | 14 | 2 | 26 | 4 | 40 | 3 |
| Other | 4 | <1 | 0 | – | 4 | <1 |
| **Total** | **696** | **100** | **713** | **100** | **1,373** | **100** |

### *Gender of subjects of allegation and type of reportable conduct*

Of the 713 individual subjects of allegation in 2018–19, half were male and half were female.

Physical violence made up 54 per cent of all allegations and was the largest category of reportable allegations for both genders.

In 2018–19, over 90 per cent of all sexual misconduct and sexual offence reportable allegations were made against male subjects of allegation. Female subjects of allegation were more likely to be the subject of a reportable allegation of significant neglect of a child (71 per cent) compared with men (29 per cent).

In 2018–19, there was a notable increase in the number of allegations of physical violence against female subjects of allegation, and this is likely attributable to the full entry of the early childhood sector into the Scheme, given the high percentage of women in that workforce.

88 An individual can be the subject of allegation in more than one notification and may have different roles in different organisations.

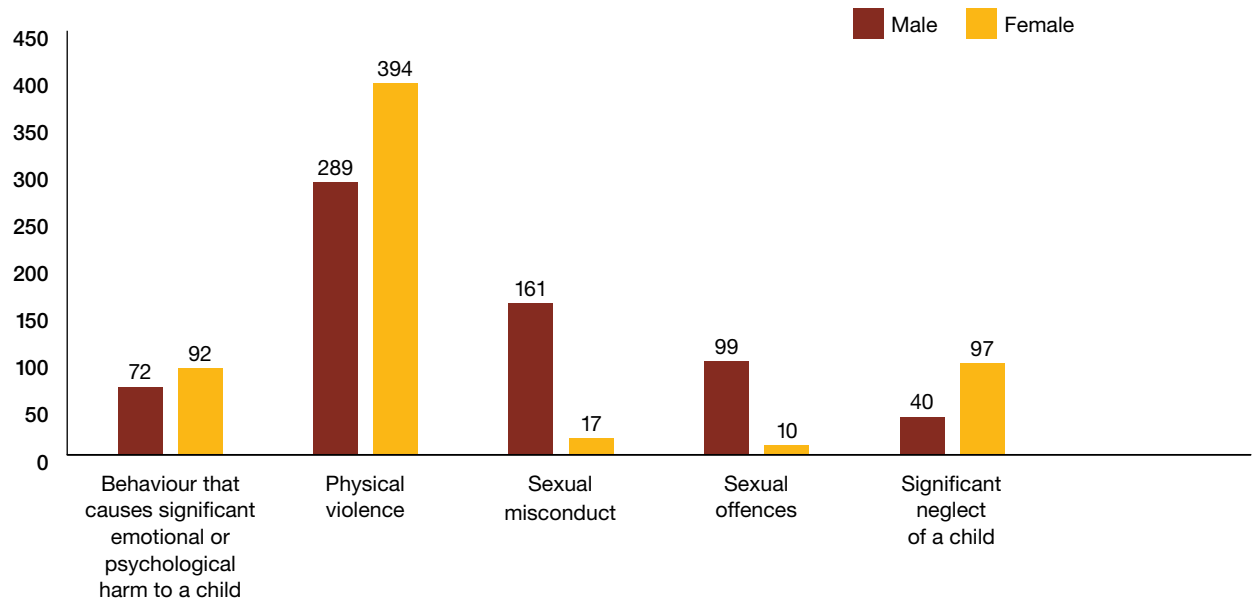
89 In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 annual report. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified as one notification.

90 Unique subjects of allegation refers to an individual who has been the subject of a reportable allegation at least once during the Scheme. Where the unique subjects of allegation are referred to in terms of the financial year, then this refers to the number of individuals who were the subject of a reportable allegation within the financial year referenced. Where an individual has been the subject of multiple allegations over multiple years, they will be counted once for each financial year. Totals since the start of the Scheme only count each unique subject of allegation once for the two-year period.

***Table 22. Reportable allegations by gender of subjects of allegation and type of reportable conduct 2017–19***

| Gender of subjects of allegation and conduct type | 2017–18 | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| **Female** | **672** | **100** | **610** | **100** | **1,282** | **100**[91] |
| Physical violence | 329 | 49 | 394 | 65 | 723 | 56 |
| Behaviour that causes significant emotional or psychological harm to a child | 126 | 19 | 92 | 15 | 218 | 17 |
| Significant neglect of a child | 126 | 19 | 97 | 16 | 223 | 17 |
| Sexual misconduct | 70 | 10 | 17 | 3 | 87 | 7 |
| Sexual offences | 21 | 3 | 10 | 2 | 31 | 2 |
| **Male** | **754** | **100** | **661** | **100** | **1,415** | **100** |
| Physical violence | 301 | 40 | 289 | 44 | 590 | 42 |
| Sexual misconduct | 216 | 29 | 161 | 24 | 377 | 27 |
| Behaviour that causes significant emotional or psychological harm to a child | 134 | 18 | 72 | 11 | 206 | 15 |
| Sexual offences | 73 | 10 | 99 | 15 | 172 | 12 |
| Significant neglect of a child | 30 | 4 | 40 | 6 | 70 | 5 |
| **Total** | **1,426** | **100** | **1,271** | **100** | **2,697** | **100** |

***Figure 4. Reportable allegations by type of conduct and gender of subjects of allegation 2018–19***




[91] Rounding may result in percentages not adding up to 100.

### *Age and gender of subjects of allegation at date of first alleged reportable conduct*

Consistent with the previous year, in 2018–19 the mean age of subjects of allegation when they allegedly committed their first act of reportable conduct was 44 years.

Nearly one quarter of all female subjects of allegation were aged between 50 to 59 years (24 per cent), while male subjects of allegation were proportionally younger with nearly one quarter aged between 30 and 39 years (22 per cent).

## Findings from investigations into reportable allegations

The head of an organisation must investigate a reportable allegation and provide findings to the Commission.

While organisations have some flexibility in how they conduct investigations to meet legal requirements, the Commission has a statutory objective under the *Child Wellbeing and Safety Act 2005* to ensure that investigations are properly conducted and are of a sufficiently high standard to achieve the purposes of the Act. The Commission has issued guidance for organisations to assist them to meet their obligations.

Investigations into reportable allegations can take time to be finalised. Sometimes this is due to a criminal investigation by Victoria Police. Other times organisations are simply following good investigatory practice by gathering evidence, engaging with alleged victims, interviewing relevant witnesses and affording natural justice to subjects of allegation. In some cases, organisations have not prioritised investigations to ensure a timely and appropriate finding is made. Delays in investigations can impact all parties, including the alleged victims and subject of allegation. While some delays may be unavoidable, such as awaiting a criminal investigation, it is important that all parties are regularly updated on progress.

### *Finalised mandatory notifications*

Out of the 1,611 mandatory notifications received by the Commission since the start of the Scheme, 818 (51 per cent) were finalised as at 30 June 2019 and 113 (14 per cent) were assessed as being outside the Scheme's jurisdiction. At 30 June 2019, 793 mandatory notifications remained open.

Of the 806 mandatory notifications received by the Commission in 2017–18, 605 (75 per cent) had been finalised at 30 June 2019. Twenty-six per cent of notifications received in 2018–19 were finalised within the year.

There were 170 mandatory notifications finalised in 2017–18, and 648 finalised in 2018–19. The finalisation rate for 2018–19 was 80 per cent.[92]

Ideally the Commission finalises its reviews of findings made by organisations together with investigation reports shortly after they are received by the Commission. This enables issues to be raised quickly with organisations, and feedback to occur in a timely way.

Unfortunately, the finalisation of some investigations into reportable allegations throughout the Scheme was delayed due to the large volume of matters being overseen by the Commission. The Commission received some supplementary funding from DHHS to support hiring additional short-term staff to assist with the high volume. The Commission prioritised the finalisation of cases presenting higher risks to the safety of children, in particular where there had been substantiated reportable conduct. The continued implementation of the risk-based framework set out in the new regulatory approach will assist the Commission to better manage the high volume of mandatory notifications going forward. The Commission will also continue to keep government advised of demand and its associated resourcing needs.

[92] This is the rate of closures of notifications compared with new notifications being received.

### *Reportable conduct findings*

The Commission considers a notification is finalised when the organisation has conducted an investigation in accordance with requirements of the *Child Wellbeing and Safety Act 2005*, submitted its findings to the Commission and provided all requested information and documents to the Commission. The Commission reviews the investigation and, if satisfied, makes necessary referrals to other regulators, including referring substantiated reportable conduct to the Secretary of the Department of Justice and Community Safety for the purposes of a Working with Children Check reassessment.

The 705 notifications[93] finalised since the Scheme commenced involved the investigation of 1,470 reportable allegations by organisations subject to the Scheme. Organisations must make findings on the balance of probabilities and each reportable allegation must have a finding.

In 2018–19, 32 per cent of reportable allegations were substantiated. For all allegations finalised since the start of the Scheme, the substantiation rate was 31 per cent as at 30 June 2019.

Allegations of different types of conduct appear to have different substantiation rates. For example, since the Scheme began 50 per cent of allegations of significant neglect of a child and 31 per cent of allegations of physical violence committed against a child have been substantiated, compared to only 22 per cent of allegations regarding behaviour that causes significant emotional or psychological harm to a child, and 11 per cent of sexual offences committed against a child.

***Table 23. Findings per allegation by year of finalisation by the Commission 2017–19***

| Finding type | 2017–18 | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| Substantiated | 76 | 31 | 386 | 32 | 462 | 31 |
| Unsubstantiated – insufficient evidence | 55 | 22 | 312 | 26 | 367 | 25 |
| Unsubstantiated – lack of evidence of weight | 34 | 14 | 250 | 20 | 284 | 19 |
| Unfounded | 13 | 5 | 86 | 7 | 99 | 7 |
| Conduct outside Scheme | 71 | 29 | 187 | 15 | 258 | 18 |
| **Total** | **249** | **100** | **1,221** | **100** | **1,470** | **100** |

[93] This excludes mandatory notifications determined to be outside the scope of the Scheme.

## Substantiated reportable conduct

Since the start of the Scheme, 462 reportable allegations have been substantiated. Over half of the incidents of substantiated reportable conduct were committed by workers or volunteers[94] in the out-of-home care sector (55 per cent), followed by the education sector (35 per cent). Workers and volunteers in these sectors have more frequent contact with children than some other sectors. These two sectors have also been in the Scheme since 1 July 2017 whereas other sectors have been in for a shorter period.

***Table 24. Substantiated reportable conduct incidents by sector by year of finalisation by the Commission 2017–19***

| Sector | 2017–18<br>No. | 2018–19<br>No. | Since start of Scheme<br>No. |
|---|---|---|---|
| OOHC | 39 | 216 | 255 |
| Education | 28 | 134 | 162 |
| Early childhood | 0 | 19 | 19 |
| Disability services | 3 | 7 | 10 |
| Religious body | 3 | 3 | 6 |
| Other | 2 | 3 | 5 |
| Victorian Government departments | 1 | 2 | 3 |
| Child protection | 0 | 2 | 2 |
| **Total** | **76** | **386** | **462** |

The largest category of substantiated reportable conduct was physical violence (54 per cent).

[94] The term 'worker or volunteer' includes foster carers, kinship carers, religious leaders and all other adults with a substantiated allegation of reportable conduct.

***Table 25. Substantiated reportable conduct incidents by conduct type and year of finalisation by the Commission 2017–19***

| Conduct Type | 2017–1<br>No. | 2018–19<br>No. | Since start of Scheme<br>No. |
|---|---|---|---|
| **Physical violence** | **26** | **224** | **250** |
| Physical violence committed against a child | 21 | 156 | 177 |
| Physical violence committed in the presence of a child | 5 | 67 | 72 |
| Physical violence committed with a child | 0 | 1 | 1 |
| **Significant neglect of a child** | **14** | **68** | **82** |
| **Sexual misconduct** | **20** | **45** | **65** |
| Sexual misconduct committed against a child | 19 | 37 | 56 |
| Sexual misconduct committed in the presence of a child | 1 | 6 | 7 |
| Sexual misconduct committed with a child | 0 | 2 | 2 |
| **Behaviour that causes significant emotional or psychological harm to a child** | **16** | **42** | **58** |
| **Sexual offences** | **0** | **7** | **7** |
| Sexual offence committed against a child | 0 | 6 | 6 |
| Sexual offence committed with a child | 0 | 1 | 1 |
| **Total** | **76** | **386** | **462** |

### *Victims of substantiated reportable conduct*

The 462 incidents of substantiated reportable conduct since the Scheme began involved 302[95] unique identified victims. Over half of the victims were male (58 per cent), and the majority were aged five to 14 years at the time of the first incident of substantiated reportable conduct. The majority of victims (53 per cent) had only one substantiated incident.

[95] Unique victims refer to an individual child or young person who has been the victim of an incident of substantiated reportable conduct at least once during the Scheme. Where the unique victims are referred to in terms of the financial year, then this refers to the number of individuals who were the victim of an incident of substantiated reportable conduct within the financial year referenced. Where a child or young person has been the victim of multiple incidents over multiple years, they will be counted once for each financial year. Totals since the start of the Scheme only count each unique victim once for the two-year period.

### *Persons found to have engaged in substantiated reportable conduct*

The 462 incidents of substantiated reportable conduct since the Scheme began involved conduct by 221 individuals. Over half of the persons found to have engaged in substantiated reportable conduct since the Scheme commenced were employees of an organisation (61 per cent). A further 37 per cent were foster or kinship carers, and the remaining two per cent were spread across volunteers and others.[96]

Of the 221 individuals, over half (53 per cent) were female and 47 per cent were male. Most persons found to have engaged in substantiated reportable conduct were aged between 40 and 69 years. The majority had one substantiated mandatory notification[97] (86 per cent), and only five individuals had three or more substantiated mandatory notifications.[98]

***Table 26. Unique persons found to have engaged in substantiated reportable conduct by gender and year of Commission finalisation 2017–19***[99]

| Gender | 2017–18 | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. (%) | Prop. (%) |
| Female | 18 | 55 | 103 | 54 | 118 | 53 |
| Male | 15 | 45 | 88 | 46 | 103 | 47 |
| **Total** | **33** | **100** | **191** | **100** | **221** | **100** |

96 Rounding may result in percentages not adding up to 100.

97 Each mandatory notification could include multiple allegations and multiple victims.

98 Each mandatory notification could include multiple allegations and multiple victims.

99 Unique persons found to have engaged in substantiated reportable conduct refers to an individual adult who has had a substantiated finding of reportable conduct at least once during the Scheme. Where the unique person found to have engaged in substantiated reportable conduct is referred to in terms of the financial year, then this refers to the number of individuals who had a substantiated finding of reportable conduct within the financial year referenced. Where an adult has had multiple findings of substantiated reportable conduct over multiple years, they will be counted once for each financial year. Totals since the start of the Scheme only count each unique person found to have engaged in substantiated reportable conduct once for the two-year period.

## Historical allegations

An historical allegation is an allegation of reportable conduct where the alleged conduct occurred prior to the organisation that engaged the subject of allegation coming into the Scheme.[100]

The Scheme requires certain allegations of past or historical reportable conduct to be reported to the Commission and investigated by organisations. This is a complex part of the Scheme and organisations are encouraged to contact the Commission to discuss individual cases as there are various factors to consider as to whether individual historical allegations are in scope of the Scheme.

Investigations into historical allegations can also be more difficult for organisations to undertake, requiring greater support from the Commission. Investigations can also involve adult victim/survivors.

Since the Scheme commenced, ten per cent of mandatory notifications (159) have involved alleged conduct which is historical, involving 314 allegations. Over half of these historical notifications relate to alleged conduct that occurred in the three years prior to the Scheme commencing (56 per cent). However, 15 per cent of these historical notifications refer to alleged conduct that occurred prior to 1980.

The proportion of reportable allegations for sexual offences and sexual misconduct is much higher in historical allegations than in allegations of contemporary conduct.

Of historical notifications about alleged conduct prior to the year 2000, 72 per cent related to alleged reportable conduct in religious bodies and 23 per cent in schools. Sixty-six per cent of historical allegations for this period were for sexual offences. Twelve per cent of allegations were for significant neglect of a child, with some of these potentially involving allegations of an adult in a position of organisational power failing to act to protect children from known child sex offenders.

The Loud Fence movement was established to remember the victims of child sexual abuse by religious organisations, which are covered by the Reportable Conduct Scheme.

## Sharing information

A key element of the Scheme is the sharing of information about allegations, findings and other information to assist organisations to take action to support safety for children. The information-sharing provisions in the *Child Wellbeing and Safety Act 2005* have now been supplemented by the commencement of the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme in Victoria.

[100] For example, religious bodies were brought into the Scheme on 1 January 2018. An historical allegation in relation to a religious body concerns conduct alleged to have occurred before 1 January 2018. These allegations will be covered by the Scheme where the allegation was raised after that date, and the subject of allegation was employed or engaged by an organisation covered by the Scheme after that date.

With new organisations in the early childhood sector brought into the Scheme from 1 January 2019 the Commission has commenced sharing certain information about reportable conduct allegations and investigations with the early childhood regulator, the Quality Assessment and Regulation Division of the Department of Education and Training.

In 2018–19, the Commission also started discussions with the Australian Health Practitioner Regulation Agency as the regulator of health professionals, and the NDIS Quality and Safeguards Commission as the new regulator of disability providers, to support expanded information-sharing in these sectors. The Commission will continue to expand its collaboration and information-sharing network of regulators to support the safety of children.

## Notifications to Victoria Police

Organisations are required to notify Victoria Police of all reportable allegations that involve conduct that may be criminal in nature. Victoria Police investigations take priority, which means that if an allegation may involve criminal conduct an organisation cannot commence an investigation until they receive clearance from Victoria Police to do so. The Commission reviews each mandatory notification to assess whether the conduct may be criminal in nature and, if so, whether it has been referred to Victoria Police.

Of the 805 notifications of reportable allegations made to the Commission in 2018–19, 59 per cent were reported to Victoria Police by either the organisation or the Commission due to possible criminal conduct.[101]

Victoria Police conducted an investigation in 60 per cent of notifications reported to them – 51 per cent have been completed and the remaining nine per cent are in progress.

Victoria Police advises that for the period 1 July 2017 to 30 June 2019, the Commission referred 198 notifications that had not previously been reported to police. In addition, the Commission referred 37 matters that involved conduct that might be criminal in nature that were not within the jurisdiction of the Scheme.

Where a notification has been investigated and charges laid, outcomes since the start of the Scheme have included:

- terms of imprisonment, including suspended sentences
- good behaviour bonds
- community corrections orders
- diversion
- adjournment without conviction.

***Table 27. Status of notifications of reportable allegations reported to Victoria Police 2017–19***

| Victoria Police status of notification | Number of notifications | Percentage |
|---|---|---|
| Awaiting update from Police | 47 | 5 |
| Investigation complete (no further police action) | 418 | 46 |
| Investigation complete (criminal charges laid/ pending)[102] | 43 | 5 |
| No further police action | 322 | 35 |
| Under investigation | 81 | 9 |
| **Total** | **911** | **100** |

[101] Of all the mandatory notifications received by the Commission since the start of the Scheme, again 59 per cent were reported to Victoria Police due to possible criminal conduct.

[102] Includes matters where the subject of allegation was exonerated, or no criminal offence detected; the alleged victim withdrew their complaint; family violence was identified with no criminal offence; the subject of allegation was deceased, or the subject of allegation was interviewed but there was insufficient evidence to prosecute.

## Referrals to Working with Children Check Unit

An important part of the Commission's role in supporting safety for children is to refer substantiated allegations of reportable conduct to the Secretary to the Department of Justice and Community Safety (DJCS) for the purpose of a reassessment of the appropriateness of the subject of allegation retaining a Working with Children Check under the *Working with Children Act 2005*.

In 2018–19, 191 individuals found to have engaged in substantiated reportable conduct were referred to DJCS in relation to 386 substantiated allegations of reportable conduct.

Since the start of the Scheme, 223 individuals found to have engaged in substantiated reportable conduct have been referred to DJCS in relation to 465[103] substantiated allegations of reportable conduct.

## Referrals to Victorian Institute of Teaching (VIT)

On becoming aware that a registered teacher is the subject of a reportable allegation, the Commission must notify the VIT pursuant to the *Education Training and Reform Act 2006*. Teachers are the only profession where their professional regulator must be advised of all reportable allegations, not only substantiated findings.

The Commission must also refer any findings of substantiated reportable conduct to the VIT at the completion of an investigation. In practice, the Commission referred all findings from completed reportable conduct investigations to VIT in 2018–19 consistent with last year. The Commission has adopted this practice to assist VIT to have information on record about the final outcome of an investigation, whether substantiated or not. In this way, subjects of allegation can have confidence that VIT has information in relation to the final finding, not just that an allegation was made.

In 2018–19, the Commission advised VIT of 137[104] notifications of reportable allegations[105] in relation to registered teachers. Since the start of the Scheme, the Commission has advised VIT of 329 notifications, relating to 320 unique registered teachers

The Commission has shared information with VIT about the findings in 174 finalised notifications since the start of the Scheme.

## Public notifications

The Commission can be notified of allegations by any person. Persons making a public notification can remain anonymous and have protection under the *Child Wellbeing and Safety Act 2005* if disclosures are made in good faith.

In 2018–19, public notifications came from a range of sources including workers in organisations subject to the Scheme, parents, Victoria Police, other regulators and members of the general public. In 2018–19, 14 per cent of public disclosures to the Commission were from Victoria Police.

Where the Commission receives a public notification, it examines whether it is covered by the Scheme. Usually, contact will be made with the relevant organisation to provide information so that a mandatory notification can be made and an investigation commenced.

[103] One additional referral was made by the Commission to DJCS but was subsequently identified as being outside jurisdiction of the Scheme and has been excluded from these figures. This figure includes three incidents of substantiated reportable conduct referred to DJCS that are not included in the substantiated reportable conduct section of this report. These matters were subject to a review within the organisation which changed the finding, or were still under review as at 30 June 2019.

[104] Differing counting rules between organisations may result in small variances. This variance is <1 per cent between the VIT and the Commission.

[105] This refers to notifications of reportable allegations, not individual teachers. Individual teachers could have more than one notification of reportable allegations.

The Commission received 117 disclosures of potential reportable allegations from persons other than the head of an organisation for the period 1 July 2018 to 30 June 2019, an increase of 60 per cent on public notifications in 2017–18.

Disclosures in 2018–19 related to 81 unique organisations. Mandatory notifications were subsequently submitted by organisations in relation to 37 per cent of public notifications.[106]

Due to the relatively small numbers, public notifications received by the Commission can vary substantially from month to month. However, in the last six months to 30 June 2019, public notifications have been consistently higher than in the preceding 18 months.

***Table 28. Public notifications received by sector 2017–19***

| Sector | 2017–18[107] | | 2018–19 | | Since start of Scheme | |
|---|---|---|---|---|---|---|
| | No. | Prop. (%) | No. | Prop. (%) | No. | Prop. (%) |
| Education | 39 | 53 | 53 | 45 | 92 | 48 |
| Out-of-home care | 7 | 10 | 21 | 18 | 28 | 15 |
| Other | 10 | 14 | 12 | 10 | 22 | 12 |
| Religious body | 5 | 7 | 13 | 11 | 18 | 9 |
| Disability services | 4 | 5 | 6 | 5 | 10 | 5 |
| Early childhood | 1 | 1 | 6 | 5 | 7 | 4 |
| Victorian Government departments | 3 | 4 | 2 | 2 | 5 | 3 |
| Child protection | 1 | 1 | 2 | 2 | 3 | 2 |
| Health | 2 | 3 | 1 | <1 | 3 | 2 |
| Accommodation | 1 | 1 | 0 | – | 1 | <1 |
| Youth justice | 0 | – | 1 | <1 | 1 | <1 |
| **Total** | **73** | **100** | **117** | **100** | **190** | **100** |

[106] In some cases, public notifications may be made by multiple people about the same subject of allegation and conduct resulting in one mandatory notification being made.

[107] In some cases, 2017–18 data expressed in this report is different from that in the Commission's 2017–18 annual report. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified as one notification.

## Public enquiries

A critical component of the Commission's approach to supporting organisations to comply with the Reportable Conduct Scheme, and to also drive thorough and effective reportable conduct investigations, is providing advice and guidance in response to contact made by individuals and organisations. The Commission responded to in excess of 1,000 enquiries about the Reportable Conduct Scheme in 2018–19.[108]

## Own-motion investigations and other compliance actions

In limited circumstances, the Commission may, on its own motion, investigate an allegation of reportable conduct by a worker or volunteer who is or was engaged by an organisation subject to the Scheme.

In 2018–19, the Principal Commissioner approved the conduct of the Commission's first two own-motion investigations. The subjects of allegation in these cases are engaged in the education sector and religious bodies.

***Table 29. Reportable Conduct Scheme compliance actions 2018–19***

| Action type | Number |
|---|---|
| Section 16K – recommendation for action regarding reportable conduct systems | 0 |
| Section 16O – own-motion investigation concerning a reportable allegation | 2 |
| Section 16ZG – notice to produce | 0 |

***Table 30. Reportable Conduct Scheme enforcement action 2018–19***

| Action type | Number |
|---|---|
| Section 16ZF – prosecution for providing false or misleading information | 0 |
| Section 16ZH – application for civil penalty – failure to comply with a notice to produce | 0 |

In 2018–19, no Commission decisions were subject to internal review or review by the Victorian Civil and Administrative Tribunal.

***Table 31. Reportable Conduct Scheme decisions reviewed 2018–19***

| Action type | Number |
|---|---|
| Section 16ZI – internal review | 0 |
| Section 16ZJ – review by VCAT | 0 |

[108] Data capture issues this year mean some enquiries were not recorded in a form enabling analysis in 2018–19.

# Corporate services and financial summary

# Corporate services and financial summary

Under section 53 of the *Financial Management Act 1994*, on 20 July 2016, the Minister for Finance approved Commission financials to be included in the accounts of DHHS in its annual report.

Table 32 provides a summary of the Commission's expenditure for 2018–19.

***Table 32. Commission expenditure 2018–19***

| Expenditure | 2018–19 ($) | 2017–18 ($) | 2016–17 ($) |
|---|---|---|---|
| Salaries and on costs | 9,063,503 | 7,545,580.23 | 5,847,138.77 |
| Grants and other transfers | | 396,040.84 | 185,720.60 |
| Operating expenses | 3,514,349 | 3,007,654.08 | 3,170,709.80 |
| Depreciation | | | 10,156.23 |
| **Total** | **12,577,852** | **10,949,275.15** | **9,213,725.40** |

# Appendices

# Appendix 1.
# Disclosure index

Commission for Children and Young People financial statements are now included in the accounts of DHHS and, therefore, disclosures under 'Financial statements required under Part 7 of the *Financial Management Act 1994'*, 'Other requirements under Standing Direction 5.2', and 'Other disclosures are required by FRDs in notes to the financial statements' are referenced in the DHHS report of operations and disclosure index.

***Table 33. Commission disclosures***

| Legislation | Requirement | Page |
|---|---|---|
| ***Standing Directions and Financial Reporting Directions*** | | |
| ***Report of operations*** | | |
| **Charter and purpose** | | |
| FRD22H | Manner of establishment and the relevant ministers | 7, 13 |
| FRD 22H | Purpose, functions, powers and duties | 13 |
| FRD 22H | Key initiatives and projects | 16 |
| FRD 22H | Nature and range of services provided | 13–18 |
| **Management and structure** | | |
| FRD 22H | Organisational structure | 108 |
| **Financial and other information** | | |
| FRD 10A | Disclosure index | 106 |
| FRD 12B | Disclosure of major contracts | 116 |
| FRD 15E | Executive officer disclosures | 114 |
| FRD 22H | Employment and conduct principles | 110 |
| FRD 22H | Occupational health and safety policy | 109 |
| FRD 22H | Summary of the financial results for the year | 104 |
| FRD 22H | Significant changes in financial position during the year | N/A |
| FRD 22H | Major changes or factors affecting performance | N/A |
| FRD 22H | Subsequent events | N/A |
| FRD 22H | National Competition Policy | N/A |
| FRD 22H | Application and operation of *Freedom of Information Act 1982* | 116 |
| FRD 22H | Compliance with building and maintenance provisions of the *Building Act 1993* | 117 |
| FRD 22H | Application and operation of the *Protected Disclosure Act 2012* | 117 |
| FRD 22H | Application and operation of the *Carers Recognition Act 2012* | 118 |
| FRD 22H | Details of consultancies over $10,000 | 115 |
| FRD 22H | Details of consultancies under $10,000 | 115 |
| FRD 22H | Disclosure of government advertising expenditure | 114 |

***Table 33. Commission disclosures (continued)***

| Legislation | Requirement | Page |
|---|---|---|
| ***Standing Directions and Financial Reporting Directions*** | | |
| FRD 22H | Disclosure of ICT expenditure | 116 |
| FRD 22H | Statement of availability of other information | 118 |
| FRD 22H | Compliance with the *Disability Act 2006* | 119 |
| FRD 24C | Reporting of office based environmental impacts | 119 |
| FRD 25C | Local jobs first | 114 |
| FRD 29C | Workforce data disclosures | 112 |
| SD 5.2 | Specific requirements under Standing Direction 5.2 | 1–120 |
| **Compliance attestation and declaration** | | |
| SD 3.2.1.1 | Audit committee membership and roles | 109 |
| SD 3.7.1 | Attestation for compliance with Ministerial Standing Direction | 120 |
| SD 3.7.1 | Financial management attestation statement | 120 |
| SD 5.2.3 | Declaration in report of operations | 1 |
| *Freedom of Information Act 1982* | | 116 |
| *Building Act 1983* | | 117 |
| *Protected Disclosure Act 2012* | | 117 |
| *Carers Recognition Act 2012* | | 118 |
| *Local Jobs First Act 2003* | | 114 |
| *Occupational Health and Safety Act 2004* | | 109 |
| *Public Administration Act 2004* | | 113 |
| *Financial Management Act 1994* | | 1, 104, 120 |

# Appendix 2. Governance and organisational structure

## The Commissioners

### *Principal Commissioner*

Liana Buchanan was appointed Principal Commissioner for Children and Young People in April 2016. She has all the functions and powers of the Commission and any other powers or functions conferred on her by the CCYP Act or any other Act.

### *Commissioner for Aboriginal Children and Young People*

In May 2018, Justin Mohamed was appointed to the role of Commissioner for Aboriginal Children and Young People. He is responsible for leading the functions of the Commission relating to Aboriginal children and young people.

## Executive officers

### *Annie Tinney*

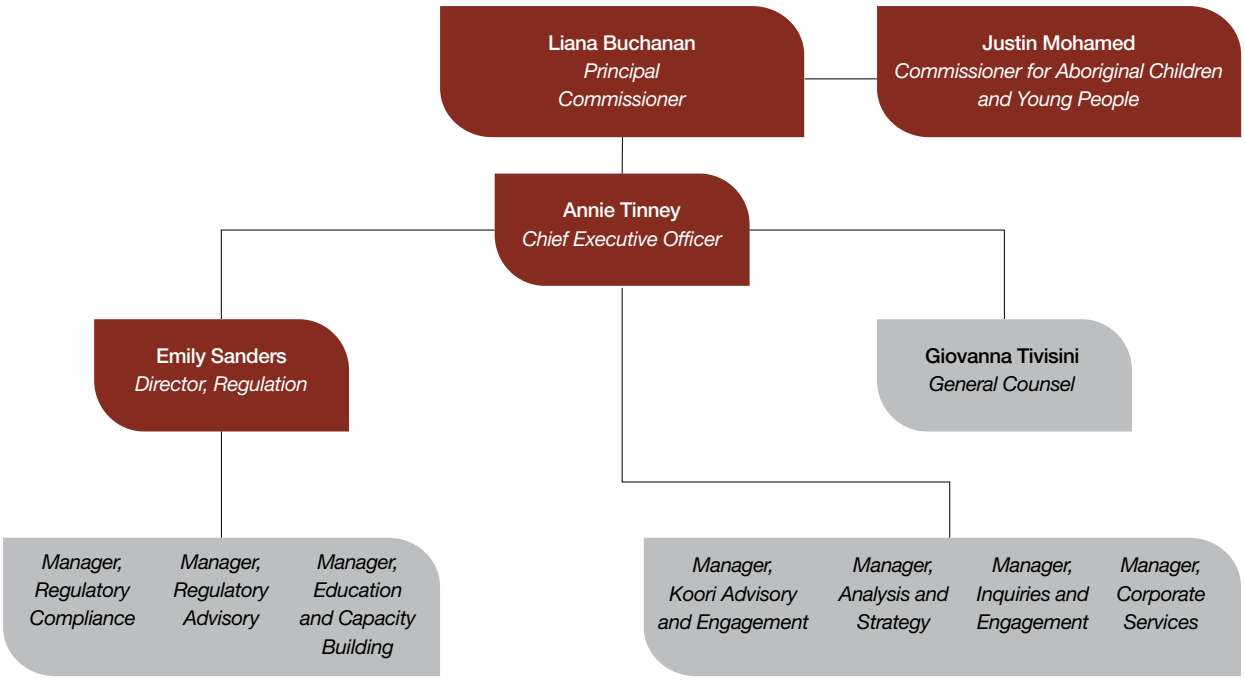
In September 2018, Annie Tinney commenced as the Chief Executive Officer of the Commission replacing Brenda Boland. She provides operational leadership to the Commission and ensures its effective and efficient management.

### *Emily Sanders*

Emily Sanders is Director, Regulation. She is responsible for managing the operational components of the Reportable Conduct Scheme and Child Safe Standards.

## Organisational structure as at 30 June 2019

***Figure 5. Commission organisational chart***



## Audit and risk committee membership and roles

The audit and risk committee consists of the following members:

- David Gibbs, Chairperson
- Sue Crook, Independent Member
- Tony Nippard, Independent Member.

The primary role of the audit and risk committee is to review and advise the executive of the Commission on matters of financial accountability, internal financial control, and risk management.

The audit and risk committee provides oversight and advice to the executive of the Commission in relation to the:

- Commission's financial performance
- Commission's financial reporting processes
- effective operation of the Commission's risk management framework
- charter, scope of work, performance and independence of the Commission's internal audit function
- recommendations made by the internal auditor, including actions to resolve issues raised
- matters of accountability and internal control affecting the financial operations of the Commission
- effectiveness of management information systems and other systems of internal financial control
- acceptability, disclosure of and correct accounting treatment for significant transactions that are not part of the Commission's normal course of business.

## Occupational health and safety

We are committed to ensuring all staff remain safe and healthy at work in accordance with the Commission's obligations under the *Occupational Health and Safety Act 2004* and the *Occupational Health and Safety Regulations 2007*.

In 2018–19 we continued our ongoing internal safety reporting process, workplace inspections, ergonomic assessments for staff and an Employee Assistance Program.

For the third consecutive year, we also continued our engagement with Medibank Health Solutions to deliver expert wellbeing support to all staff at the Commission. The Wellbeing Check program consists of bi-monthly telephone-based counselling for staff to discuss any issues they may be experiencing, either as a result of the subject matter they deal with at work, or any personal concerns.

### *Occupational health and safety committee meetings*

The Commission also has an occupational health and safety committee. The committee consists of elected management and staff representatives, the Commission's health and safety representatives and secretariat. The committee is chaired by the Commission's Manager, Corporate Services.

During 2018–19, four occupational health and safety committee meetings were held.

### *Injuries and incident management*

During 2018–19 there were two reported minor injuries. By comparison, in 2017–18 there were four reported minor injuries.

One injury was classified as an incident, and the other a hazard. The incident related to a staff member walking into a stationary object and the hazard related to the low temperature of the office. Whilst the two were reported, neither of them required any ongoing management or formal follow-up.

In 2018–19 there were no recorded major incidents.

## Employment and conduct principles

We are committed to applying merit and equity principles when appointing staff. Our selection processes ensure that applicants are assessed and evaluated fairly and equitably on the basis of the key selection criteria and other accountabilities without discrimination. Employees have been correctly classified in workforce data collections.

### *Our commitment to child safety*

We are committed to providing a child-safe and child-friendly environment, where children and young people with whom we have contact are safe and feel safe and are able to participate in decisions that affect their lives. Our child-safe policy and child-safe code of conduct apply to the commissioners, staff, contractors, volunteers and authorised persons engaged by the Commission.

# Appendix 3. Workforce data

## Public sector values and employment principles

The *Code of Conduct for Victorian Public Sector Employees of Special Bodies* applies within the Commission.

## Comparative workforce data

We employed 75 people as at 30 June 2019, which is an increase of 19 people at the same time last year (Tables 34a and 34b).

A notable change is the number of fixed-term and casual staff as at 30 June 2019 (26), compared to 30 June 2018 (6).

The changes to workforce trends relate to an increased workload for our new functions, the Child Safe Standards and Reportable Conduct Scheme, and the need for additional employees to manage this work.

# Appendix 3. Workforce data
*continued*

***Table 34a. Workforce data as at 30 June 2019***

| 30 June 2019 | | All employees | | Ongoing | | | Fixed term and casual | |
|---|---|---|---|---|---|---|---|---|
| | | Number (headcount) | FTE | Full-time (headcount) | Part-time (headcount) | FTE | Number (headcount) | FTE |
| Demographic data | **Gender** | | | | | | | |
| | Men | 24 | 23.7 | 13 | 1 | 13.8 | 10 | 9.9 |
| | Women | 51 | 46.9 | 25 | 10 | 32.7 | 16 | 14.2 |
| | Self-described | n* | n | n | n | n | n | n |
| | **Age** | | | | | | | |
| | 15–24 | 1 | 1 | 0 | 0 | 0 | 1 | 1 |
| | 25–34 | 21 | 20.9 | 13 | 0 | 13 | 8 | 7.9 |
| | 35–44 | 28 | 25.5 | 11 | 6 | 15.3 | 11 | 10.2 |
| | 45–54 | 14 | 13.8 | 10 | 2 | 11.8 | 2 | 2 |
| | 55–64 | 11 | 9.4 | 4 | 3 | 6.4 | 4 | 3 |
| | 65+ | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Classification data | **VPS 1–6 grades** | **73** | **68.6** | **36** | **11** | **44.5** | **26** | **24.1** |
| | VPS 3 | 7 | 5.5 | 2 | 2 | 3.5 | 3 | 2 |
| | VPS 4 | 16 | 15.9 | 10 | 1 | 10.9 | 5 | 5 |
| | VPS 5 | 32 | 30.1 | 13 | 6 | 17.2 | 13 | 12.9 |
| | VPS 6 | 18 | 17.1 | 11 | 2 | 12.9 | 5 | 4.2 |
| | **Senior employees** | **2** | **2** | **0** | **0** | **0** | **2** | **2** |
| | Executives | 2 | 2 | 0 | 0 | 0 | 2 | 2 |
| | Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **Total employees** | **75** | **70.6** | **36** | **11** | **44.5** | **28** | **26.1** |

*n=non-described

***Table 34b. Workforce data as at 30 June 2018***

| 30 June 2018 | | All employees | | Ongoing | | | Fixed term and casual | |
|---|---|---|---|---|---|---|---|---|
| | | Number (headcount) | FTE | Full-time (headcount) | Part-time (headcount) | FTE | Number (headcount) | FTE |
| Demographic data | **Gender** | | | | | | | |
| | Men | 17 | 16.9 | 16 | 0 | 15.9 | 1 | 1 |
| | Women | 39 | 36.9 | 24 | 10 | 31.9 | 5 | 5 |
| | Self-described | n* | n | n | n | n | n | n |
| | **Age** | | | | | | | |
| | 15–24 | 1 | 1 | 1 | 0 | 1 | 0 | 0 |
| | 25–34 | 12 | 12 | 12 | 0 | 12 | 0 | 0 |
| | 35–44 | 20 | 19.2 | 12 | 5 | 16.2 | 3 | 3 |
| | 45–54 | 15 | 14.4 | 11 | 3 | 13.4 | 1 | 1 |
| | 55–64 | 8 | 7.2 | 5 | 3 | 7.2 | 0 | 0 |
| | 65+ | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Classification data | **VPS 1–6 grades** | **54** | **51.8** | **39** | **11** | **47.8** | **4** | **4** |
| | VPS 3 | 5 | 4.6 | 4 | 1 | 4.6 | 0 | 0 |
| | VPS 4 | 13 | 12.9 | 11 | 1 | 11.9 | 1 | 1 |
| | VPS 5 | 24 | 22.6 | 14 | 7 | 19.6 | 3 | 3 |
| | VPS 6 | 12 | 11.7 | 10 | 2 | 11.7 | 0 | 0 |
| | **Senior employees** | **2** | **2** | **0** | **0** | **0** | **2** | **2** |
| | Executives | 2 | 2 | 0 | 0 | 0 | 2 | 2 |
| | Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **Total employees** | **56** | **53.8** | **39** | **11** | **47.8** | **6** | **6** |

*n=non-described

The figures in Tables 34a and 34b exclude those on leave without pay or absent on secondment, external contractors/consultants, temporary staff employed by employment agencies, and a small number of people who are not employees but are appointees to a statutory office, as defined in the *Public Administration Act 2004*.

All figures reflect employment levels during the last full pay period of each year.

'Ongoing' employees means people engaged on an open-ended contract of employment and executives engaged on a standard executive contract who are active in the last full pay period of June.

## Executives and other non-executive senior staff

Table 35 discloses the annualised total salary for senior employees of the Commission, categorised by classification.

***Table 35. Annualised total salary by $40,000 bands for executives and other senior non-executive staff***

| Income band (salary) | Executives | Other |
|---|---|---|
| $200,000–239,999 | 2 | 0 |
| $240,000–279,999 | 0 | 2 |
| **Total** | **2** | **2** |

The salary amount is reported as the full-time annualised salary.

### *Data*

The number of executive officers employed by the Commission is provided in Table 36, and Table 37 provides a reconciliation of executive and non-executive senior staff numbers in 2018–19 and 2017–18.

***Table 36. Total number of executive officers for the Commission by gender***

| | Total | | Men | | Women | | Self-described | |
|---|---|---|---|---|---|---|---|---|
| Class | No. | Var. | No. | Var. | No. | Var. | No. | Var. |
| EO3 | 2 | 0 | 0 | 0 | 2 | 0 | n* | n |
| Total | 2 | 0 | | | 2 | 0 | n | n |

*n=non-described

***Table 37. Reconciliation of executive and non-executive senior staff numbers***

| | | 2018–19 | 2017–18 |
|---|---|---|---|
| | Executives | 3 | 3 |
| | Non-executive senior staff | 1 | 2 |
| | Accountable Officer | 1 | 1 |
| *Less* | Separations | (1) | (2) |
| | Total executive numbers at 30 June | 4 | 4 |

Table 37 lists the actual number of executive officers and non-executive senior staff over the reporting period. Separations are executives and non-executive senior staff who have left the Commission during the reporting period.

## Local jobs first

The *Local Jobs First Act 2003* introduced in August 2018 brings together the Victorian Industry Participation Policy (VIPP) and Major Project Skills Guarantee (MPSG) policy which were previously administered separately.

Departments and public sector bodies are required to apply the Local Job first policy in all projects valued at $3 million or more in Metropolitan Melbourne or for statewide projects, or $1 million or more for projects in regional Victoria.

MPSG applies to all construction projects valued at $20 million or more.

We did not engage in any applicable tenders or projects during the reporting period.

## Advertising expenditure

In 2018–19 we have not commissioned any advertising campaigns.

# Appendix 4.
# Other disclosures

## Consultancy expenditure

### *Consultancies $10,000 or greater*

In 2018–19 we engaged ten consultancies with individual costs greater than $10,000. The total value of those consultancies was $683,537 (Table 38).

***Table 38. Consultancies valued at $10,000 or greater***

| Consultant | Purpose of consultancy | Total approved project fee (excl. GST) | Expenditure 2018–19 (excl. GST) | Future expenditure (excl. GST) |
|---|---|---|---|---|
| Drummond Street Services | Capacity-building support for Child Safe Standards of LGBTIQ+ children and young people | $41,000 | $39,927 | $1,073 |
| Cube Group | Development of an operational performance framework | $75,979 | $70,754 | $5,225 |
| Pirac Economics | Risk based audit approach & training | $129,819 | $129,819 | |
| Group Hug Creative | Creation of parent and carer engagement video | $34,996 | $34,996 | |
| Jenny Dwyer Associates | Resources, consultation and training related to the Reportable Conduct Scheme | $32,531 | $32,531 | |
| K Murray Consulting | Reviews of Aboriginal Children's Forum and Working with Children Act | $98,005 | $48,450 | $49,555 |
| Kulturbrille | Child Safe Standards Principles Guidance | $44,850 | $43,940 | $910 |
| Nous Group Pty Ltd | Demand Forecasting Model | $75,100 | $75,100 | |
| Griffith University | Interviewing Children Resources | $128,413 | $128,413 | |
| Blue Knot Foundation | Trauma-informed Approach training and resources | $22,844 | $22,844 | |
| **Total** | | **$683,537** | **$626,774** | **$56,763** |

### *Consultancies less than $10,000*

In 2018–19 we engaged nine consultancies in this category, for a value of $48,222.

### *Information and communication technology expenditure*

For the 2018–19 reporting period we had a total ICT expenditure of $684,989, the details of which are shown in Table 39.

Our non-business-as-usual expenditure was focused on further improvements relating to our case management system to capture and report on Child Safe Standards and the Reportable Conduct Scheme cases, as well as other Commission functions. Costs include hosting and licensing fees.

***Table 39. Commission ICT expenditure***

| Business as usual | Nonbusiness as usual | Operational expenditure | Capital expenditure |
|---|---|---|---|
| (Total) | (Total = Operational expenditure and capital expenditure) | | |
| **$23,696** | **$661,293** | **$93,155** | **$568,138** |

## Disclosure of major contracts

The Commission did not enter in any contracts greater than $10 million in value.

## Freedom of information

The *Freedom of Information Act 1982* (the FOI Act) enables the public to apply to access documents held by public sector agencies including the Commission. The purpose of the FOI Act is to extend as far as possible the right of the community to access information held by government departments, local councils, Ministers and other bodies subject to the FOI Act.

An applicant has a right to apply for access to documents held by the Commission. This comprises documents both created by the Commission or supplied to the Commission by an external organisation or individual, and may also include maps, films, microfiche, photographs, computer printouts, computer discs, tape recordings and videotapes.

The FOI Act allows the Commission to refuse access, either fully or partially, to certain documents or information. Examples of documents that may not be accessed include: cabinet documents; some internal working documents; law enforcement documents; documents covered by legal professional privilege, such as legal advice; personal information about other people; information provided to the Commission in confidence and information acquired by the Commission through its functions.

If an applicant is not satisfied by a decision made by the Commission, under section 49A of the FOI Act they have the right to seek a review by the Office of the Victorian Information Commissioner within 28 days of receiving a decision letter.

### *Making a freedom of information request*

Freedom of Information requests can be made using the options available on our website. An application fee of $28.40 applies. Access charges may also be payable if the document pool is large, and the search for material is time consuming.

Access to documents can also be obtained through a written request to the Commission, as detailed in section 17 of the FOI Act.

When making a Freedom of Information request, applicants should ensure requests are in writing, and clearly identify what types of material/documents are being sought.

Requests for documents in the possession of the Commission should be addressed to:

Freedom of Information Officer
Commission for Children and Young People
Level 18, 570 Bourke St
Melbourne Victoria 3000

### *Freedom of information statistics*

During 2018–19, the Commission received three applications from members of the public. There were no decisions reviewed by the Office of the Victorian Information Commissioner or the Victorian Civil and Administrative Tribunal.

### *Further information*

Further information regarding the operation and scope of Freedom of Information can be obtained from the FOI Act; regulations made under the Act; and www.foi.vic.gov.au.

## Compliance with the *Building Act 1993*

The Commission does not own or control any government buildings and is exempt from notifying its compliance with the building and maintenance provisions of the *Building Act 1993*.

## Compliance with the *Protected Disclosure Act 2012*

The *Protected Disclosure Act 2012* (PDA Act) encourages and assists people in making disclosures of improper conduct by public officers and public bodies. The PDA Act provides protection to people who make disclosures in accordance with the PDA Act, and establishes a system for the matters disclosed to be investigated and rectifying action to be taken.

The Commission does not tolerate improper conduct by employees, nor the taking of reprisals against those who come forward to disclose such conduct. It is committed to ensuring transparency and accountability in its administrative and management practices and supports the making of disclosures that reveal corrupt conduct, conduct involving a substantial mismanagement of public resources, or conduct involving a substantial risk to public health and safety or the environment.

The Commission will take all reasonable steps to protect people who make such disclosures from any detrimental action in reprisal for making the disclosure. It will also afford natural justice to the person who is the subject of the disclosure to the extent it is legally possible.

### *Reporting procedures*

Disclosures of improper conduct or detrimental action by the Commission or any of its employees may be made to:

Principal Commissioner
Commission for Children and Young People
Level 18, 570 Bourke Street
Melbourne VIC 3000

Alternatively, disclosures may also be made directly to the Independent Broad-based Anti-corruption Commission:

Level 1, North Tower 459 Collins Street
Melbourne VIC 3000
**Phone:** 1300 735 135
**Website:** www.ibac.vic.gov.au

***Protected disclosure statistics***

During 2018–19, the Commission did not receive a disclosure from an individual, nor did it notify the Independent Broad-based Anti-corruption Commission of any disclosures.

## Compliance with the *Carers Recognition Act 2012*

We support the principles of the *Carers Recognition Act 2012* and demonstrate this through our commitment to providing flexible working arrangements for our staff to support their roles as carers.

## Additional Commission information available on request

In compliance with the requirements of the Standing Directions of the Minister for Finance, details in respect of the items listed below have been retained by the Commission and are available on request, subject to the provisions of the FOI Act and any other relevant laws and Commission policies.

(a) A statement that declarations of pecuniary interests have been duly completed by all relevant officers.

(b) Details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary.

(c) Details of publications produced by the entity about itself, and how these can be obtained.

(d) Details of changes in prices, fees, charges, rates and levies charged by the entity.

(e) Details of any major external reviews carried out on the entity.

(f) Details of major research and development activities undertaken by the entity.

(g) Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit.

(h) Details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of the entity and its services.

(i) Details of assessments and measures undertaken to improve the occupational health and safety of employees.

(j) A general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes.

(k) A list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved.

(l) Details of all consultancies and contractors including:

  i) consultants/contractors engaged

  ii) services provided

  iii) expenditure committed to for each engagement.

The information is available on request from:

Chief Executive Officer
Commission for Children and Young People
Level 18, 570 Bourke Street
Melbourne VIC 3000

## Compliance with the *Disability Act 2006*

The Commission acknowledges the importance of strengthening the rights of people with a disability and is committed to creating and maintaining an accessible and inclusive environment for all people with a disability. This includes Commission employees, stakeholders or members of the public.

DHHS has developed a *Disability Action Plan 2018–2020* to outline its commitment to enhance the health and wellbeing of people with a disability. The Commission supports the DHHS approach to comply with the *Disability Act 2006* and through the current corporate services arrangement looks forward to implementing relevant action items and recommendations that arise from the plan.

## Reporting of office-based environmental impacts

The Commission minimises the use of electricity and water by using efficient appliances and office equipment, including energy-efficient lighting. The Commission uses 100 per cent recycled paper, creates and stores records electronically and encourages double-sided printing.

The Commission also separates waste systems into recycled, landfill and compost and bins are cleared daily. During 2018–19, a takeaway coffee cup recycling program was also implemented at the Commission.

The Commission does not have any assigned government vehicles and staff are encouraged to use public transport in undertaking business activities.

## Attestation for compliance with Ministerial Standing Direction 3.7.1

I, Liana Buchanan, certify that the Commission for Children and Young People has complied with the Ministerial Standing Direction 3.7.1 – Risk management framework and processes. The Commission audit and risk committee has verified this.

**Liana Buchanan**

*Principal Commissioner*
*Commission for Children and Young People*

## Commission for Children and Young People Financial Management Compliance Attestation Statement

I, Liana Buchanan, on behalf of the Responsible Body, certify that the Commission for Children and Young People has complied with the applicable Standing Directions of the Minister for Finance under the *Financial Management Act 1994* and Instructions.

**Liana Buchanan**

*Principal Commissioner*
*Commission for Children and Young People*

Commission for Children
and Young People

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COMMISSION FOR CHILDREN
AND YOUNG PEOPLE