Commission for Children and Young People

Annual report

2017–18

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

13 September 2018

The Hon. Jenny Mikakos MLC
Minister for Families and Children
Minister for Youth Affairs
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 2018.

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 and sketches have also been used to protect children's identities.

Abbreviations and acronyms

ACCO	Aboriginal Community Controlled Organisation
ACF	Aboriginal Children's Forum
ACPP	Aboriginal Child Placement Principle
ACSASS	Aboriginal Child Specialist Advice and Support Service
CCYP Act	*Commission for Children and Young People Act 2012*
CRIS	Client Relationship Information System
CSO	Community sector organisation
DEDJTR	Department of Economic Development, Jobs, Transport and Resources
DELWP	Department of Environment, Land, Water and Planning
DET	Department of Education and Training
DHHS	Department of Health and Human Services
FTE	Full Time Equivalent
IVP	Independent Visitor Program
NDIS	National Disability Insurance Scheme
OOHC	Out-of-home care
SESG	Security and Emergency Services Group
VACCA	Victorian Aboriginal Child Care Agency
VEOHRC	Victorian Equal Opportunity and Human Rights Commission
VRQA	Victorian Registration and Qualifications Authority

From the

Principal Commissioner

2017–18 represented an important year for the Commission in its work recognising, protecting and defending the rights of Victoria's children and young people.

Our regulatory responsibilities, designed to improve the safety of children in organisations, have been fully operational for 12 months as we worked to embed Victoria's legislated Child Safe Standards and commenced operation of the new Reportable Conduct Scheme. In December 2017, the *Royal Commission into Institutional Responses to Child Sexual Abuse* recommended the roll-out of similar schemes nationwide. Victoria was then and is still the only jurisdiction to have these two schemes in operation, making the Commission's work to prevent and improve responses to institutional child abuse important not only for Victorian children but also at a national level.

In Victoria, many organisations engaged constructively with these schemes and worked with us at the Commission to improve children's safety and properly address allegations of harm to children by their workers or volunteers. However, some organisations and indeed some sectors have been slower to act on their obligations. While the Commission's primary focus is on raising awareness of Child Safe Standards and the Reportable Conduct Scheme and supporting organisations to meet their responsibilities, our compliance and enforcement activities will increase over time.

In this first year of the Reportable Conduct Scheme the Commission received 851 notifications of more than 1,300 allegations of harm to children in out-of-home care, schools, religious and many other organisations. We have seen highly variable responses to these allegations, some of which reflect many of the problems identified by the Royal Commission. This includes a tendency to defer to the views of adults rather than asking children about their experiences, and a reluctance to believe complaints made by children viewed as 'difficult' or 'troubled'. Ultimately these issues confirm the value of the Reportable Conduct Scheme and the need for the Commission to work constructively and closely with organisations to ensure suspected or alleged harm to children is properly addressed.

Beyond our new regulatory role, the Commission continued to use its unique powers to examine and improve the experiences of vulnerable children and young people involved in the child protection, out-of-home care and youth justice systems.

We welcomed the Victorian Government's introduction of the *Children Legislation Amendment (Information Sharing) Act 2018*, which will improve agencies' capacity to share important information relevant to children's safety and wellbeing. Our child death inquiries have, for years, revealed consistent problems with siloed information that contributed to the circumstances in which a child died or suffered.

The Commission continued its evidence-based advocacy and oversight of Victoria's youth justice system, during a year of unprecedented scrutiny and attention on youth offending. In policy debates, we continued to highlight best-practice approaches to preventing and addressing youth crime, which are grounded in diversion, rehabilitation and supportive interventions.

We maintained strong and essential oversight over youth justice facilities in Parkville and Malmsbury, particularly over the use of isolation and lockdowns, inadequate staff training, use of force by staff against children and responses to vulnerable children self-harming or attempting suicide. The resumption of applications to the Youth Parole Board to transfer children to adult prisons was closely monitored, noting the incompatibility between the adult corrections environment and a rehabilitative and specialised response to children.

While the Commission questioned the basis of new measures to extend preventative detention of people thought to have information relevant to a terrorist plan or event to include children aged 14 years and over, we were pleased to secure some safeguards – importantly, a direct monitoring role for the Commission as soon as a child is taken into custody.

Three systemic inquiries completed in the past year exposed the consequences of a child protection system under immense and ongoing pressure.

We examined a sample of child deaths involving cumulative harm and suicide, revealing children's devastating and sustained exposure to neglect and abuse without meaningful intervention. These issues continue to present in our child death inquiries.

A separate inquiry into a sample of child deaths between 2013 and 2017 examined services provided to vulnerable children with complex medical needs or a disability. The review found that these children were not systematically identified by the Department of Health and Human Services, with poor engagement and coordination with disability services. We hope this review will inform the statewide roll-out of the National Disability Insurance Scheme and lead to meaningful improvements for these children and young people and their families.

The Commission was tasked with reviewing the first six months of operation of the *Children, Youth and Families Amendment (Permanent Care and Other Matters) Act 2014*, which is intended to avoid unnecessary delays in achieving safe and suitable permanent care arrangements for children. Our review did not find clear evidence of unintended consequences from the reforms, but did reveal the child protection system was not resourced and equipped to properly support fair and timely permanency outcomes. It highlighted many of the problems plaguing the child protection system more broadly: case managers spread too thinly, high numbers of unallocated cases, inadequate access to support services and failures to support Aboriginal children to maintain vital connections to culture and community.

> …the myriad and often appalling failures in our policy and service responses that we see in our work can be confronting and frustrating. However, I am heartened by government's acknowledgement that the youth justice, child protection and out-of-home care systems require additional investment and attention. This must be sustained.

Our ongoing function to review the circumstances surrounding the death of all children and young people who were subject to child protection involvement in the preceding 12 months continues to reflect recurring problems with the identification and assessment of risk, siloed and fractured approaches to supporting families with complex needs and a paucity of mental health and drug and alcohol services. We have been heartened by increased engagement and a demonstrated willingness from Child Protection to use these findings to inform changes to policy and practice. We look forward to maintaining a robust review program in the year ahead, while continuing to drive accountability and compliance with our recommendations by the Department of Health and Human Services, and others.

It was with great sadness that we farewelled Victoria's inaugural Commissioner for Aboriginal Children and Young People, Andrew Jackomos – a skilled and passionate advocate for the rights of Koori children. Andrew made an enormous contribution to the Commission, leading groundbreaking work exposing the chronic over-representation of Aboriginal children in out-of-home care. While we miss Andrew greatly, we were excited to welcome Justin Mohamed as my fellow Commissioner. Justin will lead our Aboriginal Youth Justice Taskforce and is already proving himself a strong and persistent advocate for Aboriginal children and young people.

Two years into my term as Commissioner, the myriad and often appalling failures in our policy and service responses that we see in our work can be confronting and frustrating. However, I am heartened by government's acknowledgement that the youth justice, child protection and out-of-home care systems require additional investment and attention. This must be sustained. I also have the privilege of witnessing the many dedicated, professional and committed people working to support the safety and wellbeing of children and young people – often in trying circumstances and with limited resources. I have the pleasure of meeting and learning from children and young people across Victoria, whose remarkable resilience, insight and charm continue to inspire and motivate me and my team every day.

Liana Buchanan
Principal Commissioner

From the

Commissioner for Aboriginal Children and Young People

I am honoured to be appointed Victoria's Commissioner for Aboriginal Children and Young People as Victoria continues to be the only Australian state or territory to have established such a position. The position was established in 2013 in recognition of the unacceptable over-representation of Aboriginal children, young people and families in the child protection and criminal justice systems, and I am committed to responding to these challenges differently than we have in the past to reverse these tragic trends across Victoria.

In commencing this role, it is important to pay tribute and acknowledge the leadership of our first Commissioner for Aboriginal Children and Young People, Andrew Jackomos. Andrew established, from the beginning of his tenure, that this position would hold itself accountable to Victoria's Aboriginal community and ensure our state's systems and services are held accountable in its practices and policies in establishing the drive and commitment required to achieve the change needed for Aboriginal children, families and communities. This work included leading *Taskforce 1000* and the associated inquiry reports, *Always was, always will be Koori children* and *In the child's best interests*. These inquiries and reports have brought about groundbreaking positive change to the child protection system in Victoria with regard to Aboriginal families.

This continues to be pivotal in the emergence of Aboriginal self-determination within Department of Health and Human Services policies, as is evident in the establishment of section 18 guardianship and transitioning Aboriginal children to Aboriginal care.

Over the last twelve months, the Commission has worked tirelessly to ensure the issues and challenges brought to light in previous work haven't been forgotten or thought of as being overcome. This is a reminder to us as we continue to see the numbers of Aboriginal children and young people involved in our child protection and youth justice systems rise, with over-representation at alarming levels despite the work that has been done to date.

With the establishment of the Aboriginal Children's Forum (ACF) we are seeing a committed approach across the sector. The forum has proven to be a vital mechanism in providing greater transparency and accountability across our child protection system for the decisions being made in the best interests of our children and compliance of legislation and policies relating to:

- cultural support plans
- the Aboriginal Child Placement Principle
- Aboriginal-led family decision-making.

The ACF has ensured that momentum and commitment to section 18 authorisation and transfer of care of Aboriginal children is not lost, with Minister Mikakos and DHHS re-affirming the commitment to agreed targets and timeframes as recently as June 2018 at the ACF meeting held in Melbourne.

> …we continue to see the numbers of Aboriginal children and young people involved in our child protection and youth justice systems rise, with over-representation at alarming levels despite the work that has been done to date…

Together with the ACF, the Commission has been actively involved in the development of the Aboriginal Children and Families Agreement – *Wungurilwil Gapgapduir*. This agreement provides a consistent framework to guide government and community sector engagement with Aboriginal children and families based on self-determination and improved coordination across all levels, promoting the best outcomes for Aboriginal children and families.

I would like to congratulate all parties who have been involved in this development as this work and innovation are creating the opportunity and direction for the real work to begin in implementing the agreement.

Youth justice has continued to be a particularly challenging space for the Commission and, more importantly, for Aboriginal children and young people, who continue to be over-represented in custody and community-based orders. In the past 12 months numbers have risen as high as 50 per cent of young women and girls detained in Parkville being Aboriginal.

These figures highlight a number of areas in need of urgent improvement, particularly the importance of cultural programs and the recognition of culture as a strengthening, protective and healing factor for our children while in custody. The Commission has undertaken work with the Victorian Equal Opportunity and Human Rights Commission this year, examining the cultural rights of Aboriginal children in custody and how these rights are recognised and supported, with recommendations geared to improving this human right.

Though improvements are still required, the Commission acknowledges the steps taken over the past 12 months by the Department of Justice and Regulation to improve this area of the youth justice system, by looking at cultural training for staff and program provision. We acknowledge there is further work to be done to ensure cultural rights are embedded across the system as integral steps of young people's healing, connectedness and rehabilitation. Statements of commitment from the department to date are encouraging and we look forward to continuing this work into the future.

The next 12 months for the Commission will see a major piece of work commence with regard to Aboriginal children and young people involved in youth justice. The Commission will be undertaking a review of the circumstances of all Aboriginal children and young people in custody and subject to community-based orders, with this approach being modelled on the success of *Taskforce 1000*.

The Commission will undertake the Koori Youth Justice Taskforce in collaboration with the department over the next 18 months. Simultaneously, the Commission will be conducting an independent own-motion inquiry into Aboriginal children and young people in the youth justice system. I am personally very excited about these pieces of work and the potential for structural change to our system that can bring about positive change for our Aboriginal young people and communities, as seen through *Taskforce 1000*.

From the Commissioner for Aboriginal Children and Young People *continued*

In my role as Commissioner for Aboriginal Children and Young People, I will work with Commission staff to begin to expand our focus and attention into additional areas that are key precipitants in Aboriginal families and young people entering the child protection and youth justice systems. We intend to broaden our scope to include important areas such as maternal, physical and mental health, as well as homelessness. These areas have been acknowledged globally to disproportionately impact on First Nations children and young people in their developmental years.

If we can gain a better understanding and harness change in how our current systems and services can respond and support the needs of Aboriginal children and young people, it is envisaged that numbers entering our statutory systems could be reduced.

The other important cohort the Commission will look into over the coming years is the vast majority of Aboriginal children and young people who have no contact with child protection or youth justice. It is important for us to recognise and remember that one of the challenges we face is how focusing only on deficits when looking at Aboriginal communities can often negatively impact the task ahead and limit the possibilities of change.

We need to ensure the balance is right when focusing and placing our energy in the areas of need, versus celebrating and supporting the successes of many Aboriginal young people as they forge towards the future achieving beyond the statistics. It is very important we continue to stand with all of our young people, 'our next generation', as we work towards improving the outcomes for the most disadvantaged within our society, while celebrating the strength, resilience and successes that are evident in our young people.

When we better understand the touchstones that have created the circumstances for young people and their accomplishments, we will be better equipped to create the change that is needed within our system.

The role of Commissioner for Aboriginal Children and Young People is challenging, transformative and a privilege. It is a role that serves our community and has the opportunity to promote and oversee real transformation. I am honoured to undertake this role and am looking forward to building on and advancing the important work that has been achieved to date, and utilising the strength and leadership of the Victorian Aboriginal community.

We are committed and will continue to rewrite the negative narratives to focus on the strengths and resilience of Aboriginal communities, as we continue to advocate for change that is informed by the voices of Aboriginal children and young people, placing Aboriginal culture at the centre and Aboriginal families in the driving seat.

Justin Mohamed
Commissioner for Aboriginal Children and Young People

Farewell to a champion for Aboriginal children

Inaugural Commissioner for Aboriginal Children and Young People, and respected Yorta Yorta/Gunditjmara man, Andrew Jackomos, ended his term on 31 January 2018.

As a passionate advocate and educator, Andrew was instrumental in furthering community understanding of the importance, and inherent right, of Koori children maintaining strong cultural connections to promote their safety, resilience, wellbeing and sense of identity. He has strengthened collaboration and trust as an honest broker between government, community organisations and the Aboriginal community, while demonstrating the importance of self-determination and community-led initiatives in supporting Aboriginal families.

During his tenure, Andrew led transformational reforms to policy and practice that seek to reverse the unacceptable over-representation of Aboriginal children in our child protection and youth justice systems.

His achievements included establishing the Victorian Aboriginal Children and Young People's Alliance and the Aboriginal Children's Forum. Andrew also led two landmark inquiries: *In the child's best interests* and *Always was, always will be Koori children*.

These inquiries drew from Andrew's *Taskforce 1000* initiative during which, in partnership with the Department of Health and Human Services, he examined the treatment of almost 1000 Aboriginal children in out-of-home care and exposed some appalling truths.

Andrew's voice was central in highlighting the unacceptable over-representation of Aboriginal children and young people in the youth justice system and the importance of ensuring cultural safety and connectedness for Koori children in detention. His work was recognised by the report of the *Royal Commission into Child Protection and Youth Detention in the Northern Territory*, which recommended the appointment of an Aboriginal Children's Commissioner in that jurisdiction.

Andrew's achievements as Australia's first Commissioner for Aboriginal Children and Young People are testament to the importance of the role and his genuine passion for ensuring that Aboriginal and Torres Strait Islander children fully enjoy the rights that others take for granted.

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.

The Commission consists of Liana Buchanan, Principal Commissioner, and the Commissioner for Aboriginal Children and Young People.

Andrew Jackomos was the Commissioner for Aboriginal Children and Young People until 31 January 2018. Justin Mohamed commenced as the new Commissioner for Aboriginal Children and Young People on 28 May 2018.

What we do

At the Commission we:

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

Our vision

That the rights of 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 make our work stronger.
- We accomplish more as we are a united team.

Legislation

Our 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 approach and priorities

In 2017–18 we established seven key priorities:

1. Work to ensure Koori children and young people retain connection to family and culture and advocate for Aboriginal self-determination

2. Fully establish and operationalise Child Safe Standards and the Reportable Conduct Scheme to strengthen child-safe organisations across the state

3. Strengthen the participation and influence of children and young people in the work of the Commission for Children and Young People

4. Increase oversight of out-of-home care and visibility of the experience of children in out-of-home care

5. Drive a humane, evidence-based approach to youth justice

6. Ensure lessons learnt from the Commission's inquiries drive system improvements to benefit children and young people

7. Build a culturally-rich, high-impact Commission that is recognised as a great place to work

Highlights: our year in review

Promoting children's safety in organisations

This year, the Commission significantly expanded its ability to prevent and reduce the abuse suffered by children and young people, and to improve organisations' responses to allegations of abuse.

Establishing Victoria's Reportable Conduct Scheme and administering the Child Safe Standards has seen a significant shift in the function and size of the Commission. This shift has placed the Commission in an even stronger position to make a difference in the lives of Victoria's children.

Our monitoring and oversight of organisations provides an important new protection for children that will contribute significantly to achieving the vision of safer organisations as set out by the *Royal Commission into Institutional Responses to Child Sexual Abuse*. In the work undertaken in 2017–18, the Commission has clearly seen the need for the Scheme and the Standards, and the benefits they can bring.

This year the Commission was notified of over 850 instances of potentially concerning conduct by adults with children. We independently monitored and oversaw investigations of this conduct, and provided support and advice to organisations throughout. We took action with respect to 58 organisations where information suggested they may not be complying with their obligations to create an environment that reduces the risk of child abuse, increasing our compliance activity significantly.

Effective oversight of youth justice

This year we continued our work to ensure youth justice detention is used as a last resort that respects the human rights of children and young people, protects their wellbeing, and supports their rehabilitation.

Our monitoring identified serious deficiencies in staff response to children and young people who harm themselves or attempt suicide, resulting in an overhaul of training and procedure to clarify that staff are expected to intervene.

Our inquiry into incidents in the Grevillea Youth Justice Precinct at Barwon Prison resulted in 11 recommendations to improve how Corrections Victoria staff work with vulnerable children and young people if they are to continue to have contact with them through any role in Youth Justice (see page 21). The inquiry also resulted in allegations of assault against 11 children and young people being referred for investigation.

Earlier inquiries also continued to spark reform. Following *The same four walls* inquiry, isolation cells were upgraded, and training on the use of isolation and the legal requirement to record it were improved, with a review commenced of the isolation applied to Aboriginal children and young people at Malmsbury Youth Justice Centre (see page 20).

Ongoing monitoring of youth justice also continued through our Independent Visitor Program, with more Aboriginal volunteers engaged in the program, and improvements to safety conditions and privacy (see page 26).

> Our monitoring and oversight of organisations provides an important new protection for children that will contribute significantly to achieving the vision of safer organisations as set out by the *Royal Commission into Institutional Responses to Child Sexual Abuse*.

Making a difference for Aboriginal children and young people

Two inquiries – *Always was, always will be Koori children* and *In the child's best interests* – continued to influence significant change this year. Following our recommendations, the chief executive officer of the Victorian Aboriginal Child Care Agency (VACCA) was authorised to assume guardianship for identified Aboriginal children and young people. There was also a commitment to transfer the case management of 100 per cent of Aboriginal children and young people to Aboriginal Community Controlled Organisations (ACCOs) by 2021 (see page 32).

Aboriginal children and young people were also the focus of the Commission's work in youth justice this year, with substantial work to recognise and support cultural rights through a joint report with the Victorian Equal Opportunity and Human Rights Commission (see page 54). Work also commenced to prepare for an independent inquiry and to establish an Aboriginal Youth Justice Taskforce to tackle the over-representation of Aboriginal children and young people in the youth justice system (see page 54).

With the departure of Andrew Jackomos, Australia's inaugural and only Commissioner for Aboriginal Children and Young People, we were pleased that the Victorian Government continued its commitment to Aboriginal children and young people with the appointment to the role of Justin Mohamed in May 2018.

Safer, better care for children

In our work to achieve safer and better care for children, the Commission's capacity to undertake independent inquiries was again complemented this year by our vital work to monitor and advocate for the adoption of our recommendations.

Our *'…safe and wanted…'* report published in December 2017 examined the first six months of permanency amendments to the *Children Youth and Families Act 2005*. We found increased demand and under-resourcing in the child protection system was adversely impacting timely and appropriate permanency decisions in the best interests of vulnerable children and young people. A longitudinal study initiated as a result of our report will now monitor the impacts we identified, although our recommendations for legislative change will not be actioned at this time (see page 29).

The roll-out of family violence training for new and current Child Protection staff was a welcome move to improve responses to the unique needs and experiences of children and young people impacted by family violence. However, we remain concerned that some actions to improve responses to child victims and address the recommendations of the *Royal Commission into Family Violence* and *Neither seen nor heard* inquiry remain invisible. Improving responses to children affected by family violence, including by Child Protection, will remain a focus for the Commission.

This year two inquiries detailed more fully later in this report also highlighted the vulnerability of children with complex needs and disability, and the significant role of cumulative harm in the deaths by suicide of children and young people known to Child Protection.

The first of these reports will be vital to ensuring the needs of vulnerable children and families are at the forefront of thinking about how services will be delivered through the roll-out of the National Disability Insurance Scheme (see page 28).

Through our second inquiry, we highlighted the role of cumulative harm in the significant number of children and young people who died by suicide during or following their involvement with the child protection system. The inquiry also identified that gaps between our statutory and voluntary service systems are failing children (see page 27).

Learning from deaths to protect children

The Commission this year completed 33 child death inquiries to learn from the experiences of children and young people who died following or during their involvement with the child protection system.

These inquiries revealed recurring themes, including the need to better support vulnerable mothers before the birth of their children.

Poor or inadequate information-sharing between Child Protection and other services was also revealed. This included the lack of a shared understanding between services about risk to children and young people, and a failure to establish referral pathways between hospital emergency departments and maternal child health services.

Oversight and monitoring

Oversight and monitoring

Overview

The Commission performs a vital role in oversight and monitoring to protect children and young people both through our capacity to conduct independent inquiries and make recommendations under the *Commission for Children and Young People Act 2012*, and through our ongoing monitoring activities.

Our inquiries this year focused on serious challenges to and concerns about Victoria's youth justice system, the role of cumulative harm and suicide in the deaths of children with a history of involvement in the child protection system, and the needs of children with complex medical needs and/or disability, including their access to services under the National Disability Insurance Scheme (NDIS).

This year, we also continued to monitor the implementation of recommendations of our past inquiries to ensure that our recommendations are translated into action to benefit children and young people.

In addition to our work on inquiries, we also undertake continuous monitoring of the youth justice system, of out-of-home care, and of the deaths of children with involvement in the child protection system. This ongoing monitoring is vital to improve systems for the most vulnerable children and young people, and, in the case of child death inquiries, to identify vital changes to prevent future deaths and suffering.

Youth justice

Progress against past inquiries

The same four walls

In March 2017, the Commission tabled a systemic inquiry into the use of isolation, separation and lockdowns in the Victorian youth justice system because of concerns that excessive use of these practices has serious and long-term effects on children and young people's mental health and rehabilitation. The inquiry was the first published report that exposed serious concerns about Youth Justice staffing levels, training and the operating model.

The Commission made 21 recommendations to improve Youth Justice policies, practices and infrastructure. In addition, we recommended that legislation be strengthened to safeguard rights, and improve the treatment of children and young people in detention. Thirteen of the recommendations were fully accepted and eight were accepted in principle. In last year's annual report, the Commission noted that the Department of Justice and Regulation had developed an action plan and showed early signs of progress.

In 2017–18 the department actioned many of the recommendations of *The same four walls* including:

- the installation of sanitation in all isolation rooms in Parkville and Malmsbury, and the inclusion of the same in the design specifications of the new Cherry Creek facility
- improved guidance for staff regarding when a child or young person can be isolated
- improved recording of isolations
- development of a dedicated session in the recruitment training program on the use of isolation and separation
- development of new policies that clarify responsibility and processes associated with observations of children at risk of self-harm or suicide.

Critically, the legislative reforms recommended by the Commission have yet to be realised, which continues to leave children and young people in youth justice with fewer rights than adult prisoners. The department is also yet to

finalise work on a review of Malmsbury Youth Justice Centre's practices that lead to disproportionate isolation of Aboriginal children.

Individual inquiry into services provided to a child in youth justice

In addition, in response to recommendations arising from our 2017 individual inquiry into incidents of restraint that resulted in a child's limb being broken on two occasions in youth justice, the Commission notes a series of improvements including improvements to the Custodial Practice Manual to specifically refer to how to restrain and use force when young people have medical conditions and injuries. The Commission is also pleased to note our recommendation that specific infrastructure to accommodate clients returning from hospital and recovering from physical injuries within the new purpose-built youth justice centre has been addressed in the Functional Technical Brief for the Cherry Creek development.

Inquiries completed this year

Group inquiry into events at Grevillea Youth Justice Precinct

In February 2017, the Commission initiated 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. An interaction between children, young people and Corrections Victoria's Emergency Response Group (ERG) staff had quickly escalated into a physical altercation resulting in the deployment of oleoresin capsicum (OC) spray. The impact of the OC spray was extensive and affected children, young people and staff in the unit. Most of the children and young people were subsequently evacuated into the unit's exercise yard. Approximately three hours later, some 40 members of Corrections Victoria's Security and Emergency Services Group (SESG) entered the exercise yard and returned the children and young people individually to their cells while they remained handcuffed. Eleven children and young people reported being assaulted by SESG staff in their cells when these staff removed their handcuffs that evening. While some of the SESG staff alleged to have assaulted children and young people were wearing body-worn cameras earlier during the incident, these cameras were de-activated before staff entered the cells to remove handcuffs.

The inquiry was established pursuant to section 37(1)(b) of the *Commission for Children and Young People Act 2012*. Reports of inquiries established under this section of the legislation cannot be made public.

Inquiry findings

The inquiry found:

- the ERG response to the initial incident did not reflect an approach tailored to children
- deployment of OC spray exceeded what was reasonable or necessary and affected a broad group of children, young people and staff, including many children who were not involved in the initial incident
- there were significant deficiencies in Corrections Victoria's use of body-worn cameras and OC spray
- Corrections Victoria's response to the disturbance was disproportionate, both in the number of staff involved and the manner in which children and young people were managed
- the universal use of handcuffs on all children and young people in the unit failed to account for the individual risk presented by each child and young person
- the decision by Corrections Victoria staff to keep the children and young people handcuffed in their cells for up to 20 minutes after the incident was resolved may have amounted to an inappropriate use of restraints and a breach of section 487 of the *Children, Youth and Families Act 2005*.

Based on the available facts, the inquiry could not conclusively determine whether the alleged assaults occurred. Unfortunately, this outcome was influenced by the fact that Corrections Victoria staff responsible for removing the children's handcuffs declined to be interviewed and body-worn cameras were not operative during the time of the alleged assaults.

Key recommendations and the department's response

The inquiry made 11 recommendations that were accepted by the Department of Justice and Regulation. As a result of these recommendations, as at 30 June 2018, the department has:

- referred the allegations of assault to the department's People and Culture unit for assessment
- reviewed and confirmed that Youth Justice retains control of a youth justice facility in the event of an incident
- issued an interim Director's Instruction on the use of OC spray
- issued a new Director's Instruction for Tactical Options (Use of Force) on 5 March 2018
- commenced Daily Safety Advice to SESG officers working in youth justice facilities from 27 June 2018
- developed a training package targeting SESG members to ensure Corrections Victoria staff working in youth justice are aware of legislative and human rights obligations when working in a youth justice facility. The training also provides information about the complexity of young people in Youth Justice custody, and the importance of responding to trauma in an informed way.

The Commission will monitor implementation of this inquiry's recommendations.

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 all alleged assaults by Victoria Police. The Commission monitors the submission by Youth Justice of each allegation to Victoria Police. In 2017–18, the Commission received 46 incident reports of this type.

In July 2017, the Commission identified a lack of visibility of a number of serious category two incidents. Youth Justice agreed to provide the Commission with incident reports relating to all incidents involving a child or young person being taken offsite to hospital following a self-harm or attempted suicide incident, or an assault-related incident. In 2017–18, the Commission received 13 incident reports of this nature.

Youth justice category one incidents 2017–18

This financial year, Youth Justice (custody) recorded 240 category one incidents. This figure represented a 107 per cent increase on the year before (see Table 1, on page 23). Each of the three categories of incidents (assault incidents/allegations, behaviour-related incidents and other incidents) increased by at least 70 per cent this financial year.

Youth Justice attributes the significant increase in incidents to its efforts to improve reporting practices, in addition to its completion of several internal audits, which identified additional matters that required reporting. The Commission accepts that the increase in incidents is due partly to improved reporting. However, concerns remain about the frequency of serious incidents during this 12-month period.

The Commission found that assault-related incidents have increased among, by and upon children and young people. These numbers suggest that youth justice centres are environments where limited capacity to prevent and control violence impacts on the safety and wellbeing of children and staff alike.

Table 1. Category one incidents in youth justice 2016–17 and 2017–18

	2016–17	2017–18	
Assault-related incidents/allegations	**73**	**129**	**77 per cent increase**
Sexual assault/indecent/client on staff	1	6	
Physical assault/client on staff	7	31	
Physical assault/client on client	10	24	
Physical assault/other on client	3	4	
Sexual assault/indecent/other on client	5	6	
Physical assault/staff on client	34	36	
Sexual assault/rape/client on client	0	1	
Sexual assault/rape/client on other	0	2	
Sexual assault/indecent/staff on client	0	9	
Sexual assault/rape/other on client	0	3	
Sexual assault/rape/staff on client	0	1	
Physical assault/client on other	0	1	
Sexual assault/indecent/client on client	13	5	
Behaviour	**20**	**34**	**70 per cent increase**
Behaviour – dangerous	7	16	
Behaviour – sexual	12	17	
Behaviour – disruptive	1	1	
Other	**23**	**77**	**235 per cent increase**
Poor quality of care	1	19	
Self-harm	1	15	
Injury	4	9	
Suicide attempted	1	7	
Property damage/disruption	6	7	
Possession	1	5	
Community concern	0	6	
Medical condition (known) – deterioration	1	4	
Medication error – other	2	1	
Breach of privacy/confidentiality matters	1	0	
Escape from centre	3	0	
Illness	2	3	
Drug/alcohol	0	1	
Total	**116**	**240**	**107 per cent increase**

The Commission's queries about incidents in youth justice centres

The Commission receives incident reports, and reviews them with a particular focus on the rights 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 or CCTV footage is sought from Youth Justice.

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 Regulation.

This year, the Commission sought and reviewed information, including CCTV footage, about 71 youth justice incidents – almost double the number of queries made in the previous year (37 matters).

The Commission's queries related to physical assault of staff on client (19 incidents, 27 per cent of queries), followed by self-harm incidents (eight incidents, 11 per cent of queries). Queries involving Aboriginal children accounted for 37 per cent of the youth justice incidents further examined by the Commission (26 matters).

Table 2. Commission's youth justice incident queries by incident type 2017–18

Incident type	Count	Percentage
Physical assault/staff on client	19	27
Self-harm	8	11
Poor quality of care	7	10
Physical assault/client on staff	7	10
Suicide attempted	5	7
Physical assault/client on client	5	7
Property damage/disruption	4	6
Sexual assault/indecent/client on client	3	4
Behaviour – dangerous	3	4
Other incidents	10	14
Total	**71**	**100**

This year, the Commission started categorising our queries into themes aligned with the United Nations Convention on the Rights of the Child. The greatest proportion of our incident queries over the past 12 months related to safety, health and wellbeing (57 incidents, 80 per cent).

Table 3. Commission's youth justice incident queries by theme 2017–18

Query theme	Count	Percentage
Safety, health, wellbeing	57	80
To stay healthy and well and go to a doctor, dentist or other for help when I need to	7	10
Rights and freedoms	5	7
Family environment and people who matter to me	1	1
Reaching my full potential	1	1
Total	**71**	**100**[1]

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

Our impact – improving youth justice's responses to self-harm in youth justice facilities

In July 2017, through our monitoring function, the Commission identified a number of incidents that had occurred involving children and young people engaging in self-harming behaviours while Youth Justice staff observed them without intervening. On one occasion, a child appeared to have lost consciousness while self-harming under observation.

The Commission raised these issues formally with the Department of Justice and Regulation on three occasions from July 2017 to January 2018.

In response, Youth Justice identified major shortcomings in policy, staff training and practice relating to responding to children and young people self-harming.

A suicide and self-harm training program was developed and delivered to all Youth Justice staff from December 2017. In June 2018, Youth Justice released two new Director's Instructions: *Framework for prevention of suicidal and self-harming behaviour* and *Immediate response to suicidal and self-harming behaviour* and amended the practice instruction, *Observation of young people in custody*.

The Commission will continue to closely monitor incidents involving self-harm or suicidal behaviour in youth justice to ensure staff respond appropriately and in the best interests of children and young people.

Independent Visitor Program

Our Independent Visitor Program (IVP) conducts regular visits to Victoria's youth justice centres at Parkville and Malmsbury. Our independent volunteer visitors go to each centre on a monthly basis, observe conditions and talk to children and staff about services and issues. The volunteers report on their observations to the Commissioners after each visit. We seek to resolve issues reported to independent visitors by raising them with senior Youth Justice staff and managers.

In 2017–18 we called for more Aboriginal visitors to join the program and visit Aboriginal children and young people in custody, and were pleased to welcome three more Aboriginal visitors. We continue to seek more Aboriginal volunteers.

Issues raised

This year children and young people raised 816 issues across the two locations.

Table 4. Issues raised with Independent Visitor Program in youth detention

Youth justice centre	Number of issues raised	Main topics
Malmsbury	353	Environment, programs, food
Parkville	463	Environment, health, programs

As shown in Table 4, 353 issues were raised at Malmsbury and 463 issues at Parkville. The nature of the issues raised varied. However, key issues included:

- waiting times for consultations with medical practitioners and dentists
- lack of cleanliness, broken fixtures and graffiti
- lack of suitable programs
- allegations of excessive use of force by staff
- young people self-isolating due to feeling unsafe.

Our impact – improved privacy

In November 2017, children and young people from the girls' Cullity unit at Parkville raised serious concerns about lack of privacy in the isolation/safe room with our independent visitors. The Commission's *The same four walls* inquiry recommended the installation of toilets in all isolation rooms. In response to this recommendation, the Cullity unit had installed a toilet. However, it faced a large window and was in full view of anyone walking past, including other girls and young women. The IVP advocated on behalf of the children and young people to ensure their privacy. As a result of our advocacy, an opaque film was placed over the window to improve the girls' privacy and dignity.

Our impact – furniture for mealtimes

The issue of seating in the eating area at Malmsbury had been raised regularly by children and young people with our independent visitors since February 2017. Tables and chairs were not being provided due to staff safety concerns that chairs might be thrown around, causing injury. The IVP and the Commission advocated strongly and repeatedly on behalf of the children and young people for fixed chairs to be installed, which would allow children and young people to sit for meals without compromising safety. In February 2018, fixed furniture was finally installed at Malmsbury and used at mealtimes and for playing games. Our independent visitors reported that the fixed chairs were also used by the children and young people when socialising with each other or with staff and workers.

Monitoring transfers from youth justice to adult corrections

Victoria's legislation provides that the Youth Parole Board in certain circumstances may direct that a child in youth justice aged 16 years or older be transferred to an adult prison.[2]

In January and February 2018, two 17-year-olds were transferred from youth justice to adult corrections. Before these two transfers, the last time children were transferred to adult corrections under these provisions was in 2012. The 2012 transfers, and the subsequent treatment of the children in adult corrections, attracted significant criticism from the Victorian Ombudsman who conducted an *Investigation into children transferred from the youth justice system to the adult prison system*, tabled in 2013.

Upon being advised of this year's transfers, the Commission reviewed Youth Justice's practice prior to making the application, and staff from the Commission met each child and young person to ensure their safety and wellbeing. The children and young people expressed concerns relating to the transfer process including lack of advice about the process and lack of access to personal property and suitable clothing following their relocation. The Commission immediately raised these concerns with the Department of Justice and Regulation who attended to the matters promptly.

In March 2018, the Principal Commissioner wrote to the Minister for Families and Children, expressing concern that the practice of transferring children to adult prison had resumed and to raise a number of issues concerning the transfer process and the management of the children and young people prior to their transfer.

As at 30 June 2018, the Commission has not been advised of further transfers.

2 *Children Youth and Families Act 2005*, section 467. The Youth Parole Board may only direct that a child be transferred to prison ' if – (a) it has had regard to the antecedents and behaviour of the person; and (b) it has had regard to the age and maturity of the person; and (c) it has taken into account a report from the Secretary; and (d) it is satisfied that the person – (i) has engaged in conduct that threatens the good order and safe operation of the youth justice centre; and (ii) cannot be properly controlled in a youth justice centre.'

During the Commission's monitoring, Commission staff observed a prison disciplinary hearing for one of the children in adult corrections. In May 2018, the Commission wrote to the Department of Justice and Regulation identifying a number of concerns about the lack of appropriate recognition of the rights of the child during the disciplinary hearing process. In June 2018, Corrections Victoria advised that the prison disciplinary hearing policies would be reviewed, taking into account the matters raised by the Commission. The Commission welcomes this response.

In addition to the specific monitoring described above, the Commissioner sits as an observer on the Young Offender Transfer Review Group, a forum jointly convened by the Youth Parole Board and Corrections Victoria to review the management of children and young people who have been, or are likely to be, transferred between a youth justice centre and prison.

Out-of-home care and child protection

Systemic inquiries completed this year

Systemic inquiry into cumulative harm and suicide in child deaths

This 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 the services provided to 26 children who were involved with Child Protection and who died as a result of suicide.

Reviewing each child's story for this inquiry, the over-riding impression was one of missed opportunities. These children were often exposed to significant and persistent harm from an early age, yet the service system generally did not intervene in a meaningful way to better support them or their families or provide them with protection.

Another significant insight provided by the cases was the extent to which children and young people were both unseen and unheard by the very system designed to protect them. Although the inquiry focused on the experiences of children who died between 2007 and 2015, we continue to see evidence of the systemic issues identified in this report in all aspects of our work.

The inquiry made a number of findings including:

- the children came to the attention of Child Protection an average of seven times; the number of reports ranged from two to 25[3]
- of the total 169 reports made regarding the 26 children, 91 per cent were closed at intake or investigation
- more than one-third of the children reviewed died within eight weeks of their final report being closed or placed in closure phase
- Child Protection failed to adequately identify and respond to the risk of cumulative harm and its impact on the safety, wellbeing and development of the 26 children reviewed
- the concept of cumulative harm was frequently misunderstood in terms of its application to practice and rarely considered in the context of adolescents
- referrals by Child Protection to Child FIRST were ineffective where parents were not successfully engaged and there was no evidence of Child FIRST services reporting back to Child Protection where engagement was unsuccessful
- protection applications by notice were under-utilised by Child Protection, resulting in protective intervention being commenced by emergency care or not at all
- connections to culture for Aboriginal children were inadequately prioritised
- there was a general absence of child-focused practice, including insufficient direct contact with a child and their family, infrequent interviewing of children away from family members, and infrequent involvement of children in decision-making processes
- for schools, recognising cumulative harm from trauma or abuse is critical when assessing behavioural management issues for children.

3 Note the number 25 includes reports in relation to one child made outside of Victoria (the highest number of reports made within Victoria was 19).

The Commission made recommendations to the Department of Health and Human Services, including:

- improving the department's identification and response to cases involving cumulative harm
- ensuring that Child Protection practice is more child-focused
- ensuring fewer children miss out on support and protection because they are not deemed to require Child Protection intervention but child and family services do not or cannot intervene
- supporting schools to be more aware of cumulative harm and how they can better work with Child Protection to support children who have experienced cumulative harm
- ensuring that hospitals and Child Protection develop protocols for better collaboration in relation to the provision of specialist mental health treatment for children.

The Commission also made recommendations directed at supporting schools to be more aware of cumulative harm and how they can better work with Child Protection to support children who have experienced cumulative harm.

The Commission made the decision not to table this report in Parliament, so that it could provide a greater level of detail about individual children's cases to drive change. We will monitor the proposed responses to our recommendations closely and have advised government we will conduct and table in Parliament an updated inquiry protecting children's identities if we are not satisfied these issues are being adequately addressed.

Systemic inquiry into vulnerable children and young people with complex medical needs and/or disability

This year, the Commission also completed an inquiry into services provided to vulnerable children and young people with complex medical needs and/or disability.

The inquiry considered 72 child death inquiries finalised between 1 March 2013 and 28 February 2017. This systemic inquiry examined 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.

Like all children and young people, these children have a right to be safe, live the best possible life and participate in decisions that affect them. However, the Commission found they face a much higher risk of abuse, neglect, of not being heard and not getting the support from services they need to live the best life they can.

The inquiry found that, too often, services working with these children and young people and their families did not gain a full picture of the risk of harm to which they were exposed or their parents' capacity to look after them. The inquiry also found services often did not ensure children and young people were connected to the ongoing supports they needed.

The findings of this inquiry, which considered the service system prior to the introduction of the National Disability Insurance Scheme, also considered how the NDIS could best uphold the rights and needs of vulnerable children and young people with complex medical needs and/or disability.

The Commission made a number of findings including the following:

- Child Protection does not currently record information about whether a child has complex medical needs and/or disability, which undermines opportunities to monitor and review case practice and plan for service provision[4]
- in many cases there was an under-assessment of risk in relation to children with complex medical needs and/or disability
- there was a high degree of variation between and within divisions about when and how to respond to unborn-child reports
- the voices of children and young people were consistently absent in decision-making and planning about them

4 Since the report was submitted, CRIS changes have been made allowing but not requiring Child Protection to record this information.

- there was a lack of tailored service supports to build the capacity of parents with cognitive impairments or intellectual disabilities to care for children with complex medical needs and/or disability
- there was a lack of communication, information-sharing and necessary co-ordination between Child Protection and disability services
- a one-size-fits-all approach will not work for engaging with the parents of vulnerable children and young people with complex medical needs and/or disability who already struggle to negotiate and engage with the service system and who are often overwhelmed by the sheer number of services involved in their lives.

The inquiry recommended, amongst other things, that the Department of Health and Human Services:

- systematically collect and report on the number of children with complex medical needs and/or disability who are clients of Child Protection
- train all Child Protection workers to undertake risk assessment of children with complex medical needs and/or disability
- direct Child Protection practitioners to take account of the fact that a mother will likely give birth to a child with complex medical needs and/or disability and encounter difficulties providing the requisite level of care to that child.

The findings of the report have significant implications for how NDIS services will be provided to vulnerable families and how families will access and navigate that system. Where NDIS funding is unavailable to families or children, the report recommended the department ensure the availability of case management and coordination supports. The inquiry report also encouraged the Department of Health and Human Services to work with the National Disability Insurance Authority to:

- support vulnerable children and young people to participate in planning and decision-making including through the provision of independent advocates in the NDIS pre-planning and planning processes to children and young people known to Child Protection
- ensure the NDIS 'market' includes services for children and young people living in hard-to-reach families
- ensure that robust information-sharing mechanisms exist between Child Protection, NDIS-approved service providers and NDIS planners to ensure that NDIS planners are aware of protective concerns and can be responsive to these
- relieve stress on families through the provision of case management, respite care and parenting capacity supports for parents with disabilities
- ensure that NDIS-approved service providers are accredited and capable of identifying and reporting on risk of harm to children and young people as well as empowering them – and the people who support them – to speak out about abuse.

Like the previous inquiry, the Commission has not tabled this report in Parliament, but will monitor responses to our recommendations and will conduct and table in Parliament an updated inquiry if we are not satisfied these issues are being adequately addressed.

'…safe and wanted…'

The 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*.

These amendments were a response to pressing concerns that it was taking too long to find a permanent placement for vulnerable children in the child protection system. The changes sought to ensure that decisions about the care of children are made in a timely way, and to promote permanency of care arrangements.

This inquiry examined the first six months of operation of the permanency amendments to see if the stated objectives were being realised and to identify any unintended consequences.

In June 2017, we provided our report *'…safe and wanted…'* to the 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. In the short period under review, we did not find conclusive evidence that the legislation had widespread unintended consequences. However, we did find that the amendments were introduced in the context of a child protection system struggling with increasing demand and not operating as it needed to achieve permanent outcomes for children sooner.

It was clear that legislative change alone was not going to improve children's path to permanency, and that broader resourcing and child protection practice concerns are critical. We also found that aspects of the amendments, especially in the context of a pressured service system, had potential to cause negative outcomes for some children.

The Commission made a number of findings based on the first six months since commencement of the amendments, including:

- the number of children reunified with their parents had fallen by 11 per cent
- the number of children placed on permanent care orders had increased by nearly 60 per cent
- identification of a range of barriers to children being reunified with their parents, including limited services to help parents to safely reunite with their children
- no recorded evidence of critical case management being done for significant proportions of children on family reunification orders
- a large number of children in the out-of-home care system continued to have no allocated case manager, with, on average, 3,116 children each month who did not have an allocated worker[5]
- the proportion of unallocated cases where a child was on a protection order increased by 57.9 per cent, compared with the equivalent period 12 months earlier
- widespread and persistent non-compliance with legislative requirements to provide cultural support to Aboriginal children in out-of-home care persists[6]
- widespread concern in the community, particularly the Aboriginal community about the inclusion of adoption in the hierarchy of permanency objectives.

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 make further changes to the legislation to address the risk of negative outcomes for children. The government has advised legislative changes will not be progressed at this time, but that other recommendations relating to additional resourcing, training and workforce, improving policy and practice are approved in full or in principle. For example, in 2017–18 the government invested funding for 453 FTE child protection practitioner positions and the Department of Health and Human Services advises the case allocation rate has improved from 80 per cent to 85.8 per cent between June 2017 and June 2018. We hope to see ongoing improvement.

We note that work has commenced in response to one of our key recommendations through the establishment of a longitudinal study of children subject to child protection involvement. The Department of Health and Human Services recently announced the appointment of a consortium led by the University of Melbourne to undertake the study, which will monitor and track outcomes and determine whether permanency amendments are achieving their objectives. The study is due to be completed by June 2020.

5 This figure includes an average of 1,210 children whose cases of alleged abuse and neglect were in the investigation and assessment phase, 491 children whose cases of substantiated abuse and neglect were subject to protective intervention, 1,319 children on a protection order and 96 children whose cases were in the closure phase.

6 The data provided by the department showed that in the first six months of the operation of the permanency amendments, over 80 per cent of Aboriginal children in out-of-home care had no cultural support plan, despite the legislative requirements under the *Children Youth and Families Act 2005*.

Progress against past inquiries

Neither seen nor heard

Neither seen nor heard was tabled in the Victorian Parliament on 7 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 to address their trauma. The report made 13 recommendations to ensure that vulnerable children are at the centre of Victoria's family violence response.

In June 2018, the Commission raised concerns with the department at the slow progress against several significant recommendations of *Neither seen nor heard*. The department advised that further work will be undertaken to address the Commission's concerns including providing further information about activities the Department of Health and Human Services is undertaking in response to the Victorian *Royal Commission into Family Violence*.

There is no question that the government's unprecedented investment in, and reform of, responses to family violence will benefit children. However, the Commission is disappointed by the limited visibility of action to increase counselling and support for child victims and to improve Child Protection's response to child victims of family violence.

'…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, and inadequate strategies to prevent abuse. The inquiry's nine recommendations were accepted in principle.

The Commission welcomes the government's recent announcements that additional targeted care packages will be provided to transition children out of residential care and $82.5 million of funding over four years to provide children in residential care with around the clock staffing and support reflective of the complex care needs of these children.[7] It is also encouraging that from July 2017 to April 2018, there had been a further seven per cent reduction in the number of children in residential care (from 432 to 400 children). The Commission looks forward to this number reducing further.

Although the department has not provided advice on implementation of recommendations from *'…as a good parent would…'* since September 2017, we note work is ongoing. However, sexual exploitation and sexual assaults continue to be reported to the Commission, and further effort to understand and address sexual exploitation may be needed.

Among other findings, *'…as a good parent would…'* identified a lack of specialised service to receive and respond to children's complaints about their care.[8] In response to this recommendation, the department advised the Commission that the Victorian Ombudsman will be promoted as an independent complaints option for children in residential care.

The absence of a specialised, independent complaints option for children in out-of-home care continues to concern the Commission. The Commission received a record number of contacts from members of the public including children this year with 763 approaches, representing a 22 per cent increase from the previous year.

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

In October 2016, the Commission for Children and Young People 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*.

7 premier.vic.gov.au/improving-residential-care-in-victoria/, accessed 20 July 2018

8 Recommendation 3 of *'…as a good parent would…'* was that 'a complaints body, which is independent of the department (funder) and CSOs, must be established to hear directly from children'.

Oversight and monitoring *continued*

Together, these reports and the preceding *Taskforce 1000* highlighted that family violence and alcohol and/or drug misuse by parents were the leading reasons for Aboriginal children entering the care system and then, when removed from family, that the child protection system failed to preserve, promote and develop cultural safety and connection for Aboriginal children.

Always was, always will be Koori children made 79 recommendations to improve policy and practices for Aboriginal children in out-of-home care and the Victorian Government accepted all of the recommendations in full, in part or in principle.

In the child's best interests examined Victoria's compliance with the Aboriginal Child Placement Principle (ACPP) by reviewing a sample of 65 Aboriginal children and young people involved in the child protection system. Our inquiry found not a single case where agencies had complied with all elements of the ACPP.

All 54 recommendations to improve ACPP compliance and provide greater opportunities for Aboriginal self-determination in Child Protection decision-making were accepted by the government, either in principle, in part, or in full.

These two inquiry reports continue to have a profound impact on the child protection system's responses to Aboriginal children, young people, families and communities.

Targets have been established to transfer 100 per cent of Aboriginal children to Aboriginal care by 2021, with 30 per cent to be transferred by 2017, and 80 per cent to be transferred by the end of 2018.

Approximately 25 per cent of children were transferred by 2017. There are some concerns as to current progress towards the 80 per cent 2018 target, but also a strong continuing commitment to its achievement.

A further significant impact was the implementation of section 18 of the *Children, Youth and Families Act 2005*, allowing the Secretary of the Department of Health and Human Services to authorise an appropriately resourced Aboriginal CEO of an Aboriginal Controlled Community Organisation (ACCO) to take on prescribed guardianship responsibilities for Aboriginal children and young people, subject to set Child Protection Orders.

In November 2017, the Victorian Aboriginal Child Care Agency (VACCA) became the first ACCO to be authorised under this legislation. This year, the Bendigo and District Aboriginal Co-operative (BDAC) also completed the pilot program required for authorisation, and is anticipated to be authorised in 2018–19. The Victorian Government has committed to fund a further ACCO to undertake the pilot program in 2018–19, with an additional ACCO to commence in 2019–20.

There was also funding this year for the new model of cultural planning – including ongoing funding for 18 senior advisers in ACCOs, a statewide coordinator in VACCA, and funding for *DeadlyStory.com*, an online cultural portal, together with a half-time portal administrator. The Aboriginal Child Specialist Advice and Support Service (ACSASS) also saw continued funding growth.

A Statewide Principal Practitioner for Aboriginal children and families within the department's Office of Professional Practice was also appointed this year.

The Commission welcomes the government's significant investment and commitment to reform in this area.

Out-of-home care incidents and incident monitoring

Section 60A of the *Commission for Children and Young People Act 2012* requires the Department of Health and Human Services 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 escalated to the department, or the Commission may establish an inquiry under the *Commission for Children and Young People Act 2012*.

Changing how incidents are reported

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

- incidents involving children case-managed by the department continued to be reported against the CIR[9] Framework through the full financial year
- from 15 January 2018, incidents that involved children case-managed by department-funded organisations were reported via CIMS.[10]

Broader scrutiny has resulted in more incidents being made available to the Commission. This year, the Commission received 3,896 incident reports from CIMS and the CIR Framework – almost 50 per cent more than last year (2,623 reports). Of those reports:

- 1,599 incidents were via CIR (category one incidents)
- 2,297 were from CIMS (417 major incidents, 1,880 non-major incidents).

9 Client Incident Reporting Framework.

10 Client Incident Management System.

Out-of-home care incidents reported to the Commission 2017–18

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. The overall trend of incidents occurring can be broadly considered against this context.

Incident trends

Across both reporting frameworks, the most frequently reported incident related to children being absent or missing, which accounted for 13 per cent of CIR incidents and 28 per cent of CIMS incidents.[11] The Commission will continue to monitor absent/missing incidents and the department's response to this concerning trend.

The second most reported incident this year related to dangerous behaviour/dangerous actions by children (19 per cent of CIMS incidents and 11 per cent of CIR incidents). This incident type includes actions that cause the client harm or place them at risk of harm, including substance abuse and high-risk driving or sexual activities. Dangerous behaviour/dangerous actions have represented 12 per cent of all incidents over the past two years and are often linked to incidents involving absent/missing children.

We note a significant reduction in the number of sexual exploitation incidents reported with CIMS. While the incident definition has not altered in nature, only two per cent of CIMS incidents (41 matters) were reported as sexual exploitation. In contrast, within the CIR framework, sexual exploitation was the most reported incident type, making up 15 per cent of incidents (235). The CIR pattern reflects previous years' data where sexual exploitation was the most reported incident.[12] As at July, the Commission was awaiting advice from the Department of Health and Human Services to further understand this discrepancy.

11 Of these, 607 incidents occurred in January – June 2018 period and were assessed as being of 'non-major' impact.

12 In 2015–16, sexual exploitation made up 14 per cent of category one incidents. In 2016–17, sexual exploitation incidents represented 15 per cent of category one incidents.

Incident by care type

Reflecting the previous two years' incident trends, the majority of incidents reported to the Commission this year related to children in residential care. In 2017–18, residential care accounted for 64–68 per cent of incidents,[13] a slight decrease from the year before (70 per cent). It is encouraging to see that the proportion of incidents relating to children in residential care decreased this year.

There was little variation in the distribution of incident reports across the other care types with, on average, 20 per cent relating to home-based (foster) care, eight per cent involving kinship care and two per cent relating to other care types, such as lead tenant settings and secure welfare services.

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

This year, the Commission asked for further information for 135 out-of-home care incidents, 60 per cent more than the previous year (60 queries) to be assured no systemic issues presented, and that individual children's needs were being met. Of the matters where we asked for further information, most related to residential care (65 per cent of the matters), followed by kinship care (18 per cent), as shown in Table 5 opposite.

Table 5. Commission's OOHC incident queries by care type 2017–18

Care type	Count	Percentage
Residential care (all)	88	65
Kinship care	24	18
Home-based care	16	12
Child protection – not OOHC	3	2
Secure welfare	2	1
Lead tenant	2	1
Total	**135**	**100**

As shown in Table 6, most of our queries about out-of-home care incidents related to poor quality of care incidents and self-harm incidents.

13 Residential care incidents this year accounted for 68 per cent of CIR incidents and 64 per cent of CIMS incidents provided to the Commission.

Table 6. Commission's OOHC incident queries by incident type 2017–18

Incident type[14]	Count	Percentage
Poor quality of care	18	13
Self-harm	17	13
Behaviour – dangerous	12	9
Suicide attempted	10	7
Physical assault/staff on client	7	5
Absent/missing person	7	5
Behaviour/sexual	6	4
Behaviour/sexual exploitation	6	4
Dangerous actions/client	6	4
Emotional/psychological trauma	5	4
Injury	5	4
Sexual assault/rape/ other on client	4	3
Physical assault/other on client	4	3
Sexual assault/indecent/client on client	3	2
Drug/alcohol	3	2
Sexual assault/indecent/other on client	3	2
Physical assault/client on client	3	2
Sexual assault/sexual abuse	3	2
Other incidents	13	10
Total	**135**	**100**

Queries about incidents involving Koori children accounted for 23 per cent of the out-of-home care incidents examined further by the Commission (31 matters). In 11 matters, we asked for copies of the children's cultural support plans.

This year, the Commission commenced theming our queries.[15] As shown in Table 7, the greatest proportion of our incident queries over the past 12 months related to safety, health and wellbeing (62 incidents, 46 per cent).

Table 7. Commission's OOHC incident queries by query theme 2017–18

Query theme	Count	Percentage
Safety, health and wellbeing	62	46
Family environment and people who matter to me	26	19
Reaching my full potential	25	19
Cultural experience	11	8
Rights and freedoms	11	8
Total	**135**	**100**

Key themes arising from our monitoring of incidents include the need for:

- children to receive mental health assessments, support and services when involved in self-harm or attempted suicide incidents
- careful placement consideration by DHHS, especially when children have been moved between placements, or are in contingency arrangements for long periods of time, or whose placement is no longer considered suitable
- cultural support plans to be developed and implemented for every Aboriginal child in out-of-home care.

14 CIR and CIMS categories are reflected in this table.

15 The themes align with the themes and rights of the United Nations Convention on the Rights of the Child.

Our impact – scrutiny of practices for vulnerable children

In January 2018, the Commission received a report of an incident in secure welfare that resulted in a child being injured during the restraint and subsequently being taken to hospital. The Commission's review of the CCTV footage and preliminary information identified a series of concerns in relation to the child's support prior to and during the period at secure welfare. As a result of these significant concerns, an individual inquiry was established under section 37(1)(a) of our legislation. The inquiry is scheduled to be completed in 2018.

Approaches from the public

While the Commission does not have a legislated complaint-handling function, we often receive calls or emails from members of the community raising concerns about the safety and welfare of children and young people, or the actions of government departments and other agencies.

This year we received 763 contacts from the public, which is 137 more than last year, when we received 626 contacts.

Last year we were able to identify that 30 per cent of these kinds of inquiries related to Koori children. In 51 per cent of cases, no information was provided regarding the Aboriginal status of the child, meaning that in reality the proportion may have been higher.

Where possible, we also record information about the placement context of the child. The largest proportion of calls related to children in kinship care (32 per cent). The second largest category related to children in home-based care (20 per cent).

Child death inquiries

Under the *Commission for Children and Young People Act 2012* we must conduct an inquiry into the services provided to a child who 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 the trigger for an inquiry, the Commission makes no findings as to the cause of death. Instead we focus on services provided or not provided to a child in the time preceding their death.

Child deaths reported to the Commission 2017–18

We were notified of the deaths of 26 children in 2017–18, including six 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 8. Child death notifications received by the Commission by Aboriginal status and category of death 2017–18

Category of death	Aboriginal	Non-Aboriginal	Total	Percentage
Illness	4	7	11	42.3
Sudden unexpected death in infancy (SUDI)[16]	1	6	7	25.9
Pending determination	1	3	4	15.3
Accident		2	2	7.4
Suicide/self-harm		1	1	3.7
Non-accidental trauma		1	1	3.7
Total	**6**	**20**	**26**	**100**[17]
Percentage	**22.2**	**77.8**		

Table 9. Child death notifications to the Commission by Aboriginal status and age 2017–18

Child's age at death	Aboriginal	Non-Aboriginal	Total	Percentage
0–5 months	4	8	12	44.4
6–11 months		2	2	11.1
1–3 years		2	2	3.7
4–12 years		3	3	14.8
13–17 years	2	5	7	25.9
Total	**6**	**20**	**26**	**100**
Percentage	**22.2**	**77.8**		

Child death notifications received by the Commission for the last five years

Consistent with previous years, the highest proportion of children who died after being involved with Child Protection were infants aged 0–5 months (48 per cent). The next largest cohort was made up of adolescents aged 13–17 years (24 per cent). This is also consistent with previous years' data. The high rate of very young infants is of serious concern. In particular, the number of infants who appear to have died due to SUDI is of concern and the Commission will monitor this closely to determine patterns or themes.

Also of concern is the fact that two thirds of Aboriginal children who died this year were under the age of six months and Aboriginal children also made up a higher overall proportion of child deaths who were the subject of Commission inquiries (23 per cent compared with 12.5 per cent) in the prior year.

16 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).

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

Table 10. Child death notifications received by the Commission by category of death 2013–17[18]

Category of death[19]	2013–14	2014–15	2015–16	2016–17	2017–18	Total
Illness	12	15	13	13	11	64
Accident	3	3	7	6	2	21
Suicide/self-harm	4	4	5	4	1	18
Non-accidental trauma	5	1	6	3	1	16
Unascertained[20]	7	0	2	1	0	10
Sudden unexpected death in infancy (SUDI)	2	0	4	3	7	16
Drug/substance related	3	0	0	3	0	6
Pending determination[21]	1	1	1	3	4	10
Total	**37**	**24**	**38**	**36**	**26**	**161**

Table 11. Child death notifications received by the Commission by Aboriginal status 2013–17

Status	2013–14	2014–15	2015–16	2016–17	2017–18	Total	Percentage
Aboriginal	2	4	4	4	6	20	12.2
Non-Aboriginal	36	20	34	32	20	142	87.6
Total	**38**	**24**	**38**	**36**	**26**	**162**	**100**[22]

Child death inquiries completed

In 2017–18 we finalised 33 inquiries and made 43 recommendations. These related to children who died between 2016 and 2018. Five of the inquiries related to Aboriginal children and 28 inquiries related to non-Aboriginal children. Over half of the children in our finalised inquiries were living at home (54 per cent) while none of the Aboriginal children were at home. Illness accounted for 15 child deaths reviewed (45 per cent). Over three-quarters of children in our finalised inquiries had been subject to between one and three reports to Child Protection while two children were subject to nine or more reports.

Seventeen (51 per cent) of our inquiries related to children whose cases had been closed by Child Protection in the 12 months prior to the child's death.

18 This table shows categories of death (not cause of death) for the relevant financial year as at 30 June 2018. Cause of death is determined by the Coroner's Court of Victoria.

19 The category of death is indicative only; it is based on information available to the Commission.

20 Unascertained refers to deaths in which a coroner could not determine the cause of death.

21 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.

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

Table 12. Child death inquiries completed by the Commission by age, category of death and Aboriginal status 2017–18

Category of death	Aboriginal	Non-Aboriginal	Total
Illness	**2**	**13**	**15**
0–5 months	2	6	8
6–11 months		1	1
4–12 years		4	4
13–17 years		2	2
Sudden unexpected	**0**	**5**	**5**
0–5 months		5	5
6–11 months		0	0
Accident	**0**	**5**	**5**
1–3 years		1	1
4–12 years		2	2
13–17 years		2	2
Drug-related	**0**	**1**	**1**
4–12 years		1	1
Suicide/self-harm	**1**	**3**	**4**
13–17 years	1	3	4
Pending determination	**2**	**0**	**2**
13–17 years	2	0	2
Unascertained	**0**	**1**	**1**
0–5 months		1	1
Total	**5**	**28**	**33**

Table 13. Child death inquiries completed by the Commission by living arrangements at death 2017–18

Child's living arrangements at time of death	Aboriginal	Non-Aboriginal	Total
At home with parent	0	20	20
Foster care	1	0	1
Homeless	0	0	0
Hospital	0	4	4
Kinship care	1	0	1
Living independently	1	0	1
Never left hospital	2	4	6
Total	**5**	**28**	**33**
Percentage	**15.6**	**84.4**	**100**

Practice themes

In the child death inquiries we conducted in 2017–18 we identified a number of recurring issues that prompted recommendations for improvements to services. These included:

- reaching the hard-to-reach
- unborn child reports
- collaboration between services
- Aboriginal Children's right to culture
- identification and assessment of risk
- family violence
- access to mental health and alcohol and drug supports.

Reaching the hard-to-reach

In six cases, the inquiry found that Child Protection referrals to Child FIRST were inappropriate given the level of risk of harm to which the child was exposed.

One inquiry also raised concerns that Child FIRST did not appear to be resourced to be capable of engaging with hard-to-reach families. The same inquiry found that, early in his life, the child missed out on educational supports as his involvement was contingent on his parents' engagement with the service, consent for him to attend, and his school attendance.

We are concerned that these inquiries may point to the existence of a cohort of children and young people who do not meet the threshold for statutory intervention by Child Protection, but whose families are unable or unwilling to engage with Child FIRST and family services and whose safety, wellbeing and development is diminished as a consequence. This echoes findings made in the Commission's inquiries into child deaths involving cumulative harm and suicide and into child deaths involving children with complex needs and/or disability.

Case study

The refer-and-close roundabout

Tia's death was due to an accidental injury when she was a teenager. Before her death, Tia was living with her mother, step-father and siblings. Tia's stepfather was in and out of prison due to violent offending.

Child Protection received seven reports about Tia and her family. These reports were related to her poor school attendance, as well as family violence committed by her step-father against Tia and her siblings. Tia's mother was reported to have poor mental health and a history of drug use.

Many of the reports received by Child Protection highlighted that Tia's mother found it difficult to engage with services. However, prior to ceasing its involvement, Child Protection referred Tia's mother to Child FIRST on a number of occasions to help improve her parenting capacity, promote the family's wellbeing and improve Tia's school attendance.

When Child FIRST attempted to engage Tia's mother by phone or SMS, she either did not respond or refused assistance. Child FIRST then closed her case. As Tia's mother refused to engage with these services, Tia did not get the help she needed to stay at school and reduce her exposure to family violence.

Despite her repeated refusal to engage with the service, we found that Child Protection and Child FIRST did not determine why Tia's mother did not want to engage with the services or develop strategies to overcome these barriers to engagement once identified.

As a result of Tia's case, we recommended that the Department of Health and Human Services work with Child FIRST services to develop and extend its evidence-based strategies for engaging with hard-to-reach families. We also recommended the department implement a funding model that enables family services to work longer and more intensely with complex and vulnerable families.

Unborn child reports and responses to high-risk infants

The *Children Youth and Families Act 2005* allows Child Protection to receive reports before a child is born when a person has a significant concern about the wellbeing of a child before birth. The purpose of these unborn reports is to prevent harm to the child and provide support to the parents of a child at risk.[23] In 2017–18, 12 of the 33 cases we reviewed involved children who had been the subject of an unborn report.[24]

This year, six of our inquiries found Child Protection did not use the period of the unborn report to assess risk to the child when born, consider the type of referrals required to address the risks to the baby, or bring services working with an expecting mother together. These were missed opportunities to engage with the mother, share information and collaborate to bring about an earlier, coordinated response prior to the birth of the child.

However, the Commission has raised concern about responses to unborn reports in past years and noted some improved practice in response to unborn reports. In three cases, when Child Protection became aware of unborn babies who were at risk, Child Protection put in place supports which were sensitive to the mother's parenting capacity and family dynamics.

In 2017–18, six of our child death inquiries found that Child Protection staff did not follow guidelines about infants with a high-risk status. In these cases, Child Protection practitioners did not hold case conferences with other services and so did not have vital information necessary to assess risks and respond to the needs of these infants. We also found that services, including Child Protection, did not adequately assess and respond to the risks posed by factors such as drug use and family violence to high-risk infants.

Case study

Responding to unborn reports

Justin died from what appears to be SIDS aged less than six months. His mother had an acquired brain injury which impaired her cognitive ability and she was not linked in to disability services. She also had older children whom she was struggling to care for. During her pregnancy, Child Protection received an unborn report about Justin and his three-year-old sibling's failure to thrive. Child Protection referred the family to a family support service and after seeking further information from the three-year-old's child care centre, closed the unborn report.

Once Justin was born, the maternity hospital noted a number of concerns about the capacity of Justin's mother to care for her baby but did not make any reports to Child Protection.

The Commission found that neither Child Protection nor the maternity hospital had done enough to assess the risk to Justin, given his mother's cognitive capacity and previous history of concerns about her parenting capacity and that Justin should have been referred to the High Risk Infant register.

We recommended that the report be used in training to highlight the kinds of circumstances in which early identification of risk and adequate coordinated case planning is advisable for vulnerable children who come to the attention of Child Protection through unborn reports.

23 DHHS, Child Protection Manual, Unborn reports – advice (website) accessed 3 August 2017.

24 The Commission notes that the unborn report was not always the subject of in-depth analysis for children and young people who were subject to multiple reports over the course of their lives.

The department's *Focus on infant strategy* has been developed in large part as a response to these findings. The strategy intends to strengthen the capacity of Child Protection staff to identify key risks to infants and to build strong relationships with infant services to ensure that high-risk infants are well supported by the broader service system. Each of the divisions of DHHS now has a senior practitioner focused on practice and processes in relation to infants and new Child Protection practitioners are provided with training about the particular vulnerabilities of infants during the department's Beginning Practice Program.

The Commission will continue to monitor the impact that this new strategy has on Child Protection practice in relation to high-risk infants.

Collaboration between services

As in previous years, the Commission has again found that collaboration between services is a recurring issue in child death inquiries, often stemming from a lack of understanding of roles and responsibilities between different parts of the service system.

In 2017–18, our child death inquiries highlighted room for improvement in information-sharing and collaboration between Child Protection, medical services and schools focused on promoting the safety and wellbeing of children and young people.

The Commission has found that, as a result of poor collaboration, services have often lacked a shared understanding of risk faced by children and young people and also that formal referral pathways have not been established between hospital emergency department and maternal child health services. On the basis of such findings, the Principal Commissioner was invited to speak at a meeting in April 2018 with hospital chief executives on the development of local agreements between hospitals and Child Protection to improve how they collaborate to best promote the safety and wellbeing of vulnerable children and their families.

Case study

Collaboration around a vulnerable child with a complex medical illness

Jeremy was diagnosed with a developmental delay and a chronic illness when he was five years old. He died when he was eight due to complications managing this illness.

Child Protection received eight reports about Jeremy and his family. All reports related to Jeremy's parents' capacity to manage his complex medical needs.

There were a number of services involved in Jeremy's care including Child Protection, two health services and his school. The Commission found that each service held information relevant to the poor management of Jeremy's chronic health condition, his parents' capacity to respond to his medical needs, and the impact of their relationship on their ability to do this. However, these services did not come together to share this information, which compromised their shared understanding of the extensive medical risk he faced.

In response to this finding, we recommended that the department, in its current review of the existing Healthcare that Counts framework, make sure that children with chronic health conditions and social risk factors are readily identified and linked with skilled community workers and health professionals. We also recommended the department update the *Practice Manual* to include information about the importance of sharing information and coordinating supports.

Oversight and monitoring *continued*

Aboriginal children's right to culture

Five of our completed child death inquiries this year involved Aboriginal children. Over the last year, our inquiries continued to identify concerns about how Child Protection and other services responded to Aboriginal children's right to culture.

In two inquiries, Child Protection and other services did not take appropriate steps to connect a child to their culture after the service had become aware that they were Aboriginal and the child had expressed an interest in learning more about their culture.

In one child death inquiry, Child Protection did not contact an Aboriginal Child Specialist Advice and Support Service[25] after receiving a report about an Aboriginal child.

These poor practices – which were also identified in the Commission's inquiry report *Always was, always will be Koori Children* – failed to recognise that connection to culture is a protective factor for Aboriginal children or adequately prioritise these children and young people's right to culture.

Identification and assessment of risk

For Child Protection, assessment of vulnerability and risk of harm is critical to determining:

- appropriate referrals to services that can assist in promoting the ongoing health, safety and wellbeing of children
- whether more serious intervention is required to protect the child – for example, making a report to Child Protection or Child Protection taking a matter to the Children's Court if the child's safety cannot be ensured within the family.

In 21 cases there was evidence of inadequate assessment of risk and in two cases there was no risk assessment evident at all. Included in the specific issues noted in relation to risk assessment were that Child Protection did not:

- gather or assess critical information held by service providers or historical information held by Child Protection itself
- sight or speak directly to the child or young person who was the subject of an investigation to gain their perspective
- recognise, assess or respond to indicators of possible sexual abuse of a young person.

Our inquiries continued to find that while Child Protection is often skilled at assessing immediate risk, this year there were eight cases where assessment of cumulative risk was under-assessed, not identified, or not responded to appropriately.

Family violence

Of the 33 cases completed in 2017–18, at least 21 of the children had experienced family violence.[26]

Our child death inquiries continued to highlight significant concerns about Child Protection's response to children impacted by family violence, which the Commission had previously identified in our inquiry report, *Neither seen nor heard*.

Our inquiries noted the following:

- Child Protection appeared to rely on women to ensure the safety of themselves and their children by leaving the violent relationship (this is an unsafe and unreliable mechanism which fails to attend to the dynamics of family violence)
- there was a lack of safety planning or referrals to reduce the likelihood of further incidents

25 During initial assessment of a report regarding an Aboriginal child, Child Protection must consult with an ACSASS for the purpose of seeking advice, assessing risk or determining the most appropriate service response.

26 While family violence was a feature in the children's lives, it was not always a direct cause of death.

Case study

Recognising and responding to cumulative harm

Jade died when she was less than 14 years of age due to a drug overdose. Jade suffered from ongoing abuse and chronic neglect throughout her life. A number of assessments conducted through Jade's school indicated that she had an intellectual disability. Four of the nine reports about Jade to Child Protection were investigated, including a report about Jade still open at the time of her death.

We found that Child Protection did not adequately assess the risk to her associated with living in a family where she was exposed to ongoing family violence and neglect. This included an inadequate overall assessment of the likely impact of Jade's family circumstances on her safety, a failure to conduct adequate parenting assessment of either of her parents, an inadequate assessment of the impact of chronic neglect and cumulative harm, and an inadequate response to Jade's increasingly sexualised behaviour.

- children impacted by family violence did not appear to benefit from therapeutic responses, including to address the impact of intergenerational violence on relationships between family members
- Child Protection typically under-assessed the risk of harm that family violence posed to the child at both intake and investigation phases.

The department expects the development and roll-out of family violence training across the Child Protection workforce will address some of these recurring issues. We remain concerned about the extent of change required to protect and support children affected by family violence.

Our child death inquiries this year also noted the ongoing lack of service responses available to Child Protection for male perpetrators of family violence who refuse to engage with services to address their violence. We note the urgent need for improved and evidence-based interventions with perpetrators of family violence, to ensure accountability for their behaviour and increase the likelihood that they will engage in treatment and not reoffend.

Access to mental health and alcohol and drug supports

This year, several child death inquiries highlighted systemic issues related to the provision of mental health as well as drug and alcohol services to at-risk adolescents.

These inquiries found:

- services (including Child Protection) sometimes did not refer adolescents to mental health or drug and alcohol counselling supports when they needed them, nor did services respond adequately when referrals were made
- mental health services often did not appear to prioritise high-risk adolescents known to Child Protection and there was often a long delay between the referral and the young person receiving a service
- the mental health system at times did not appear to be sensitive to the experience of the young person (in one inquiry, a young person had to tell their story of trauma to multiple services before they could access ongoing mental health supports).

However, we also identified several examples of family services and schools actively increasing supports to adolescents deemed at risk of suicide.

Influencing policy, services and the law

Overview

The Commission provides advice to government and advocates broadly for improvements to policies, laws and services that affect children and young people.

This year, we made more than 30 formal submissions to government, parliamentary inquiries or statutory bodies. Our Commissioners also provided advice to government through a number of 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 improvements for children and young people through the media and by talking directly to the community and stakeholders at forums, conferences and other events. This year, the Principal Commissioner gave more than 50 speeches and the two successive Commissioners for Aboriginal Children and Young People spoke at more than 20 events.

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

- reforms to improve information-sharing between different services to better support children's safety and wellbeing
- measures to address offending by, and support the rehabilitation of, children and young people
- a greater focus on the impact of family violence on children and young people
- inclusive education, including submissions to the Department of Education and Training (DET) to improve expulsion processes and prevent vulnerable children being excluded from school
- children's rights, including through submissions on implementation of the Convention on the Rights of the Child and adherence to Victoria's *Charter of Human Rights and Responsibilities Act 2006*
- the recommendations of the *Royal Commission Into Institutional Responses to Child Sexual Abuse* and remaining recommendations of the *Betrayal of Trust* report, including reforms regarding the legal identity of certain organisations for redress and civil compensation purposes.

Information-sharing to support children's safety

The Commission has long advocated for reforms to facilitate better information-sharing focused on supporting children's safety.

Through our work, we often see examples where poor – or no – information exchange between professionals compromises their ability to protect and support children and young people. For these children and young people, the consequences of inadequate information-sharing can be serious, or even lethal.

For several years, recommendations arising from our child death inquiries have stressed the need for enhanced information-sharing to support the safety of children and young people. Our 2016–17 annual report found that of the 34 child death inquiries conducted, 21 highlighted issues relating to information-sharing.

In light of our advocacy on this issue, the Commission welcomed the introduction of a legislated child wellbeing information-sharing scheme and was pleased to work with government to inform the approach and implementation of these changes.

Drawing upon the unique insights gained from review of our child death inquiries, we used these submissions to highlight the importance of:

- ensuring any scheme is clear to workers, service providers, children, families and the wider community
- involving children and young people in decision-making processes that affect them, where safe and appropriate to do so
- promoting inclusive participatory practices for a diverse range of children, including those who are Aboriginal and Torres Strait Islander, those who identify as same-sex-attracted, gender diverse or intersex, those who are culturally and linguistically diverse, and those with a disability
- promoting capacity-building and consistency of approach across sectors, while embedding a child-focused culture within organisations.

Of course, legislative change is only the first step and needs to be supported by long-term effort to support a culture of appropriate information-sharing within organisations and sectors working with children and young people. This will require significant workforce development. The Commission will continue to monitor and support the significant work now required to train workers and promote cultural change to ensure the safety and protection of children.

This year, we also welcomed the introduction of a legislated family violence information-sharing scheme. The Commission used its submissions to government to highlight:

- the need to ensure recognition of children and young people who are victims of family violence
- the importance of involving children and young people in decision-making processes that affect them where safe and appropriate to do so
- the need for a differentiated approach for children and young people who use family violence based on a range of biological, psychological and social factors
- the importance of adopting a therapeutic approach to children and young people who use family violence.

Criminal justice responses to children and young people

This year saw a continued focus on offending by young people through the media and policy debate. The Commission shares an interest in improving community safety and used its advice to government, and its broader advocacy, to call for responses that are effective, age-appropriate and targeted.

Having advised during 2017–18 on reforms related to youth diversion, the dual track system, and increased penalties for certain offences, this year we also provided specific advice on five areas of reform, including proposed amendments to:

- youth parole laws and the introduction of new conditions such as electronic monitoring and drug and alcohol testing
- remove psychosocial immaturity as a relevant consideration in the mandatory sentencing of young people for attacks on emergency service workers
- laws on DNA sampling and forensic testing.

The Commission also had input into the reform of youth justice services through the Youth Justice Reference Group, our ongoing monitoring advice and submissions in relation to the design of the new youth justice facility at Cherry Creek. We will continue to provide advice in support of a strong, humane and effective youth justice system based on past inquiries and what we see through our incident monitoring and visitor functions.

Reviews of terrorism laws

Following a government-initiated review of counter-terrorism laws, conducted by an Expert Panel on Terrorism and Violent Extremism and Response Powers, Victoria's existing preventative detention scheme has been expanded to apply to children aged 14 and older. The amended scheme empowers police to detain an individual and question that person without charge or the suspicion of having committed an offence.

Through consultations and submissions, we questioned whether evidence supported the need for the scheme to apply to children and advocated for significant safeguards in the event children were to be included.

The Commission was pleased that the legislation ultimately introduced and passed contains some critical safeguards, including a direct monitoring role for the Commission as soon as a child is taken into custody. While we retain concerns about the application of such a scheme to children, the Victorian laws feature significant safeguards not included in the equivalent legislation in other jurisdictions.

Also this year, the Independent National Security Legislation Monitor invited the Commission to prepare a submission in relation to its review of the prosecution and sentencing of children and young people for Commonwealth terrorism offences. We advocated for the development of a nationally consistent approach to bail, prosecution and sentencing, which incorporates a range of safeguards specific to children and young people. We submitted that any laws impacting children and young people be underpinned with the rights enshrined by the Convention on the Rights of the Child.

ACCG Youth Justice Principles

The Australian Children's Commissioners and Guardians (ACCG) is a coalition of independent commissioners, guardians and advocates for children and young people from around Australia.

In November 2017, in the context of the report of the *Royal Commission into the Protection and Detention of Children in the Northern Territory* and issues affecting youth justice detention in a number of other jurisdictions, the ACCG agreed on a position statement on conditions and treatment in youth justice detention.

Children, young people and family violence

The Commission has 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 continued to contribute to the Victorian Government's Family Violence Steering Committee and other advisory groups guiding aspects of the reforms. The Principal Commissioner delivered 11 keynote addresses on the subject of children and family violence and spoke out on the issues in media including through an open editorial in the *Herald Sun*, 'We can't ignore kids' stories of family violence'.

Specific policy or other submissions on family violence included:

- the Crime Statistics Agency's *Draft Victorian family violence data framework: A guide for the collection of data by Victorian family violence service providers and agencies*, where we recommended inclusion of a substantive reference to children and young people and their experiences of family violence. The Commission was pleased to see the framework was amended to include a new section specifically collecting data on the involvement of children and young people.
- recorded evidence in chief in family violence proceedings, in which we recommended that the model be implemented in a way that differentiates between adults and young people who use family violence and promotes the use of diversionary and therapeutic options for young people. We were pleased to see that, in accordance with our feedback, the recorded evidence-in-chief scheme will not apply to persons under 18 years at the time the family violence offence is alleged to have been committed.
- the Victoria Police strategy to reduce family violence, sexual offences and child abuse, where we recommended that the overall approach of the strategy should recognise children as a distinct victim cohort, ensure adherence to the principle of Aboriginal self-determination, include disaggregated data reflecting the experiences of Aboriginal and Torres Strait Islander children and young people, and promote the use of trauma-informed approaches when working with children and young people.

Media and public appearances

The Commission was active in the media and through public appearances throughout 2017–18 advocating to protect children and young people across a range of areas in which they experience heightened vulnerability.

Informed by our policy, oversight and inquiry work, we made media comment on child protection and out-of-home care, children as victims of family violence, the over-representation of Aboriginal children and young people in care, and the need to extend care until young people turn 21. We also spoke out on issues affecting young people who offend, highlighting practices that harm young people and undermine their rehabilitation, such as solitary confinement. We called for action to address the over-representation of Aboriginal children and young people in youth justice, and questioned the effectiveness of anti-terror laws targeting children. In the context of the federal postal survey on same-sex marriage we also urged the community to pay particular attention to the experiences of young people who identify as LGBTI, those coming to terms with their sexuality or gender identity and children in same-sex families.

Through speaking engagements, the former Commissioner for Aboriginal Children and Young People continued to speak nationally about the need for urgent action on the growing numbers of Aboriginal children in out-of-home care, and the need to improve responses to those children and their families. The incoming Commissioner for Aboriginal Children and Young People added to this with a focus on issues facing the disproportionate numbers of Aboriginal children in our youth justice systems.

Submissions

This year, the Commission completed more than 30 formal submissions related to information-sharing, youth justice and family violence, using our contact with children and young people and insights obtained through oversight activities to contribute to policy and inquiries related to issues such as:

- inclusive education, with submissions to the Department of Education and Training on written materials, guidance and procedures designed to improve expulsion processes and prevent vulnerable children being excluded from school, the *Inclusive education policy for students with disabilities and additional needs* and the revised *Out-of-home care education commitment*
- support for kinship carers – for example, we used our insights from direct contact with kinship carers and from *Taskforce 1000* to contribute to the Victorian Ombudsman's *Investigation into the financial support provided to kinship carers*
- children's rights, including through submissions to the National Children's Commissioner's review of Australia's progress in implementing the *Convention on the Rights of the Child* and to the Victorian Equal Opportunity and Human Rights Commission in relation to its review of the adherence to the *Charter of Human Rights and Responsibilities Act 2006*
- the recommendations of the *Royal Commission into Institutional Responses to Child Sexual Abuse* and remaining recommendations of the *Betrayal of Trust* report, including reforms regarding the legal identity of certain organisations for redress and civil compensation purposes.

Improving outcomes for Aboriginal children

Overview

The Commission for Children and Young People is committed to highlighting the issues and causes of over-representation of Aboriginal children and young people within the child protection and youth justice systems. Working with government, stakeholders, the Aboriginal community and relevant forums such as the Aboriginal Children's Forum and the Aboriginal Justice Forum, we bring about long-term systemic change that respects the cultural rights of Aboriginal people, responds from a place of inclusion and understanding, and embodies the principles of Aboriginal self-determination.

The Commission engages extensively with the Aboriginal community to ensure we hear their stories and are able to effectively advocate for all Aboriginal children and young people in Victoria. These stories sometimes reflect the systemic racism and abuse that continue to exist, but also stories of achievement, success, family and loving and hopeful communities. The Commission has a responsibility to continue these difficult conversations and, where necessary, to counter some of the myths and assumptions about the Aboriginal community based on a society that enshrines a deficit model approach to that community.

The Commission is also committed to leading as an organisation in building our cultural capacity to work towards a workplace that reflects the diversity of the Victorian community. We continue to work towards fully implementing our Aboriginal Inclusion Action Plan and are due to evaluate and publicly report on our work on this in 2019. We also have continued our relationship with the Victorian Aboriginal Community Controlled Health Organisation to provide cultural awareness training and development to our staff.

The Commission, through the leadership of our Commissioner for Aboriginal Children and Young People and through our Koori Advisory and Engagement Team continues to engage in issues and policy affecting Aboriginal children and young people in the child protection system and in youth justice, but has also continued to expand oversight of education systems and outcomes for Aboriginal children, as well as beginning to better understand the role of health, mental health and homelessness services for our children, young people and families.

Illustrations in this section are details from Eileen Harrison's painting *Coming Home*.

Aboriginal cultural rights in youth justice centres

Through the Commission's Independent Visitor Program we became aware that Aboriginal children and young people in custody were not having their cultural rights and needs met. For example, the only cultural program at Parkville Youth Justice Centre was a brief weekly program, and young people were often prevented from attending due to court or security concerns.

Given this, we partnered with the Victorian Equal Opportunity and Human Rights Commission to produce a report highlighting the need to support Aboriginal cultural rights and strengthen cultural connections for Aboriginal children and young people in youth justice. The report is based on an examination of cultural and human rights principles as well as interviews with Youth Justice staff, key external stakeholders and was reviewed by Koori Caucus.

The report, which was released in July 2018, makes eight recommendations to ensure cultural rights are protected and promoted for Koori young people in custody, including through the Victorian Government's Koori Youth Justice Strategy.

The recommendations cover the development of the Koori Youth Justice Strategy, provision of cultural programs within youth justice centres, the development of a youth social and emotional wellbeing strategy, a review of existing policies to promote kinship connections, Aboriginal staffing within centres, staff training, and cultural design within the proposed Cherry Creek youth justice facility. The Commission is pleased that government's response indicates that our recommendations will be reflected in the development of a Koori Youth Justice Strategy, and we look forward to receiving an action plan for implementation from the Department of Justice and Regulation.

Aboriginal Youth Justice Taskforce

In 2016 the Victorian Government requested that Professor James Ogloff and Penny Armytage conduct a review of the youth justice system. The resulting report, *Meeting needs and reducing offending: Youth justice review* and strategy recommended that government:

> Resource the Commissioner for Aboriginal Children and Young People to undertake the equivalent of a *Taskforce 1000* project for every Koori young person involved in youth justice.

Taskforce 1000 examined the circumstances of every Aboriginal child and young person in out-of-home care. Conducting an equivalent project in youth justice will offer significant opportunities to improve the outcomes for young people in youth justice through oversight and assessment of their individual plans and consideration of all aspects of their care, education, health and connection to culture.

Since government accepted the recommendation, and funding for the taskforce was allocated in the 2018–19 state budget, we have worked closely with the Department of Justice and Regulation to develop draft terms of reference that will be approved by a reference group made up of key stakeholders from government, community organisations and Aboriginal community representatives.

The *Taskforce* will review all Aboriginal children and young people in youth justice custodial and community systems over a 12-month period, and will be conducted by the Commission and the Department of Justice and Regulation. The Commission will simultaneously run an own-motion inquiry to independently investigate the systemic issues affecting Aboriginal children and young people within the youth justice system.

Transitioning Aboriginal children to Aboriginal care

The Commissioner for Aboriginal Children and Young People and the Koori Advisory and Engagement team have continued to work closely with DHHS, CSOs and ACCOs through forums such as the Aboriginal Children's Forum, to progress and monitor the two key Aboriginal self-determination platforms that sit within Child Protection policy – implementation of section 18 guardianship and transitioning Aboriginal Children to Aboriginal Care (ACAC).

These important initiatives were driven by the reports of two Commission inquiries tabled in October 2016 – *Always was, always will be Koori children* and *In the child's best interests*, the impacts of which are discussed in more detail on page 31.

Wungurilwil Gapgapduir: Aboriginal children and families agreement

Launched in 2018, *Wungurilwil Gapgapduir* is a tripartite partnership between the Victorian Government, Aboriginal organisations and the children and family services sector that provides strategic direction and a framework to reduce the number of Aboriginal children in out-of-home care through fostering and enhancing connection to culture, Country and community. The Commission strongly supports the development of this agreement and the associated strategic action plan, which recognise recommendations made in our reports – *In the child's best interests* and *Always was, always will be Koori children*.

Wungurilwil Gapgapduir has five central objectives that will be measured and monitored via the associated strategic action plan. The five objectives are:

- encourage Aboriginal children and families to be strong in culture and proud of their unique identity
- resource and support Aboriginal organisations to care for Aboriginal children, families and communities
- commit to culturally competent and culturally safe services for staff, children and families
- capture, build and share Aboriginal knowledge, learning and evidence to inform practice
- prioritise Aboriginal workforce capability.

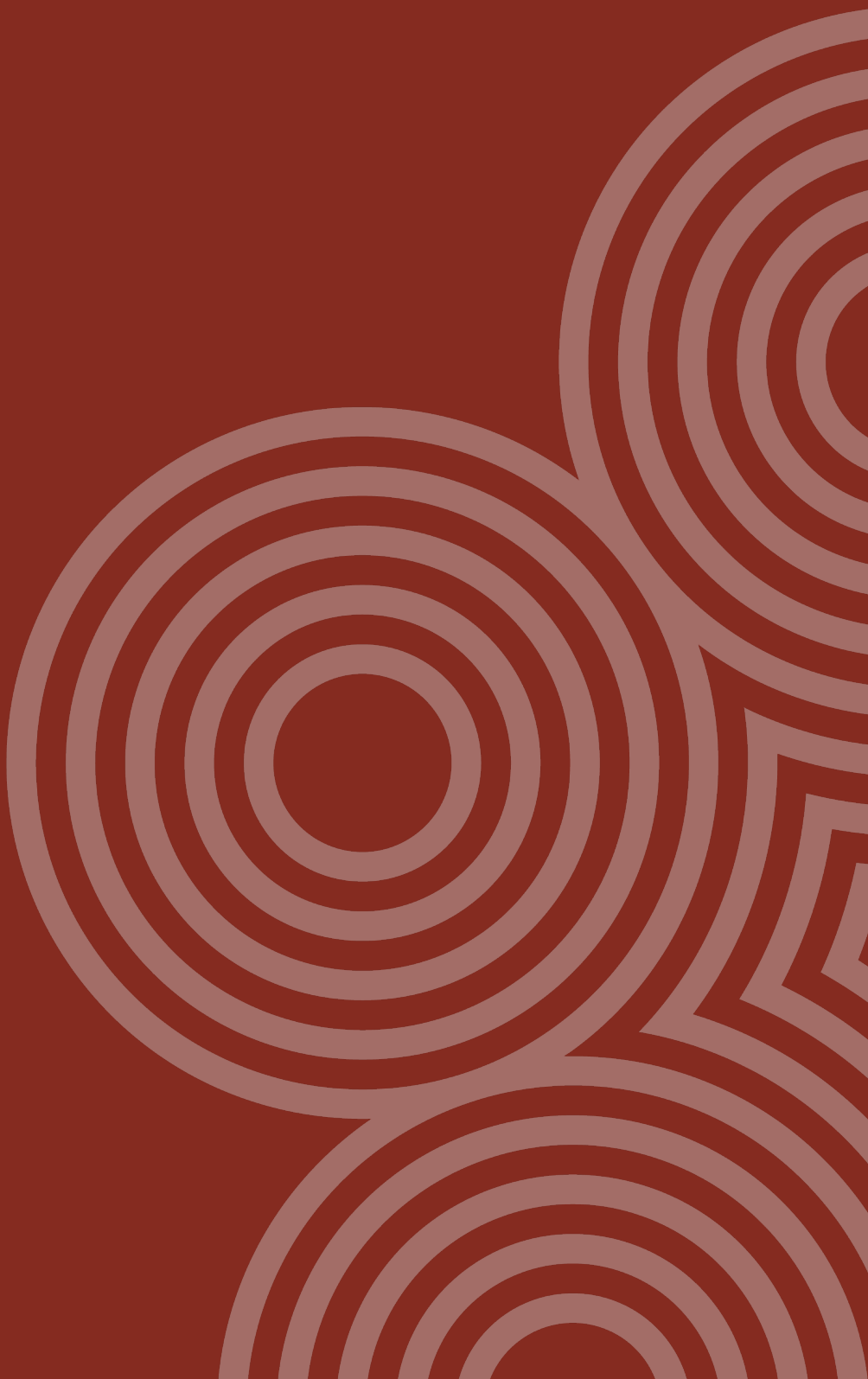
The Commission will focus on monitoring the implementation of the strategic action plan.

Aboriginal Justice Agreement Phase 4

In 2017 the Commissioner for Aboriginal Children and Young People and members of the Koori Advisory and Engagement unit supported the development of Phase 4 of the Aboriginal Justice Agreement, which was released in August 2018.

We advocated for the needs of Aboriginal children and young people to be a core focus, and for government and community partners to commit to early intervention, prevention and diversion.

Supporting and regulating child-safe organisations



The final report of the landmark *Royal Commission into Institutional Responses to Child Sexual Abuse* was tabled on 15 December 2017. This report, the culmination of five years of effort to expose, examine and ultimately prevent the abuse of children in organisational settings, recommended that all Australian states and territories legislate to establish mandatory Child Safe Standards and a Reportable Conduct Scheme for certain organisations that engage with children.

With Victoria's Reportable Conduct Scheme starting on 1 July 2017, Victoria is the only jurisdiction in Australia that has already legislated a set of mandatory Child Safe Standards together with a Reportable Conduct Scheme as recommended by the Royal Commission. The Commission for Children and Young People is responsible for administering both the Reportable Conduct Scheme and the Child Safe Standards in Victoria.

Highlights

- The Reportable Conduct Scheme commenced on 1 July 2017 with organisations submitting 851 notifications of allegations of reportable conduct in the first 12 months of operation.
- To fulfil its new regulatory role in Child Safe Standards and the Reportable Conduct Scheme, the Commission transformed its systems, staffing model and operations.
- The Commission took action because concerns were identified about potential non-compliance with Child Safe Standards in relation to 58 organisations.
- The Commission delivered 39 information sessions to 1,262 participants from organisations in the first two phases of the commencement of the Reportable Conduct Scheme and 17 information sessions with 471 participants on Child Safe Standards.

Royal Commission

Between 2013 and 2017, the Royal Commission gathered evidence of widespread sexual abuse of children in organisational settings and examined how these organisations responded when allegations or suspicions of abuse were raised. The Royal Commission's findings added to what had previously been exposed by the Victorian Parliamentary *Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations*, commonly referred to as the *Betrayal of Trust* report, that we can neither deny the extent of harm done to children in some of our most trusted organisations, nor can we deny that flawed systems and responses have allowed abuse to continue and more children to be harmed.

At the Commission, we know most organisations working with children have children's best interests at heart. However, we also see many organisations that do not have the necessary culture, policies, and practices in place to keep children in their organisation safe.

Together, the Child Safe Standards and the Reportable Conduct Scheme will help organisations, families and the wider community work to keep children safe and empowered, and to prevent and respond to institutional abuse. The kind of change needed, however, will not happen immediately. Delivering on the intent of the Royal Commission and Victoria's own *Betrayal of Trust* inquiry will take time, requiring long-term and sustained investment of effort and resources across community organisations, government departments, educational institutions, religious bodies and all organisations that engage with children. Legislating mandatory Child Safe Standards and establishing a Reportable Conduct Scheme is just the beginning.

The Commission as regulator

Whilst the Child Safe Standards commenced on 1 January 2016, the Commission assumed responsibility for their administration on 1 January 2017. Complementing the Standards, the Reportable Conduct Scheme has a staged commencement with organisations being brought into scope in three phases. The Scheme commenced on 1 July 2017 with the first group of organisations coming into scope, followed by the second phase of organisations on 1 January 2018. The final phase of organisations will become subject to the Scheme on 1 January 2019.

The Commission's new regulatory functions cover a huge number of Victorian organisations with over 10,000 organisations that will be subject to the Reportable Conduct Scheme once it is fully implemented in January 2019, and in excess of 50,000 organisations already subject to the Standards.

The Commission has expanded its staffing (26.6 FTE at 30 June 2016 to 53.8 FTE at 30 June 2018), implemented new case management and IT systems and put in place a new organisational structure to support its new role.

With 851 notifications of reportable allegations received by the Commission in 2017–18 pursuant to the Scheme and the Commission acting on 58 concerns of non-compliance with the Standards, there was a substantial increase in the workload of the Commission as a result of taking on these new regulatory functions.

The Commission is anticipating a further increase in workload and increased demand for its services across both the Scheme and the Standards in 2018–19 due to:

- the commencement of phase 3 of the Scheme on 1 January 2019, bringing an estimated 4,000 additional organisations into the Scheme
- a growing awareness in organisations of their legal obligations to comply with both the Scheme and the Standards
- an increasing awareness in the community of the existence of the Scheme and the Standards and the role of the Commission
- a greater focus in the community on preventing child abuse following the tabling of the Royal Commission's final report and the commencement of the National Redress Scheme.

The Commission anticipates a need for increased staff and resources to administer both regulatory regimes and ensure they best operate to reduce child abuse and improve organisational responses to suspected or alleged child abuse.

In becoming a regulator, the Commission has now been issued a Statement of Expectations in which the Minister for Families and Children has asked the Commission to establish a risk-based regulatory approach. This will guide the development of the Commission's regulatory practice through to 30 June 2019.

Both the Scheme and Standards set up a system of shared regulation where the Commission must work with other regulators to achieve its regulatory objectives. The Commission thanks co-regulators for their efforts, ideas and collaboration in approaching the task of protecting children and further refining the operation of both regulatory regimes throughout 2017–18. The work to develop an optimal model of shared regulation for both the Standards and the Scheme will continue in 2018–19.

Legislative amendments to both the Standards and the Scheme took effect on 27 February 2018. The largely technical amendments in the *Health and Child Wellbeing Legislation Amendment Act 2018* included:

- confirming that the Standards apply to organisations that are required to have a child employment permit, and apply whether the organisation or business engages children to provide services, facilities or goods
- allowing some organisations to nominate a head of organisation for the purposes of the Scheme
- clarifying that all formalised kinship and foster carer arrangements are covered by the Scheme
- providing the ability for the Minister to exempt part of an organisation from the operation of the Scheme.

As we administer the Standards and the Scheme, the Commission will consider the need for necessary legislative amendments to ensure the Standards and Scheme are able to best achieve their objectives. We hope to see future reform, for example, to ensure that staff engaged through agency arrangements are appropriately covered by the Scheme.

Supporting compliance

An important part of the Commission's approach to regulation involves supporting organisations to comply with the Standards and the Scheme. This includes not only helping organisations understand what they need to do to comply with legislative requirements, but also assisting organisations to understand what they can do to change culture within their organisations to improve safety for children.

During 2017–18, we continued the significant work commenced in 2016–17 to raise awareness of the regulatory requirements and support organisations to meet their obligations under the Standards and the Scheme. The significant number of organisations within the Commission's regulatory remit and the diversity of sectors covered makes this task challenging. Working with co-regulators and peak bodies is a key part of the Commission's approach to magnifying messages about the need to comply with legislative requirements and change organisational culture to better protect children.

Key actions in 2017–18 included:

- publishing a range of new information sheets, guides and posters on the Commission's website providing guidance, advice and information to organisations about the Standards and the Scheme
- delivering regular in-person information sessions on the Standards and the Scheme
- publishing narrated presentations on the Standards and the Scheme on the Commission's website
- delivering train-the-trainer programs to assist peak bodies and Victorian government departments to build capacity in specific sectors.

Education activities

Information sessions

The Commission delivered 17 information sessions dedicated to the Standards to 471 participants from in-scope organisations, reaching a broad range of sectors. Sessions provided an overview of the Standards and why we have them, strategies to create a child-safe organisation and practical activities for participants to help them consider how to implement the Standards in their organisation.

In addition, the Commission delivered 39 information sessions to 1,262 participants about the Reportable Conduct Scheme. Information sessions provided an overview of the Scheme, the responsibilities of a head of organisation and information about how to conduct an investigation. Some information sessions were targeted to particular sectors to support sector specific discussion amongst participants.

Sectors that attended information sessions included education, disability service providers, out-of-home care, child protection, religious organisations, Victorian government departments, boarding schools, overnight camps, hospitals and public health services and early years providers.

Train-the-trainer program

In December 2017, the Commission piloted a two-day train-the-trainer program for the Standards to build capacity in specific sectors and facilitate dissemination of the Commission's information and guidance. Attendees were representatives from regulators and peak bodies, including various Victorian government departments and those with a background in youth engagement and empowerment. The program was well received and further evaluated in March 2018 through a focus group with some of the original participants. Their feedback was used to inform a second train-the-trainer program, which was delivered to the local government sector in May 2018.

Working with the New South Wales Ombudsman on reportable conduct

In October 2017, the Commission partnered with the New South Wales Ombudsman to deliver four sessions on the Scheme and workplace investigations targeted at religious organisations and early years providers. A total of 340 participants attended two sessions in Melbourne, one in Pakenham and one in Ballarat.

> Excellent presentation, very grateful to have had this calibre of presenters and facilitators.

Resources

The Commission significantly expanded the amount of guidance material available on its website in relation to the Scheme in 2017–18 by progressively expanding available information and guidance to reflect learnings from time spent administering the Scheme.

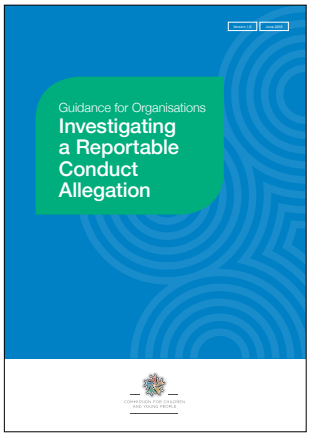
Responding to stakeholder feedback, guidance for organisations on investigating a reportable conduct allegation was developed. This guidance supports organisations and investigators that may not have formal investigations training or experience to conduct an investigation into reportable allegations. It also gives clear guidance on the expectations of the Commission for organisations conducting an investigation into a reportable allegation.

The Commission also published key guidance on the Standards. *A Guide for Creating a Child Safe Organisation* was revised and reprinted to include learnings from the Royal Commission, legislative changes and additional experience gained in creating and supporting child-safe organisations. Within one month of release, almost 2,000 guides were distributed and downloaded from the Commission's website.

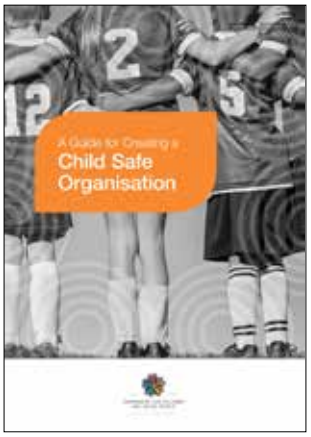
The Commission also used multimedia approaches including developing videos of narrated presentations about the Standards and the Scheme that were viewed almost 7,000 times.

Commission information sheets across a range of topics for both the Scheme and Standards continue to be well-utilised and were downloaded almost 21,000 times in 2017–18.

Victoria's Child Safe Standards poster



Guidance for Organisations: Investigating a Reportable Conduct Allegation



A Guide for Creating a Child Safe Organisation

Our approach to working with organisations

Critical to organisations being supported to comply is their ability to contact the Commission's experienced staff to seek guidance and advice in relation to their individual situation. The Commission encourages organisations to discuss reportable allegations and their investigations with the Commission so that guidance and advice can be provided in a timely manner. The Commission also receives and encourages questions from organisations working to implement the Standards.

The Commission's dedicated telephone enquiry line was also a valuable source of information and assistance on the Standards and the Scheme, including making referrals to other appropriate organisations.

Child Safe Standards

Overview

- In addition to ongoing education and capacity-building, the Commission initiated action in relation to 58 organisations over identified concerns of potential non-compliance with Child Safe Standards.
- This included action by co-regulators, and direct action by the Commission regarding 33 organisations.

The Standards and preventing child abuse

Victoria's Standards, like those recommended by the Royal Commission, are intended to be implemented in a flexible way and are not designed to be prescriptive. They focus on organisations creating cultures, adopting strategies and taking action to prevent harm to children.

Between 1 January and 30 June 2017, the Commission focused on raising awareness of the Standards and providing support to organisations to comply through the provision of information and education. In 2017–18, awareness-raising and education activities continued, and the Commission also started expanding its compliance-related activities.

Some organisations have now been required to comply with the Standards for over two years. In 2017–18, the Commission encountered some organisations that had progressed significantly with a well-developed approach to maintaining the safety of children. There were a number of largely smaller community-based organisations who were unaware of their obligation to comply with the Standards but were committed to implementing the Standards after contact with the Commission. The Commission also encountered organisations that have significant daily engagement with children yet displayed concerning lapses and slow progress in improving their approach to child safety.

The addition of powers to enforce the Standards has assisted the Commission to work with organisations at varying stages of compliance. Whilst enforcement powers such as a Notice to Comply have not yet been deployed, their existence helps organisations to understand the importance of working to implement the Standards. In 2017–18, the Commission generally found where concerns about an organisation not complying with the Standards were raised, organisations demonstrated a commitment to child safety and moved voluntarily to address deficiencies in implementation of the Standards, meaning the use of enforcement powers has not yet been necessary.

In 2016–17, the Commission took action in relation to 12 organisations where concerns were identified about non-compliance with the Standards. This increased to 58 organisations in 2017–18. This increase, due largely to an increase in members of the public contacting the Commission to advise of their concerns that an organisation may not be compliant, demonstrates a growing awareness about the Standards and the role of the Commission in enforcing the Standards.

The Commission anticipates that the number of concerns about organisations raised with the Commission will continue to grow in 2018–19 and beyond due to increasing expectations from the community that action will be taken to reduce risks of child abuse within organisations, and increasing awareness of the Standards and the Commission's role. As the Commission increases its understanding of the sectors it regulates, and builds its trend monitoring and data analysis capability, the Commission will increase its proactive targeting of organisations using an intelligence-led and risk-based approach.

Action by the Commission about non-compliance concerns

In 2017–18, the Commission took action, either directly or by referring to a co-regulator, in relation to 58 organisations where concerns were identified about non-compliance with the Standards.

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

- limited or no implementation of the Standards by small organisations such as small sporting and recreational clubs or organisations, including some that are volunteer-run
- the lack of full implementation of the Standards by large organisations with diverse functions or diffuse networks
- difficulties for religious organisations in achieving consistency in implementation of the Standards across the many individual bodies that make up the religious organisation
- screening practices, supervision policies and codes of conduct within small organisations not sufficiently guiding or empowering organisations to effectively manage alleged or known sex offenders engaging with those organisations
- lack of attention to strategies to promote the participation and empowerment of children
- reporting procedures not being updated to incorporate the Reportable Conduct Scheme.

In 2017–18 organisations were identified for action by the Commission mainly due to members of the public contacting the Commission to advise of their concerns that an organisation may not be compliant. Two other key ways in which organisations were identified were:

- the Commission proactively gathered information from a range of sources suggesting potential non-compliance by an individual organisation
- concerns about potential non-compliance identified by the Commission through a notification of potential reportable conduct.

Table 14. Organisations where the Commission took action about concerns of non-compliance with the Standards by sector as at 30 June 2018

Sector[27]	Numbers of organisations[28]
Education[29]	13
Religious bodies (excluding schools)	12
Sports and Recreation	12
Other[30]	12
Tourism and events	2
Out-of-home care	3
Early childhood	4
Total	**58**

In 2017–18, compliance action was concluded by the Commission in respect of nine organisations.[31]

Implementing and improving compliance with the Standards can be a process of significant cultural change for some organisations, and the Commission's involvement may continue over an extended period as they progressively make the changes required.

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

28 This captures action commenced in 2017–18 in respect of organisations not already the subject of Commission action commenced in previous years.

29 Includes Victorian Government, independent and Catholic primary and secondary schools, and language schools.

30 Includes disability services, Victorian Government departments, emergency service organisations and other organisations not captured in other sector types.

31 Compliance action may have been commenced in 2016–17 or 2017–18. 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.

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, they are considered a relevant authority for that organisation.[32]

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,[33] or consult that relevant authority in action taken by the Commission.

Table 15. Relevant authorities where the Commission has referred a concern of non-compliance with the Standards or consulted on compliance action as at 30 June 2018

Relevant Authority	Number of referrals made by the Commission[34]
Victorian Registration and Qualifications Authority	12
Department of Health and Human Services	8
Department of Education and Training	5
Department of Justice and Regulation	3[35]

Where there is no relevant authority, or if consultation with the relevant authority suggests it is appropriate, the Commission will directly take action. Of the 58 organisations where the Commission identified concerns about non-compliance, the Commission directly took action in relation to 33 organisations, including:

- religious bodies (excluding schools)
- sports or recreation organisations
- small businesses that provide services or facilities for children.

Often action by the Commission will involve providing guidance material and recommendations on actions an organisation could take to improve their 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 2017–18 due to organisations generally being receptive and responsive to the Commission's support to comply approach.

Table 16. Commission's enforcement activities concerning the Standards 2017–18

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

32 An organisation can have multiple relevant authorities.

33 An organisation can have multiple relevant authorities with the Commission making a referral to each authority.

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

35 For one organisation, consultation occurred in 2017–18 following the identification of a previously unknown relevant authority, however compliance action commenced in 2016–17.

Thematic study

Commission action on Child Safe Standards[36]

A parent called the Commission expressing concern about their local sporting club. The parent had made the sporting club's committee aware of inappropriate behaviour by a junior team coach towards children in the team. The parent reported to the Commission that the committee did not take any action when they raised their concerns.

The parent asked the committee what the sporting club's code of conduct for coaching staff said about appropriate behaviour with children. The committee couldn't provide a code of conduct or a child abuse reporting procedure, and said no children had raised any issues.

The Commission made contact with the sporting club's committee to raise concerns about potential non-compliance with the Standards. The Committee was advised of concerns based on the parent's information and research by the Commission of potential non-compliance with the Standards due to:

- poor screening, supervision and guidance for coaches
- no code of conduct
- failure to empower children to make complaints
- failure to respond to an allegation of abuse.

The Committee was asked by the Commission to demonstrate actions it had taken to implement the Standards and identify where further action was needed.

The Commission's contact with the Committee prompted the President of the sporting club to respond that the Committee had re-assessed its implementation of the Standards and identified significant gaps. The Committee had asked for parents to volunteer to form a group to review the club's implementation of the Standards and help the club to take action. The Commission sent its compliance officers to attend a meeting with the parents' group to answer questions on the Standards.

The Committee subsequently provided the Commission with an action plan to improve implementation, with the Commission recommending additional actions where gaps were identified. The Commission recommended a code of conduct be urgently developed to guide coaches due to the immediate risk that the parent had identified. The Committee responded quickly and a code of conduct was adopted based on a code developed by the sporting club's peak body that was specifically designed for clubs with junior teams.

The Commission is monitoring the Committee's progress as it implements the action plan with some actions requiring cultural change that will take some time to achieve.

The parent later contacted the Commission to advise that the coach had been stood down pending an investigation after allegations were raised with the Committee by another parent that the coach had breached the new code of conduct.

36 This study presents some themes emerging through the operation of the Standards, and does not represent an individual compliance matter.

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. The Department of Health and Human Services (DHHS), Department of Education and Training (DET) and the VRQA identified they took such action.

Table 17. DHHS and DET action to assess and address concerns of potential non-compliance with the Standards as at 30 June 2018

Relevant Authority	Number of organisations
DHHS	1
DET[37]	1

The VRQA has advised the Commission of a large number of compliance activities taken in addition to referrals by the Commission. These were conducted by the organisation or one of their approved school review bodies. This is 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 Child Safe Standards in schools, can be found in its annual report.

Table 18. Victorian Registration and Qualifications Authority action to assess and address concerns about potential non-compliance with the Standards as at 30 June 2018

Activity type	Number of activities[38]
School reviews	684
Non-review investigations (schools)	4
OSSEO[39] reviews	3
Registration activity including assessment of compliance against the Standards	38
Complaints investigations	20

Action by relevant authorities to educate and promote compliance

Relevant authorities have advised the Commission of a range of activities they have undertaken to proactively educate, raise awareness and promote compliance with the Standards in 2017–18.

Victorian Registration and Qualifications Authority

The VRQA completed the Child Safe Standards Implementation Feedback Project which saw over 200 principals provide insight about implementation of the Standards. The Child Safe Standards Specialist Schools project was commenced to examine the current status of implementation of the Standards in Specialist Schools. The VRQA has also commenced a 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 has also identified some areas of concern for student welfare and Standards implementation in English Language Intensive Courses for Overseas Students, with the Commission also commencing an examination of the risks present in this sector.

37 This excludes organisations where the VRQA is the relevant authority such as primary and secondary schools. It includes early childhood organisations.

38 This includes the 12 referrals made by the Commission in 2017–18.

39 Overseas Secondary Student Exchange Organisations.

Department of Education and Training

In the early childhood sector, the Quality Assessment and Regulation Division (QARD) of DET has enhanced its capacity to assess compliance and support the implementation of the Standards in the sector through training in the Standards for their authorised officers and inclusion of Standards requirements in their assessment of early childhood care providers. In addition, QARD has raised awareness of the Standards in the sector through its newsletters and presentations to key stakeholders. QARD has also provided the sector with online training.

In the higher education and skills training sector, DET has included contractual obligations for training providers to comply with the Standards which includes a mandatory annual internal audit of compliance with the Standards. Guidance has been developed to support vocational education and training, and higher education providers.

Department of Health and Human Services

DHHS has promoted the Standards through its website, as well as sector and industry related workshops and forums. It has provided funding to peak bodies and other organisations to design and deliver sector specific information sessions and online resources. This resulted in delivery of:

- ten information sessions across Victoria by the Centre for Excellence in Child and Family Welfare
- ten training sessions delivered to Aboriginal Community Controlled Organisations by the Victorian Aboriginal Child Care Agency
- a forum facilitated by National Disability Services
- 17 information sessions on the new Fair Play Code of Conduct for sport and recreation organisations, which features the Standards, delivered across metropolitan and regional Victoria.

DHHS also funded the development of e-learning modules on the Standards and an animated online resource for parents about the Standards by the Centre for Excellence in Child and Family Welfare.

DHHS developed a monitoring framework along with a compliance assessment model to assist in-scope organisations to understand their obligations to implement the Standards, and to help focus on continuous improvement following any identified non-compliance.

Department of Treasury and Finance

Recognising that appropriate reporting processes for the Reportable Conduct Scheme support compliance with aspects of the Standards, the Department of Treasury and Finance has requested that agencies registered with the Housing Registrar assess whether they may be in scope for the Scheme. Any reportable conduct allegations are to be reported to the Housing Registrar in addition to the mandatory notification to the Commission.

Department of Environment, Land, Water and Planning

The Department of Environment, Land, Water and Planning has sent a summary of obligations arising from the Standards to agencies together with a link to guidance from the Commission. A link has been published on *On board*, the site for DELWP's resources for agencies. Governance teams within DELWP divisions and regions are advising the agencies they support and oversee to ensure they are aware of the requirements and resources available. Organisations that specifically run programs for children have been given additional guidance and support by DELWP.

Position descriptions for certain DELWP-funded roles within particular community organisations that have more routine contact with children include reference to the responsibility to meet the Standards.

DELWP has raised awareness about the obligation to comply with the Standards with local councils in a newsletter.

Department of Justice and Regulation

Information on the Standards was made available by the Department of Justice and Regulation for Community Crime Prevention grant applicants.

Department of Economic Development, Jobs, Transport and Resources

The Department of Economic Development, Jobs, Transport and Resources communicated with relevant organisations within its portfolio regarding their implementation of the Standards. This included organisations in the areas of creative arts, tourism and major events. For state-owned creative institutions, DEDJTR ensured the institutions' implementation of the Standards remained up-to-date and relevant in 2017–18.

During 2017–18, the Victorian Ombudsman concluded an investigation and published a report titled *Investigation into child sex offender Robert Whitehead's involvement with Puffing Billy and other railway bodies*. DEDJTR has committed to implementing the Ombudsman's recommendation concerning oversight of the implementation of the Standards by the Board. The Ombudsman's recommendation also refers to a review by the Commission within 12 months of the Ombudsman's report.

DEDJTR has integrated information on the Standards into its child employment regulatory education and industry interactions. DEDJTR has also engaged with a key stakeholders group for organisations employing children, the Entertainment Industry Working Party, to raise awareness of the Standards. The business.vic.gov.au website has information about the Standards and a link to the Commission's website.

DEDJTR requested the Victoria Tourism Industry Council to disseminate information on the Standards in its newsletter distributed to businesses within the visitor economy sector. Requirements of the Standards have also been integrated into, or promoted to, a number of programs and services delivered by, or connected with, DEDJTR's portfolio agencies including the Responsible Pet Ownership Education Program, Koori Students in Primary Industries Science Careers Program, Agriculture Victoria Research Division, Victorian Fisheries Authority and transport sector agencies.

Reportable Conduct Scheme

Overview

- Organisations made 851 mandatory notifications of reportable allegations in the first year of the Scheme, which contained 1,328 individual allegations of reportable conduct.
- 474 of these notifications were reported to Victoria Police.
- 46 percent of all reportable allegations related to physical violence.
- The 851 notifications related to 765 alleged victims.
- 722 individual workers or volunteers were the subject of allegations.
- 170 notifications were finalised – including through an investigation being completed – in relation to 261 reportable allegations.
- 72 notifications of allegations were made by the public.

The Reportable Conduct Scheme commenced on 1 July 2017, pursuant to the ***Child Wellbeing and Safety Act 2005***. The Scheme is designed to provide a single, central point of oversight for how organisations respond to allegations of certain types of misconduct involving children and child abuse in organisations that exercise care, supervision and authority over children.

The Scheme requires heads of organisations to notify the Commission of allegations of reportable conduct against children by their workers or volunteers, to investigate those allegations and report findings to the Commission. Heads of organisations are also required to implement systems to prevent reportable conduct.

The policy intent of the legislation is clear: that heads of organisations must take responsibility for making sure they have the appropriate systems in place to keep children safe and for responding properly to allegations when they arise.

The Commission's role

The Commission's role in the Reportable Conduct Scheme includes:

- administering, overseeing and monitoring the Reportable Conduct Scheme
- supporting and guiding organisations that receive allegations to conduct fair, effective, timely and appropriate investigations into allegations of reportable conduct
- independently overseeing, monitoring and, where appropriate, making recommendations to improve investigations of those organisations
- working collaboratively with Victoria Police in respect of potentially criminal conduct and matters involving family violence
- referring substantiated findings of reportable conduct to the Working With Children Check unit to determine an individual's suitability to work with children
- referring allegations of reportable conduct to regulators including the Victorian Institute of Teaching to take appropriate action and determine the suitability of individuals to remain accredited in some professions
- undertaking an own-motion investigation in limited circumstances.

The Scheme provides a new capacity to contribute to the protection of children, particularly from people whose inappropriate and harmful conduct may not meet the criminal threshold or the criminal burden of proof.

Implementation of the Reportable Conduct Scheme

Legislation to establish the Scheme was assented to in February 2017 and the Scheme commenced shortly after on 1 July 2017, meaning organisations and the Commission were required to work quickly to implement these significant new obligations. Organisations are captured by the Scheme in three phases.[40]

Phase 1: 1 July 2017[41]

From 1 July 2017, key organisations required to comply with the Scheme included:

- schools and other education organisations (excluding early years providers)
- child protection services
- out-of-home care services
- Victorian government departments.

40 Note that there are some circumstances in which organisations can be exempt from the operation of the Scheme or otherwise not captured.

41 If an organisation provides services listed in more than one phase, the Scheme applies to the organisation as a whole from the earliest phase.

Phase 2: 1 January 2018

From 1 January 2018, additional organisations required to comply with the Scheme included:

- religious bodies
- residential facilities for boarding schools
- overnight camps for children
- hospitals and health services
- disability services.

Phase 3: 1 January 2019

From 1 January 2019, further organisations will be required to comply with the Scheme including:

- early years providers of education, care and children's services (e.g. kindergartens, after hours care services and occasional care providers)
- certain prescribed art centres, libraries, museums, zoos, parks and gardens.

The Commission has commenced raising awareness in these sectors to support their implementation of the Scheme.

It is estimated that the Scheme will apply to in excess of 10,000[42] organisations from 1 January 2019.

Observations on the operation of the Scheme in 2017–18

The Scheme has been in operation for 12 months, and consequently identifying clear trends and reaching robust conclusions about its operation is problematic, and in some respects would be premature. Given the early stage of the Scheme, data and analysis in this annual report focuses on reportable allegations made to the Commission.

Further, the Scheme's phased implementation means that different sectors have been covered by the Scheme for differing periods of time. The out-of-home care and education sectors,[43] for example, have the highest number of reportable allegations, however they have also been covered by the Scheme for a longer period than some other sectors.

The Commission greatly appreciates support throughout 2017–18 from colleagues at the NSW and the ACT Ombudsman. The NSW Scheme has been in operation since 1999. Like Victoria, the ACT Scheme only commenced on 1 July 2017. With the Royal Commission's recommendation that all state and territory governments establish nationally consistent reportable conduct schemes, collaboration between regulators in different jurisdictions will be key to achieving improved safety for children.

Commission's regulatory approach in the first year

The Commission has focused efforts in 2017–18 on supporting organisations to understand the new Scheme and comply with their obligations. A key part of the Commission's approach has been to actively provide advice and guidance to individual organisations as they are faced with a reportable allegation, and to provide feedback to organisations to improve their investigatory practice. This approach, together with the production of a range of written guidance material, information sessions and web-based tools, has raised awareness of the Scheme and provided organisations with support to be able to meet the objectives of the Scheme.

42 Victorian Reportable Conduct Scheme Frequently asked Questions – Department of Health and Human Services.

43 The term 'education sector' includes Victorian government, independent and Catholic schools and other educational institutions.

Thematic study

Independent investigation[44]

A provider of school holiday programs submitted their first mandatory notification relating to a well-respected program leader following a complaint from a parent that their child had reported the program leader was creepy and had made suggestive comments.

The head of the provider believed that the program leader was well respected, friendly and professional. With guidance from the Commission on the requirements of the Scheme, the provider submitted a mandatory notification and engaged an independent investigator to avoid any perceived bias or conflict of interest.

The independent investigator conducted a thorough investigation, interviewing a number of children from the program leader's sessions, including current and past holiday periods. This resulted in evidence from impacted children being obtained that raised a high number of allegations of sexual misconduct over a long period. The independent investigator substantiated a high number of allegations, and some allegations with only minimal or potentially unreliable evidence were found to be unsubstantiated.

The children reported not coming forward earlier with their concerns as they did not think that they would be believed given the program leader was so well respected.

The program leader was terminated from their employment and the Commission referred the substantiated findings to the Department of Justice and Regulation Working with Children Check Unit.

Organisations engaging with the Scheme

The Commission found organisations' engagement with the Scheme to be generally positive with most organisations demonstrating a good understanding of the objectives of the Scheme and a commitment to working with the Commission to ensure their compliance.

However, there have been lower than expected numbers of mandatory notifications from some sectors, suggesting there may be under-reporting of reportable allegations to the Commission. The Commission will take this into account in planning its awareness raising and compliance activities in 2018–19.

Organisations required to comply from 1 July 2017 were provided with a relatively short timeframe to adjust their systems to support the new Scheme. The Commission appreciated the efforts of peak bodies, the Department of Health and Human Services, the Department of Education and Training, and other organisations and individuals who worked alongside the Commission, to raise awareness of the Scheme and its requirements. The Commission saw a similarly cooperative approach from peak bodies in relation to Phase 2 organisations.

Investigation practice

Commission staff engage with organisations throughout a reportable conduct investigation providing information and guidance where required. The organisation's findings are then considered by the Commission together with relevant supporting reports and evidence from the organisation. The Commission usually focuses on the following key areas when reviewing investigations:

- how an organisation initially responded when the reportable allegation was first raised
- how conflicts of interest were managed

44 This study presents themes emerging through the operation of the Scheme, and does not represent an individual reportable conduct matter.

- the protection of the alleged victim and any other children
- whether procedural fairness and natural justice was given to the subject of an allegation
- how an organisation considered and planned its response and investigation
- how the safety, wellbeing and support were handled for everyone involved
- how and what information was gathered
- whether the appropriate witnesses were interviewed, including the alleged victim and the subject of allegation
- how findings were made and on what evidence
- what disciplinary or other actions were taken or not taken and the reasons for this.

In the first year of administering the Scheme, the Commission has seen both the value of the Scheme and the need for the independent monitoring and oversight. We have observed an overall improvement in the quality of investigations over the year, with a general commitment by many organisations to good investigatory practice and continuous improvement in this area. However, significant improvements are still needed in many organisations before the community can have confidence that all allegations of child abuse are receiving proper attention.

Emerging themes in administering the Scheme

In administering the Scheme in 2017–18, the Commission has noted a number of emerging themes.

Conducting reportable conduct investigations can be challenging for some organisations that have not previously conducted similar investigations – for example, where there is no human resources function. These organisations have particularly benefited from the Commission's approach in supporting them to comply.

Some organisations have chosen to adapt existing types of investigations to also fulfil obligations to investigate reportable conduct, which reduces duplication, but does not always meet the requirements of the Scheme without particular attention.

We have seen many organisations grappling with whether or how to interview children. In some cases, organisations have not interviewed children where their evidence was clearly relevant and there was no good reason not to. In some cases, children's evidence is not afforded enough weight relative to the evidence of adults. This has been a strong focus for the Commission that will continue in 2018–19.

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 a person has a reasonable belief there is a reportable allegation. The head is required to submit a notification, whether or not they themselves share that reasonable belief. There is no exemption for reportable allegations raised through the confessional.

For the period 1 July 2017 to 30 June 2018, the Commission received 851 notifications of reportable allegations from heads of organisations.[45]

The Act also allows any person, for example members of the public, to disclose allegations to the Commission. 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 investigation commenced. The Commission received 72 public notifications from persons other than the head of an organisation for the period 1 July 2017 to 30 June 2018.

45 This includes notifications made on behalf of heads of organisations by their delegates, agents or other person authorised to act on their behalf.

Table 19. Reportable conduct matters received by notification type 2017–18

Type	Number
Mandatory notification	851
Public notification	72[46]

Mandatory notifications

The following sections contain analysis of the notifications of reportable allegations received by the Commission from heads of organisations. In presenting this analysis, it is important to appreciate that this data is only in relation to allegations where facts have not been established and findings have not yet been made about whether that conduct is substantiated or not.

Of the 851 mandatory notifications received by the Commission during 2017–18, 170 (20 per cent) had been finalised and 53 (six per cent) had been assessed by the Commission as being outside the Scheme's jurisdiction as at 30 June 2018. A separate analysis is presented of finalised cases.

Analysis has been conducted on notifications by their status as at 30 June 2018.[47]

Notifications received

For the period 1 July 2017 to 30 June 2018, the Commission received 851 mandatory notifications of reportable allegations.[48]

The Commission has an online form to assist organisations to submit notifications to the Commission in a timely and efficient manner. The majority of notifications (91 per cent) were received through the Commission's online form.

The Commission received an average 71 notifications per month. In August 2017, the Commission received the highest number of notifications (108) and lower numbers were received in the first month of operation of the Scheme and during school holiday periods.

The Commission expects numbers of notifications to increase in subsequent years:

- additional organisations will become subject to the Scheme from 1 January 2019
- notifications are expected to increase due to ongoing awareness raising activities by the Commission and others of the need to comply with the Scheme
- public notifications are expected to increase over time as community awareness of the Scheme and the ability of members of the public to make a disclosure to the Commission increases
- some organisations covered by the Scheme, such as some religious bodies, haven't previously been subject to regulation of this kind. It may take some organisations longer to fully implement the robust processes that are required to ensure all reportable allegations are appropriately notified to the Commission.

Mandatory notifications by sector

The majority of the mandatory notifications in the first 12 months of the Scheme (77 per cent) were from the education and out-of-home care sectors. Workers and volunteers in these sectors have frequent engagement with children when compared with some other sectors covered by the Scheme. Further, these two sectors were covered by the Scheme for the full 12 months of the 2017–18 year, whereas some other sectors were only covered for six months of that year. Additionally, the education and out-of-home care sectors had comparatively well-developed processes for reporting allegations of child abuse prior to the introduction of the Scheme when compared with other sectors.

46 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.

47 Data is subject to change over time as investigations proceed.

48 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.

Reportable Conduct Scheme
continued

Table 20. Notifications of reportable allegations received by sector 2017–18

Sector	Number	Percentage
Out-of-home care (OOHC)[49]	**366**	**43**
Residential care	132	
Foster care	111	
Kinship care	107	
Other (includes permanent care, respite and contingency care[50] and where the subject of allegation's role is not the direct care of children such as administrative staff of an OOHC organisation)	10	
Lead tenant	6	
Education	**289**	**34**
Non-government school – Independent[51]	107	
Victorian government school[52]	91	
Non-government school – Catholic[53]	86	
Other (includes other senior secondary courses and qualifications, international student courses and student exchange programs)	5	
Youth justice[54]	**47**	**6**
Parkville Youth Justice Precinct	39	
Malmsbury Youth Justice Precinct	8	
Disability services[55]	**42**	**5**
Other[56]	**29**	**3**
Religious body[57]	**22**	**3**
Early childhood[58]	**22**	**3**
Child protection[59]	**14**	**2**
Victorian government departments[60]	**8**	**<1**
Health[61]	**7**	**<1**
Accommodation[62]	**5**	**<1**
Total	**851**	**100[63]**

Reportable allegations by type of reportable conduct

Each mandatory notification can contain multiple reportable allegations and multiple alleged victims. The 851 notifications received in 2017–18 contained 1,328 reportable allegations.

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.

The highest number of allegations (46 per cent) related to physical violence.[64]

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

50 Respite and contingency care can be provided in both out-of-home care and child protection settings.

51 Includes primary and secondary school.

52 Includes primary and secondary school.

53 Includes primary and secondary school.

54 Youth justice functions provided by the Department of Justice and Regulation.

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

56 In this category, 38 per cent were from organisations subsequently identified as not within scope of the Scheme. 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.

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

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

59 Includes child protection services provided by DHHS, child protection services provided by organisations pursuant to a DHHS contract, DHHS secure welfare, respite and contingency care. Respite and contingency care can be provided in both out-of-home care and child protection settings.

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

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

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

63 Due to rounding and action taken to support the de-identification of data in this report, percentages in some tables may not add to 100 per cent.

64 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.

Reportable Conduct Scheme
continued

Table 21. Reportable allegations from mandatory notifications received 2017–18

Type of alleged reportable conduct	Number of reportable allegations	Percentage of reportable allegations
Physical violence	**615**	**46**
Physical violence committed against a child	522	
Physical violence committed in the presence of a child	89	
Physical violence committed with a child	4	
Sexual misconduct	**232**	**17**
Sexual misconduct committed against a child	199	
Sexual misconduct committed in the presence of a child	22	
Sexual misconduct committed with a child	11	
Behaviour that causes significant emotional or psychological harm	**221**	**17**
Sexual offences	**133**	**10**
Sexual offence committed against a child	129	
Sexual offence committed in the presence of a child	2	
Sexual offence committed with a child	2	
Significant neglect	**127**	**10**
Total	**1,328**	**100**

Reportable allegations by sector and type of reportable conduct[65]

Table 22. Reportable allegations by sector and type of reportable conduct 2017–18

Sector[66]	Number of reportable allegations	Percentage of reportable allegations for each sector by reportable conduct type
Out-of-home care	**599**	**100**[67]
Physical violence	332	55
Behaviour that causes significant emotional or psychological harm	103	17
Significant neglect	97	16
Sexual offences	36	6
Sexual misconduct	31	5
Education[68]	**520**	**100**
Physical violence	186	36
Sexual misconduct	159	31
Behaviour that causes significant emotional or psychological harm	99	19
Sexual offences	62	12
Significant neglect	14	3
Youth justice	**49**	**100**
Physical violence	29	59
Sexual misconduct	11	22
Significant neglect	5	10
Sexual offences	3	6
Behaviour that causes significant emotional or psychological harm	1	2
Disability services	**44**	**100**
Physical violence	23	52
Sexual misconduct	8	18

65 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 12 months, whereas other sectors have only been subject to the Scheme for 6 months. Additionally, this analysis is of reportable allegations, not substantiated incidents of reportable conduct.

66 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.

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

68 Education includes Victorian government, independent and Catholic schools and other educational institutions.

Table 22. Reportable allegations by sector and type of reportable conduct 2017–18 (continued)

Sector[66]	Number of reportable allegations	Percentage of reportable allegations for each sector by reportable conduct type
Significant neglect	6	14
Sexual offences	6	14
Behaviour that causes significant emotional or psychological harm	1	2
Religious body	**34**	**100**
Sexual offences	13	38
Sexual misconduct	11	32
Physical violence	6	18
Behaviour that causes significant emotional or psychological harm	3	9
Significant neglect	1	3
Early childhood	**25**	**100**
Physical violence	18	72
Behaviour that causes significant emotional or psychological harm	6	24
Significant neglect	1	4
Child protection	**18**	**100**
Physical violence	9	50
Sexual offences	5	28
Sexual misconduct	3	17
Behaviour that causes significant emotional or psychological harm	1	6
Other	**16**	**100**
Sexual misconduct	6	38
Physical violence	5	31
Behaviour that causes significant emotional or psychological harm	3	19
Significant neglect	1	6
Sexual offences	1	6
Victorian government department	**9**	**100**
Physical violence	6	67
Sexual offences	1	11
Significant neglect	1	11
Sexual misconduct	1	11

Table 22. Reportable allegations by sector and type of reportable conduct 2017–18 (continued)

Sector[66]	Number of reportable allegations	Percentage of reportable allegations for each sector by reportable conduct type
Health	**9**	**100**
Sexual offences	5	56
Behaviour that causes significant emotional or psychological harm	2	22
Sexual misconduct	2	22
Accommodation	**5**	**100**
Behaviour that causes significant emotional or psychological harm	2	40
Significant neglect	1	20
Physical violence	1	20
Sexual offences	1	20
Total	**1,328**	

Alleged victims

There were 765 unique alleged victims. Alleged victims must be aged under 18 years at the time of the alleged conduct for the conduct to be covered by the Scheme.

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.

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.

On average, the number of notifications per alleged victim was 1.4 and each alleged victim was the subject of 1.5 allegations, with a range of 1–11 allegations per alleged victim. The majority of alleged victims were involved in one allegation (69 per cent), however over a fifth of alleged victims were involved in two allegations (21 per cent) and 10 per cent were involved in three or more allegations.

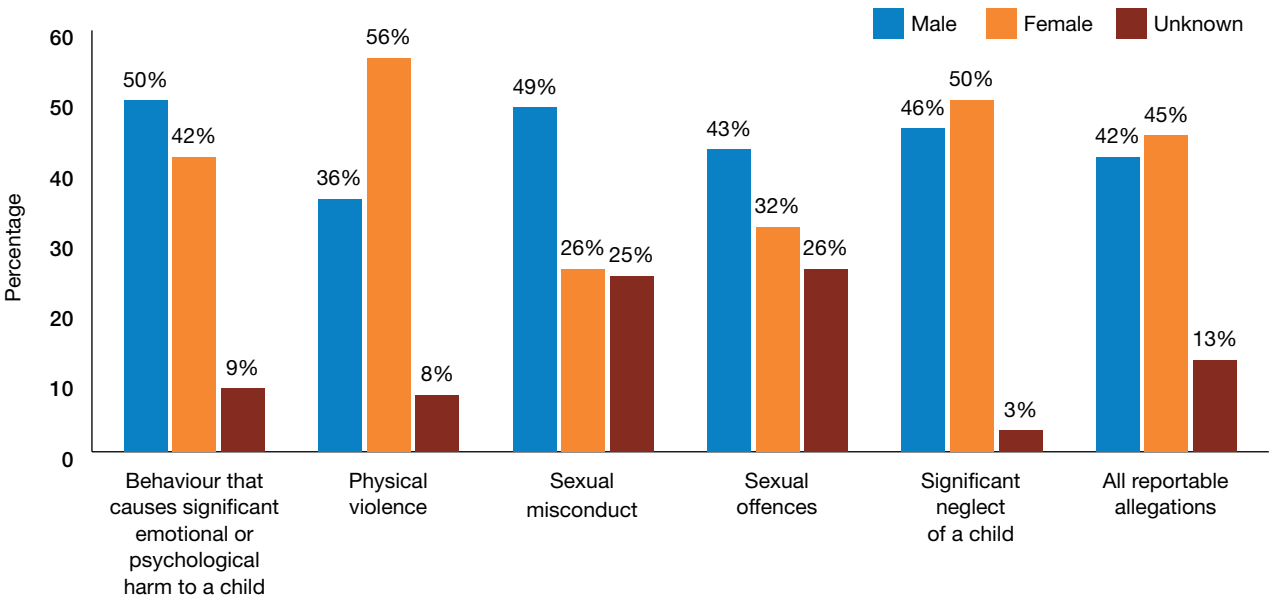
Reportable allegations by gender of alleged victim and type of alleged reportable conduct[69]

Alleged victims in a reportable allegation of physical violence committed against a child were more likely to be male than female. This type of conduct accounted for 51 per cent of all allegations involving a male alleged victim, and 31 per cent of all allegations involving a female alleged victim.

Alleged victims in a reportable allegation of sexual misconduct committed against a child were more likely to be female than male. This type of conduct accounted for 20 per cent of all allegations involving a female alleged victim and 10 per cent of all allegations involving a male alleged victim.

69 This analysis examines reportable allegations, not unique alleged victims.

Figure 1. Reportable allegations by type of reportable conduct and gender of alleged victims 2017–18[70]



Alleged victims by gender and type of reportable conduct

Of the 765 unique alleged victims[71] of an allegation of reportable conduct, 53 per cent were male and 45 per cent were female.

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.

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

71 The following analysis is related to unique individuals who have been the alleged victim of one or more allegations 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 156 allegations of reportable conduct reported to the Commission with no identified alleged victim.

Table 23. Alleged victims, by gender and type of reportable conduct[72]

Gender of alleged victim and reportable conduct type for first reportable allegation	Number of alleged victims	Percentage
Female	**347**	**100**[73]
Physical violence	156	45
Sexual misconduct	66	19
Sexual offence	47	14
Behaviour that causes significant emotional or psychological harm to a child	44	13
Significant neglect of a child	34	10
Male	**404**	**100**
Physical violence	246	61
Behaviour that causes significant emotional or psychological harm to a child	49	12
Sexual misconduct	39	10
Significant neglect of a child	37	9
Sexual offence	33	8
Other/not identified	**14**	**100**
Physical violence	8	57
Behaviour that causes significant emotional or psychological harm to a child	3	21
Sexual offence	2	14
Sexual misconduct	1	7
Significant neglect of a child	0	0
Total	**765**	

72 Where there are multiple reportable allegations reported, the earliest reportable allegation has been used to identify the child's age and the type of reportable conduct.

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

Thematic study

Improving investigations[74]

A youth service provided programs for secondary students and submitted its first mandatory notification relating to a volunteer who provided art tuition for gifted students.

An allegation was raised with the organisation that the volunteer touched a child student inappropriately on the leg and called the child 'honey' during a tutoring session.

This was the first investigation the organisation had conducted under the Scheme and it was unfamiliar with how to approach it with its volunteers. The organisation had difficulties engaging with the volunteer about their conduct and the investigation. The volunteer denied the allegation, disputed the organisation had a role in setting expectations of conduct by the volunteer when they were tutoring students and asserted that there should never have been an investigation.

The organisation advised the volunteer that the alleged conduct, had it occurred, was unacceptable and a breach of the organisation's code of conduct. However, the organisation did not find the allegation substantiated due to concerns about the reliability of the child alleged victim with some witnesses telling the organisation they had a history of lying.

Another child came forward with a similar allegation some months later about the same volunteer. This child also alleged they were called 'honey' and were touched inappropriately on the leg.

The organisation applied the feedback and learnings provided by the Commission from the first investigation. This included better planning the investigation, identifying and interviewing all relevant witnesses, providing the volunteer with a clear statement of the allegation and providing them an opportunity to state their version of events and respond to the allegation.

In the second investigation, the allegation was substantiated by the organisation as sexual misconduct. The volunteer was removed from the program and the Commission made a referral to the Department of Justice and Regulation Working with Children Check Unit.

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

Of all unique victims, 13 per cent were identified by organisations subject to the Scheme as being Aboriginal and/or Torres Strait Islander, seven per cent were identified as being from a culturally and/or linguistically diverse (CALD) background and eight per cent were identified as having a disability.

The Commission was not provided with details of the characteristics of the alleged victim in a high number of matters, and will work with organisations subject to the Scheme to improve the provision of accurate data in this area in 2018–19.

Age of alleged victim at date of alleged reportable conduct

The average age of alleged victims at the time of the first reportable conduct was 11 years of age. The majority of alleged victims were in the 10–14 year age group (28 per cent), followed by those aged between 15 and 18 years (23 per cent).

74 This study presents some themes emerging through the operation of the Scheme, and does not represent an individual reportable conduct matter.

Table 24. Age of alleged victim at date of first alleged reportable conduct[75]

Age of alleged victim in years	Number of alleged victims	Percentage of alleged victims
0–4	77	10
5–9	130	17
10–14	211	28
15–18	178	23
Not identified	169	22
Total	**765**	**100**

Age of alleged victim and alleged reportable conduct type

Across all age groups, physical violence was consistently the most likely type of reportable conduct alleged. Just under a third of all physical violence allegations and over a third of all allegations of behaviour that causes significant emotional or psychological harm to a child were reported in respect of children aged 10 to 14 years (31 per cent and 36 per cent respectively).

Subjects of allegations

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 722 unique individuals[76] who were subjects of allegations across the 851 notifications and 1,328 reportable allegations. The majority of individuals were subject to only one allegation (65 per cent), however a small proportion (five per cent) were the subject of five or more allegations. There was an average of 1.8 reportable allegations per subject of allegation.

Table 25. Number of reportable allegations per subject of allegation 2017–18

Number of reportable allegations	Number of subjects of allegations	Percentage
1	468	65
2	136	19
3	49	7
4	31	4
5–9	29	4
10–14	5	<1
15 or more	4	<1
Total	**722**	**100**

Employment status of subject 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. Seventy per cent of subjects of allegation were identified as employees of an organisation and 25 per cent were identified as foster or kinship carers.

75 Where there are multiple reportable allegations reported, the earliest reportable allegation has been used to identify the child's age.

76 At 30 June 2018, there were seven deceased subjects of allegation. The analysis in the mandatory notifications section includes data in relation to these reportable allegations as they were valid notifications when reported to the Commission.

Table 26. Employment type of subjects of allegation 2017–18[77]

Employment type	Number of subjects of allegation	Percentage
Employee	509	70
Foster or kinship carer	178	25
Volunteer	15	2
Minister of religion or religious leader	13	2
Other	7	1
Total	**722**	**100**

Gender of subject of allegation and type of reportable conduct

Of the 722 individual subjects of allegation, 54 per cent were male and 46 per cent were female.

Physical violence made up 46 per cent of all allegations and was the largest category of reportable allegations for both genders.

Male subjects of allegation are more likely to be the subject of sexual misconduct or sexual offence reportable allegations (173 and 107 reportable allegations respectively) compared to females (59 and 25 reportable allegations respectively). Female subjects of allegation are more likely to be the subject of a reportable allegation of significant neglect of a child (96 reportable allegations) as opposed to males (31 reportable allegations).

Table 27. Reportable allegations by gender of subject of allegation and type of reportable conduct 2017–18

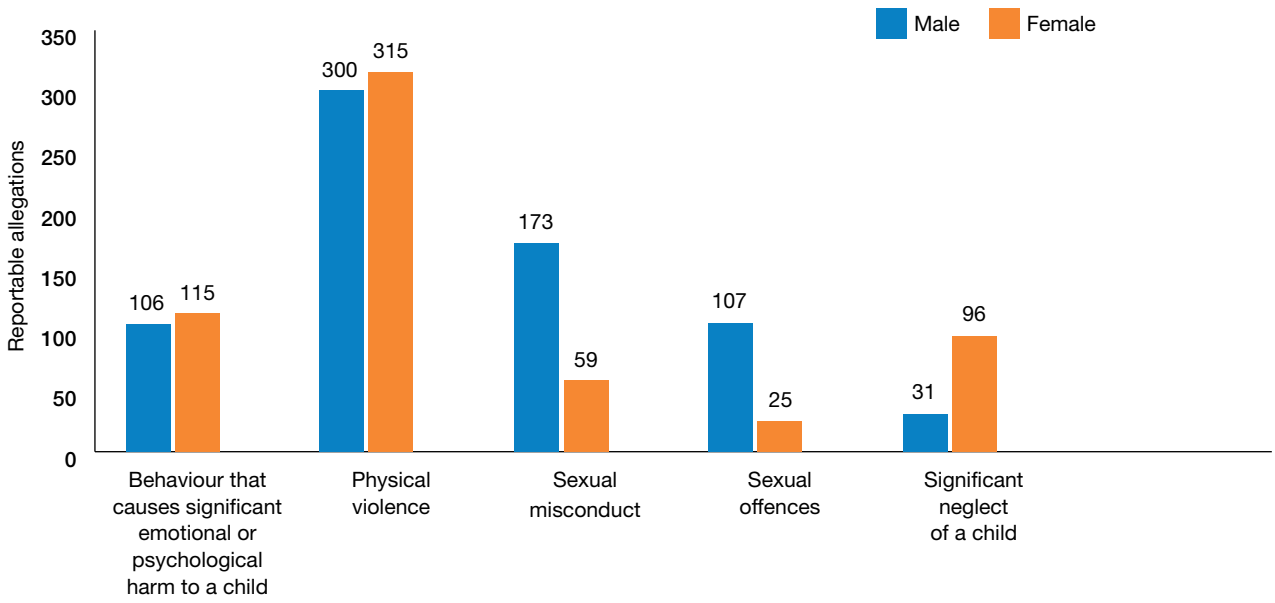
Gender of subject of allegation and reportable conduct type	Number of reportable allegations	Percentage of reportable allegations per gender
Female	**610**	**100**[78]
Physical violence	315	52
Behaviour that causes significant emotional or psychological harm to a child	115	19
Significant neglect of a child	96	16
Sexual misconduct	59	10
Sexual offences	25	4
Male	**717**	**100**
Physical violence	300	42
Sexual misconduct	173	24
Sexual offences	107	15
Behaviour that causes significant emotional or psychological harm to a child	106	15
Significant neglect of a child	31	4
Total	**1,327**[79]	

77 An individual can be the subject of allegation in more than one notification and may have different roles in different organisations. A review of the type of employment recorded against each of the unique subject of allegations from 1 July 2017 to 30 June 2018 showed that a very small proportion of individuals had more than one employment type recorded (0.3 per cent). Therefore, the analysis of employment type is based on the unique individual.

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

79 Total reportable allegations for 2017–18 is 1,328. One allegation has been excluded from this table where the subject of allegation has not yet been identified.

Figure 2. Reportable allegations by gender of subject of allegation and type of conduct 2017–18



Age and gender of subject of allegation at date of first alleged reportable conduct

The mean age of subjects of allegation when they allegedly committed their first act of reportable conduct was 44 years.

Over a third of all female subjects of allegation were aged between 40 to 57 years (37 per cent), while male subjects of allegation were proportionally younger with over a quarter aged between 25 and 34 years (27 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 should conduct investigations in a way that works best for them recognising the difference between organisations and individual allegations, 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 a guide for organisations to assist them to meet their obligations.

The Commission reviews findings made by organisations together with investigation reports and evidence provided by organisations to support their findings. The Commission considers if actions taken by organisations to manage risks to children, both throughout the investigation and in response to findings, were generally appropriate. The Commission also considers whether natural justice was afforded to subjects of allegation.

Reportable Conduct Scheme *continued*

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.

The Commission also reviews all investigations completed by organisations considering findings, evidence and investigation reports. This important part of its oversight role enables the Commission to consider if organisations are meeting their statutory obligations as well as to provide feedback and guidance to organisations to improve the quality of investigations.

Of the 851 notifications of reportable allegations received by the Commission during 2017–18, 170 (20 per cent) had been finalised and 53 (six per cent) had been assessed by the Commission as being outside the Scheme's jurisdiction as at 30 June 2018. Given these relatively low numbers, analysis on findings cannot be reliably used to draw any conclusions on trends. For example, there are reportable allegations that are the subject of criminal investigation by Victoria Police, which may take time to be finalised and represented in data on findings. As numbers of findings increase with larger numbers of investigations being finalised, the Commission will undertake further analysis to identify trends and common characteristics in findings made by organisations and reportable conduct.

The Commission considers a notification is finalised when the organisation has conducted an investigation in accordance with requirements in the *Child Wellbeing and Safety Act 2005*, submitted its findings to the Commission and provided all requested information and documents to the Commission. As part of finalising a notification, the Commission examines the organisation's finding together with relevant supporting reports and evidence relied on by the organisation. The Commission provides guidance and advice to the organisation in relation to the investigation and future investigatory practice. Part of finalisation also involves making referrals to other regulators, including referring substantiated reportable conduct to the Secretary of the Department of Justice and Regulation for the purposes of a Working with Children Check reassessment.

Reportable conduct findings

The 170 finalised notifications involved the investigation of 261 reportable allegations by organisations subject to the Scheme.

The Commission issued guidance to organisations to assist them when determining the most appropriate finding at the conclusion of their investigation. The Commission also issued guidance on each type of reportable conduct to assist organisations in assessing whether conduct alleged constituted reportable conduct. Organisations must make findings on the balance of probabilities and each reportable allegation must have a finding.

Whilst there are insufficient finalised notifications to make any robust commentary on trends, the rate of 30 per cent of reportable allegations substantiated is in line with the NSW Reportable Conduct Scheme for notifications that the NSW Ombudsman oversees.

Table 28. Findings per allegation 2017–18

Finding type	Number of allegations	Percentage
Substantiated	77	30
Unsubstantiated – insufficient evidence	55	21
Unsubstantiated – lack of evidence of weight	34	13
Unfounded	13	5
Conduct outside Scheme	82	31
Total	**261**	**100**

Table 29. Findings per reportable conduct type 2017–18

Reportable conduct type and finding	Number of allegations	Percentage
Behaviour that causes significant emotional or psychological harm to a child	**76**	**100**[80]
Substantiated	16	21
Unsubstantiated – insufficient evidence	13	17
Unsubstantiated – lack of evidence of weight	10	13
Unfounded	1	1
Conduct outside Scheme	36	47
Physical violence		
Physical violence committed against a child	**67**	**100**
Substantiated	21	31
Unsubstantiated – lack of evidence of weight	10	15
Unsubstantiated – insufficient evidence	18	27
Unfounded	2	3
Conduct outside Scheme	16	24
Physical violence committed in the presence of a child	**18**	**100**
Substantiated	5	28
Unsubstantiated – insufficient evidence	4	22
Unsubstantiated – lack of evidence of weight	0	0
Unfounded	1	6
Conduct outside Scheme	8	44
Sexual misconduct		
Sexual misconduct committed against a child	**55**	**100**
Substantiated	19	35
Unsubstantiated – insufficient evidence	12	22
Unsubstantiated – lack of evidence of weight	9	16
Unfounded	0	0
Conduct outside Scheme	15	27
Sexual misconduct committed in the presence of a child	**7**	**100**
Substantiated	1	14
Unsubstantiated – insufficient evidence	0	0
Unsubstantiated – lack of evidence of weight	0	0
Unfounded	5	71
Conduct outside Scheme	1	14

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

Table 29. Findings per reportable conduct type 2017–18 (continued)

Reportable conduct type and finding	Number of allegations	Percentage
Sexual offence		
Sexual offence committed against a child	**13**	**100**
Substantiated	1	8
Unsubstantiated – insufficient evidence	4	31
Unsubstantiated – lack of evidence of weight	4	31
Unfounded	4	31
Conduct outside Scheme	0	0
Significant neglect of a child	**25**	**100**
Substantiated	14	56
Unsubstantiated – insufficient evidence	4	16
Unsubstantiated – lack of evidence of weight	1	4
Unfounded	0	0
Conduct outside Scheme	6	24
Total	**261**	

Substantiated reportable conduct

The 77 allegations where reportable conduct was substantiated involved 50 identified individual victims. There were a further six substantiated allegations where the details of the victims were not known.

Of the 50 victims, just over half (54 per cent) were males and the remaining 46 per cent were female. The majority had one substantiated allegation (70 per cent). Just under a quarter had two substantiated allegations and the remaining six per cent had three to six substantiated allegations.

Of the substantiated allegations where the victim's date of birth was known, the largest proportion of victims were aged between 10 and 14 years of age at the time of the reportable conduct (46 per cent).

The largest number of substantiated allegations was for physical violence (34 per cent).

Sharing information

A key element of the Scheme is the sharing of information. The Commission has powers to share and request information in furtherance of the objectives of the Scheme.

The Commission is able to share information where appropriate, including with the Working with Children Check Unit, relevant regulators and Victoria Police, to better prevent and protect children from abuse.

Table 30. Substantiated reportable allegations by conduct type 2017–18

Reportable conduct type	Number of substantiated allegations	Percentage
Physical violence	**26**	**34**
Physical violence committed against a child	21	
Physical violence committed in the presence of a child	5	
Physical violence committed with a child	0	
Sexual misconduct	**20**	**26**
Sexual misconduct committed against a child	19	
Sexual misconduct committed in the presence of a child	1	
Sexual misconduct committed with a child	0	
Behaviour that causes significant emotional or psychological harm to a child	**16**	**21**
Significant neglect of a child	**14**	**18**
Sexual offence	**1**	**1**
Sexual offence committed against a child	1	
Sexual offence committed in the presence of a child	0	
Sexual offence committed with a child	0	
Total	**77**	**100**

Notifications to Victoria Police

The Scheme requires organisations and the Commission to notify Victoria Police of reportable allegations that may involve criminal conduct. If an allegation might involve criminal conduct and has been reported to Victoria Police, an organisation must not start its own investigation until police have provided clearance.

Reasons an allegation may not be reported to Victoria Police include that the conduct alleged could be reportable conduct, but might not meet definitions in the criminal law. For example, sexual misconduct is included in the Scheme to capture conduct that falls below the criminal threshold required for a sexual offence. Where there is some doubt whether conduct should be reported, the Commission consults with Victoria Police.

In 2017–18, the Commission and Victoria Police agreed to changes to the existing Memorandum of Understanding between the two organisations to cover the Scheme and Child Safe Standards. Information-sharing between the two organisations is greatly assisted by Victoria Police providing a dedicated officer who largely works from the Commission's offices. The role provides a conduit between Victoria Police and the Commission helping to support the proper operation of the Scheme and build capability within both organisations.

Of the 851 notifications of reportable allegations made to the Commission, 56 per cent were reported to Victoria Police by either the organisation or the Commission. The role the Commission plays in ensuring allegations of criminal child abuse that arise in organisations subject to the Scheme are reported to Victoria Police is one of the ways the Scheme acts to improve safety for children.

Reportable Conduct Scheme *continued*

The following is a summary of the status of reports made to Victoria Police involving a reportable allegation as at 30 June 2018.[81] Fifty per cent of all referrals involved investigations by police and ten matters involved pending criminal charges.

Table 31. Notifications of reportable allegations reported to Victoria Police 2017–18

Report made to Victoria Police	Number of notifications of reportable allegations	Percentage
Yes	474	56
No	377	44
Total	**851**	**100**

Victoria Police provides updates to the Commission on the progress of its examination of an allegation as well as the outcome. Both Victoria Police and the Commission communicate with organisations to support them and keep them up-to-date with Victoria Police action.

Given the early stage of the Scheme, reliable trends can't yet be discerned from the data on police reporting. Victoria Police has conducted an investigation in 50 per cent of notifications reported to police. Investigations are still underway for 18 per cent of notifications and in two per cent of notifications criminal charges have been laid. Victoria Police advises that the Commission referred 81 notifications that had not previously been reported to police.

Table 32. Status of notifications of reportable allegations reported to Victoria Police 2017–18[82]

Victoria Police status of notification	Number of notifications	Percentage
No further police action	181	38
Investigation complete (no further police action)[83]	140	30
Under investigation	86	18
Awaiting update from police	57	12
Investigation complete (criminal charges pending)	10	2
Total	**474**	**100**

Referrals to the 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 Regulation for the purposes of a reassessment of the appropriateness of the subject of allegation retaining a Working with Children Check under the *Working With Children Act 2005*.

The Commission and the Department of Justice and Regulation have established a strong working relationship as both organisations have taken on new responsibilities under the Scheme. An exchange of letters supports current information-sharing practices and a Memorandum of Understanding is currently in development between both organisations.

81 Analysis based on a review of Commission and Victoria Police data. Due to differences in data categorisation between the Commission and Victoria Police consistent with their differing roles, this has resulted in a small variation in these figures of less than one per cent. Data was compiled in July 2018 and, due to the frequently changing nature of investigations, is indicative of status as at 30 June 2018.

82 Data was compiled in July 2018 and, due to the frequently changing nature of investigations, is indicative of status as at 30 June 2018.

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

The 77 substantiated allegations of reportable conduct in 2017–18 resulted in referrals in relation to 33 individual subjects of allegation[84] to the Working With Children Check Unit for reassessment. Given the early stage of the Scheme, the Commission anticipates referrals to increase in subsequent years.

Referrals to the Victorian Institute of Teaching

On becoming aware that a registered teacher is the subject of a reportable allegation, the Commission must notify the Victorian Institute of Teaching (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 just substantiated allegations.

The Commission must also refer any findings of substantiated conduct to VIT after an investigation has been completed. In practice, the Commission referred all findings from completed reportable conduct investigations to VIT in 2017–18. 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.

The Commission has worked closely with VIT leading up to the commencement of the Scheme and throughout the first year of operation. This important relationship involves the active sharing of information by both organisations throughout the Commission's handling of a reportable conduct matter. A Memorandum of Understanding is currently in development between both organisations.

During 2017–18, the Commission notified VIT of 192 notifications of reportable allegations in relation to registered teachers.[85]

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 Act if disclosures are made in good faith. In 2017–18 public notifications came from sources including workers in organisations subject to the Scheme, parents, Victoria Police, other regulators and members of the general public.

Victoria Police can disclose information to the Commission where it is concerned there is potentially reportable conduct. In 2017–18, 15 per cent of public disclosures to the Commission were from Victoria Police.

The ability for any person to contact the Commission with concerns about potential child abuse occurring in organisations subject to the Scheme supports the Commission to undertake its role overseeing compliance with laws that mandate reporting and investigation of reportable allegations.

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 investigation commenced. The Commission may also contact Victoria Police.

84 Referrals are made of substantiated reportable conduct in relation to individual subjects of allegation. There may be multiple substantiated allegations contained in each Working with Children Check referral. There were an additional four referrals of individuals made in July 2018 in relation to notifications finalised just prior to 30 June 2018. The reportable allegations in relation to these individuals are contained in the analysis in this annual report, however the referrals to the Department of Justice and Regulation will appear in data for 2018–19. This means that all 77 substantiated allegations from 2017–18 were referred to the Department of Justice and Regulation.

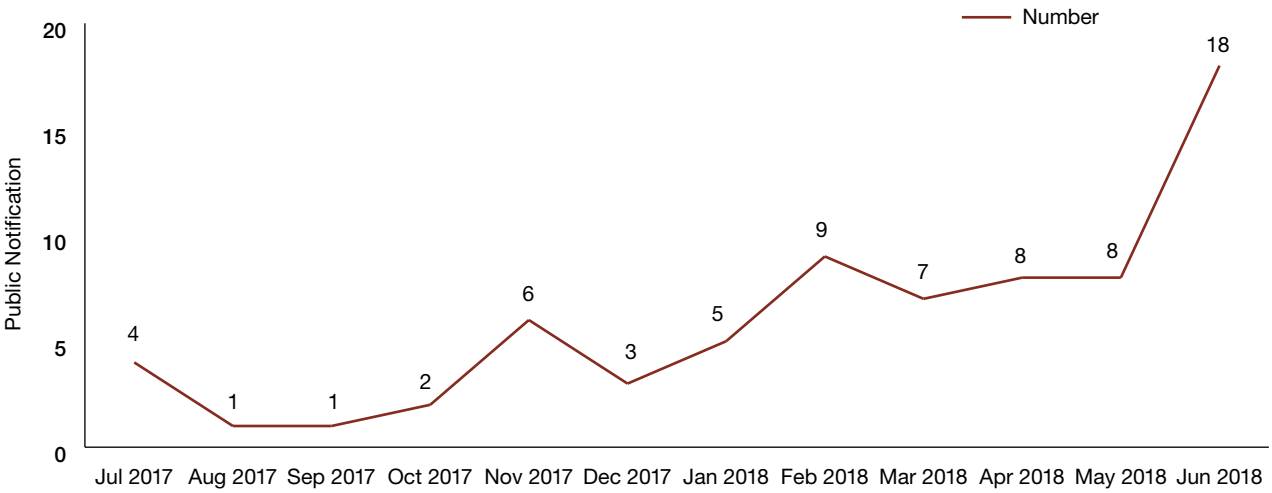
85 Differing counting rules between organisations may result in variances in figures between VIT and the Commission. Due to the early stage of the Scheme, VIT referrals are still relatively low. Further analysis, for example of allegation type or findings, presents a risk of identifying individuals and has not been included.

Reportable Conduct Scheme *continued*

The Commission received 72 disclosures of potential reportable allegations from persons other than the head of an organisation for the period 1 July 2017 to 30 June 2018. These related to 52 unique organisations.[86] Mandatory notifications were subsequently submitted by organisations in relation to 24 per cent of public notifications. The Commission assessed 18 per cent as being outside the jurisdiction of the Scheme, and 58 per cent of public notifications are currently under consideration.

The number of public notifications received by the Commission has gradually increased over the past 12 months, with a peak in June 2018. The Commission anticipates that the number of public notifications will increase in subsequent years as community awareness of the Scheme increases.

Figure 3. Public notifications by month received 2017–18



86 In some cases, the Commission may receive notifications from multiple people in relation to the one subject of allegation or organisation.

Table 33. Public notifications received by sector 2017–18

Sector	Number of public notifications	Percentage
Education	39	54
Other	9	13
Out-of-home care	7	10
Religious body	5	7
Disability services	4	6
Victorian government department	3	4
Not identified	2	3
Child protection	1	1
Early childhood	1	1
Health	1	1
Total	**72**	**100**

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 819 enquiries about the Reportable Conduct Scheme in 2017–18.[87] Key advice and guidance sought through these enquiries included clarity on the fundamentals of the Scheme, what constitutes reportable conduct and which organisations, workers and volunteers are subject to the Scheme.

Compliance activity

During the first year of the operation of the Scheme the Commission did not need to use any of the powers below to take compliance or enforcement action.

Table 34. Reportable Conduct Scheme compliance actions 2017–18

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

Table 35. Reportable Conduct Scheme enforcement action 2017–18

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

During the first year of the operation of the Scheme, no Commission decisions were subject to internal review or review by the Victorian Civil and Administrative Tribunal.

Table 36. Reportable Conduct Scheme review of decisions 2017–18

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

87 This does not include notifications of reportable conduct.

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 37 provides a summary of the Commission's expenditure 2017–18.

Table 37. Commission expenditure 2017–18

Expenditure	2017–18 ($)	2016–17 ($)	2015–16 ($)
Salaries and on costs	7,545,580	5,847,138	4,350,560
Grants and other transfers	396,040	185,720	356,260
Operating expenses	3,007,654	3,170,709	1,736,657
Depreciation		10,156	10,156
Total expenditure	**10,949,275**	**9,213,725**	**6,453,634**

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. Page references in Table 38 are to the Commission's annual report.

Table 38. Commission disclosures

Legislation	Requirement	Page
Report of operations		
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	**7, 14**
FRD 22H	Purpose, functions, powers and duties	**14**
FRD 22H	Key initiatives and projects	**16**
FRD 22H	Nature and range of services provided	**14–95**
Management and structure		
FRD 22H	Organisational structure	**101**
Financial and other information		
FRD 10A	Disclosure index	**99**
FRD 12B	Disclosure of major contracts	**109**
FRD 15E	Executive officer disclosures	**107**
FRD 22H	Employment and conduct principles	**103**
FRD 22H	Occupational health and safety policy	**102**
FRD 22H	Summary of the financial results for the year	**97**
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	Application and operation of *Freedom of Information Act 1982*	**109**
FRD 22H	Compliance with building and maintenance provisions of *Building Act 1993*	**110**
FRD 22H	Application and operation of the *Protected Disclosure Act 2012*	**110**
FRD 22H	Application and operation of the *Carers Recognition Act 2012*	**111**
FRD 22H	Details of consultancies over $10,000	**108**
FRD 22H	Details of consultancies under $10,000	**108**
FRD 22H	Disclosure of government advertising expenditure	**108**
FRD 22H	Disclosure of ICT expenditure	**109**

Appendix 1. Disclosure index *continued*

Table 38. Commission disclosures (continued)

Legislation	Requirement	Page
FRD 22H	Statement of availability of other information	**111**
FRD 22H	Compliance with the *Disability Act 2006*	**112**
FRD 24D	Reporting of office-based environmental impacts	**112**
FRD 25C	Victorian Industry Participation Policy disclosures	**108**
FRD 29C	Workforce data disclosures	**104**
SD 5.2	Specific requirements under Standing Direction 5.2	**1–112**
Compliance attestation and declaration		
SD 3.2.1.1	Audit Committee membership and roles	**102**
SD 3.7.1	Attestation for compliance with Ministerial Standing Direction	**112**
SD 5.1.4	Financial management attestation statement	**112**
SD 5.2.3	Declaration in report of operations	**1**
Legislation		
Freedom of Information Act 1982		**109**
Building Act 1993		**110**
Protected Disclosure Act 2012		**110**
Carers Recognition Act 2012		**111**
Victorian Industry Participation Policy Act 2003		**108**
Financial Management Act 1994		**1, 97**

Appendix 2. Governance and organisational structure

The Commissioners

Principal Commissioner

Liana Buchanan was appointed Principal Commissioner for Children and Young People in April 2016. The Principal Commissioner 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

The inaugural Commissioner for Aboriginal Children and Young People, Andrew Jackomos retired from the Commission in January 2018. In May 2018, Justin Mohamed was appointed to the role. Justin is responsible for leading the functions of the Commission relating to Aboriginal children and young people.

Executive officers

Brenda Boland

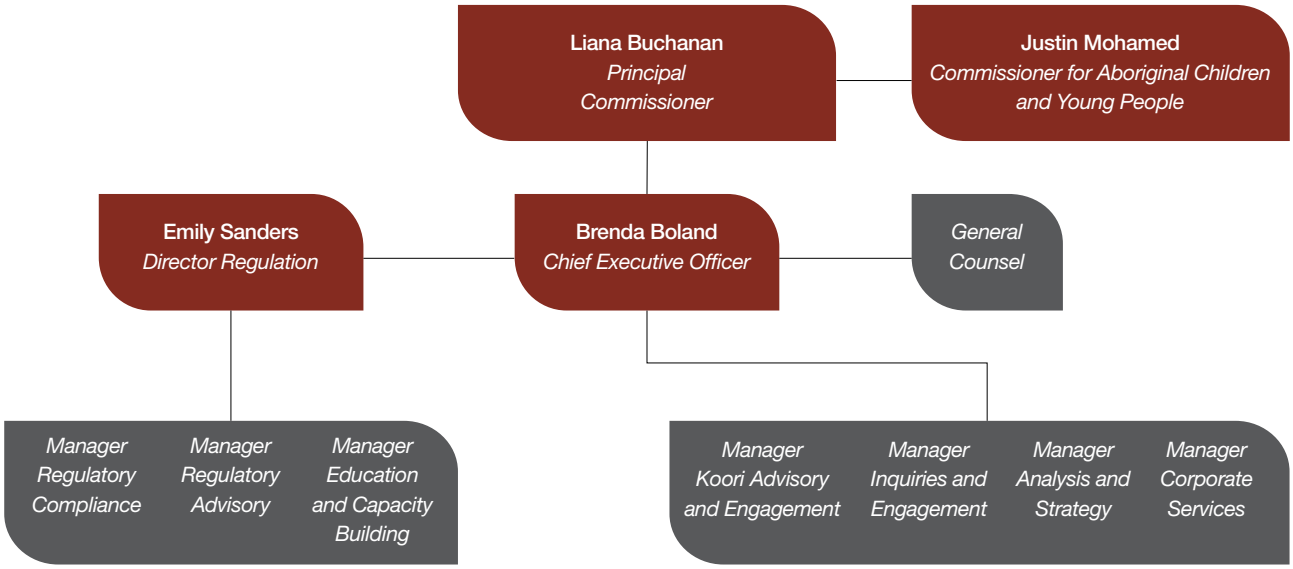
Brenda Boland is Chief Executive Officer of the Commission. She provides operational leadership to the Commission and ensures its effective and efficient management.

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 2018

Figure 4. Commission organisational chart



Appendix 2. Governance and organisational structure *continued*

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 and review the implementation of 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 to the Commission's obligations under the *Occupational Health and Safety Act 2004* and the Occupational Health and Safety Regulations 2007.

In 2017–18 we continued our ongoing internal safety reporting process, workplace inspections, ergonomic assessments for staff and an Employee Assistance Program.

In June 2017, the Commission also held its first Occupational Health and Safety Committee. The committee consists of elected management and staff representatives, the Commission's Health and Safety Representative and secretariat. The committee is chaired by the Commission's Manager, Corporate Services.

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 bimonthly 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.

Incident management

During 2017–18 there were four reported minor injuries. In 2016–17, there were no reported injuries.

The four injuries related to a skin irritation, office odour and head knocks. Whilst all four were reported and the staff impacted received the necessary treatment, none of the four injuries required any ongoing management or formal follow-up.

In 2017–18 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, which are available on our website, 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 56 people as at 30 June 2018, a small increase from the same time last year (Tables 39 and 40).

A notable change is the number of ongoing staff as at 30 June 2018 (50), compared to 30 June 2017 (31). This has been offset by a reduction in fixed term and casual staff from 22 as at 30 June 2017, to only six at 30 June 2018.

These workforce trends relate to our new functions, the Child Safe Standards and Reportable Conduct Scheme, and the employment of the majority of those staff members in ongoing roles.

Table 39. Workforce data as at 30 June 2018

		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	1	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**

Appendix 3. Workforce data *continued*

Table 40. Workforce data as at 30 June 2017

		June 2017						
		All employees		Ongoing			Fixed term and casual	
		Number (headcount)	FTE	Full-time (headcount)	Part-time (headcount)	FTE	Number (headcount)	FTE
Demographic data	**Gender**							
	Men	7	7	3	0	3	4	4
	Women	46	42.9	20	8	25.4	18	17.5
	Age							
	15–24	1	1	1	0	1	0	0
	25–34	8	8	1	0	1	7	7
	35–44	16	14.83	5	2	6.3	9	8.5
	45–54	12	11.3	5	2	6.3	5	5
	55–64	16	14.8	11	4	13.8	1	1
	65+	0	0	0	0	0	0	0
	VPS 1–6 grades	**53**	**49.9**	**23**	**8**	**28.4**	**22**	**21.5**
Classification data	VPS 3	5	4.6	3	1	3.6	1	1
	VPS 4	5	5	1	0	1	4	4
	VPS 5	25	23.43	11	5	14.43	9	9
	VPS 6	16	14.9	7	2	8.4	7	6.5
	Senior employees	**2**	**2**	**1**	**0**	**1**	**1**	**1**
	Executives	2	2	1	0	0	1	0
	Other	0	0	0	0	0	0	0
	Total employees	**53**	**49.9**	**23**	**8**	**28.4**	**22**	**21.5**

The figures in Tables 39 and 40 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 41 discloses the annualised total salary for senior employees of the Commission, categorised by classification.

Table 41. 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.

Executive officer data

The number of executive officers employed by the Commission is provided in Table 42, and Table 43 provides a reconciliation of executive numbers in 2017–18 and 2016–17.

Table 42. Total number of executive officers for the Commission by gender

	Total		Men		Women		Self-described	
Class	No.	Var.	No.	Var.	No.	Var.	No.	Var.
EO 3	2	0	0	0	2	0	n	n
Total	**2**	**0**			**2**	**0**	**n**	**n**

Table 43. Reconciliation of executive numbers

		2017–18	2016–17
	Executives	3	2
	Non-executive senior staff	2	1
	Accountable Officer	1	1
Less:	Separations	(2)	-
	Total executive numbers at 30 June	**4**	**4**

Table 43 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.

Appendix 4. Other disclosures

Local jobs first – Victorian Industry Participation Policy

The *Victorian Industry Participation Policy Act 2003* requires departments and public sector bodies to report on the implementation of the Local Jobs First – Victorian Industry Participation Policy (Local Jobs First – VIPP). Departments and public sector bodies are required to apply the Local Jobs First – VIPP in all procurement activities valued at $3 million or more in metropolitan Melbourne and for statewide projects, or $1 million or more for procurement activities in regional Victoria.

We did not engage in any applicable tenders during the reporting period.

Advertising expenditure

In 2017–18 we have not commissioned any advertising campaigns.

Consultancy expenditure

Consultancies $10,000 or greater

In 2017–18 we engaged four consultancies with individual costs greater than $10,000. The total value of those consultancies was $106,850 (Table 44).

Consultancies less than $10,000

In 2017–18 we engaged one consultancy in this category, for a value of $9,600 (excluding GST).

Information and communication technology expenditure

For the 2017–18 reporting period we had a total ICT expenditure of $657,662.70, the details of which are shown in Table 45.

Our non-business-as-usual expenditure was focused on finalising the development of a new case management system to capture and report on Child Safe Standards and Reportable Conduct Scheme cases, as well as other Commission functions. Costs include hosting and licensing fees. Other non-business-as-usual expenditure costs relate to enhancements of our website.

Table 44. Consultancies valued at $10,000 or greater

Consultant	Purpose of consultancy	Total approved project fee (excl. GST)	Expenditure 2017 18 (excl. GST)	Future expenditure (excl. GST)
Cube Group	Development of an operational performance framework	$44,800	$14,545	$30,255
Pirac Economics	Risk based audit approach & training	$60,455	$54,545	$5,910
Rapid Impact Pty Ltd	Strategic Planning and Governance Review for 2017–18	$26,510	$26,510	
Dr. Teresa Flower	Psychiatric Review of Child Death Inquiry	$13,636	$11,250	$2,386
Total		**$145,401**	**$106,850**	**$38,551**

Table 45. Commission ICT expenditure

Business as usual†	Non-business-as-usual†	Operational expenditure#	Capital expenditure#
$17,946	**$658,491**	**$18,775**	**$657,662**

† Total

Total = Operational expenditure and Capital expenditure

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 function.

From 1 September 2017, the FOI Act has been amended to reduce the Freedom of Information processing time for requests received from 45 to 30 days. In some cases, this time may be extended.

If an applicant is not satisfied by a decision made by the Commission they have the right under section 49A of the FOI Act 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 $28.90 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:

Chief Executive Officer
Commission for Children and Young People
Level 18, 570 Bourke St
Melbourne Victoria 3000.

Freedom of information statistics

During 2017–18, the Commission did not receive a Freedom of Information application from a member of the public. There were also 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 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:

Independent Broad Based Anti-corruption Commission
Level 1, North Tower 459 Collins Street
Melbourne VIC 3000

Phone: 1300 735 135

Website: ibac.vic.gov.au

Protected disclosures statistics

During 2017–18, 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

Appendix 4. Other disclosures *continued*

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.

The Department of Health and Human Services is developing a *Disability Action Plan 2018–2020* to outline the department's commitment to enhance the health and wellbeing of people with a disability. The Commission supports the department's approach to comply with the *Disability Act 2006* and through the current corporate services arrangement with the department, 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.

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

Level 18, 570 Bourke Street
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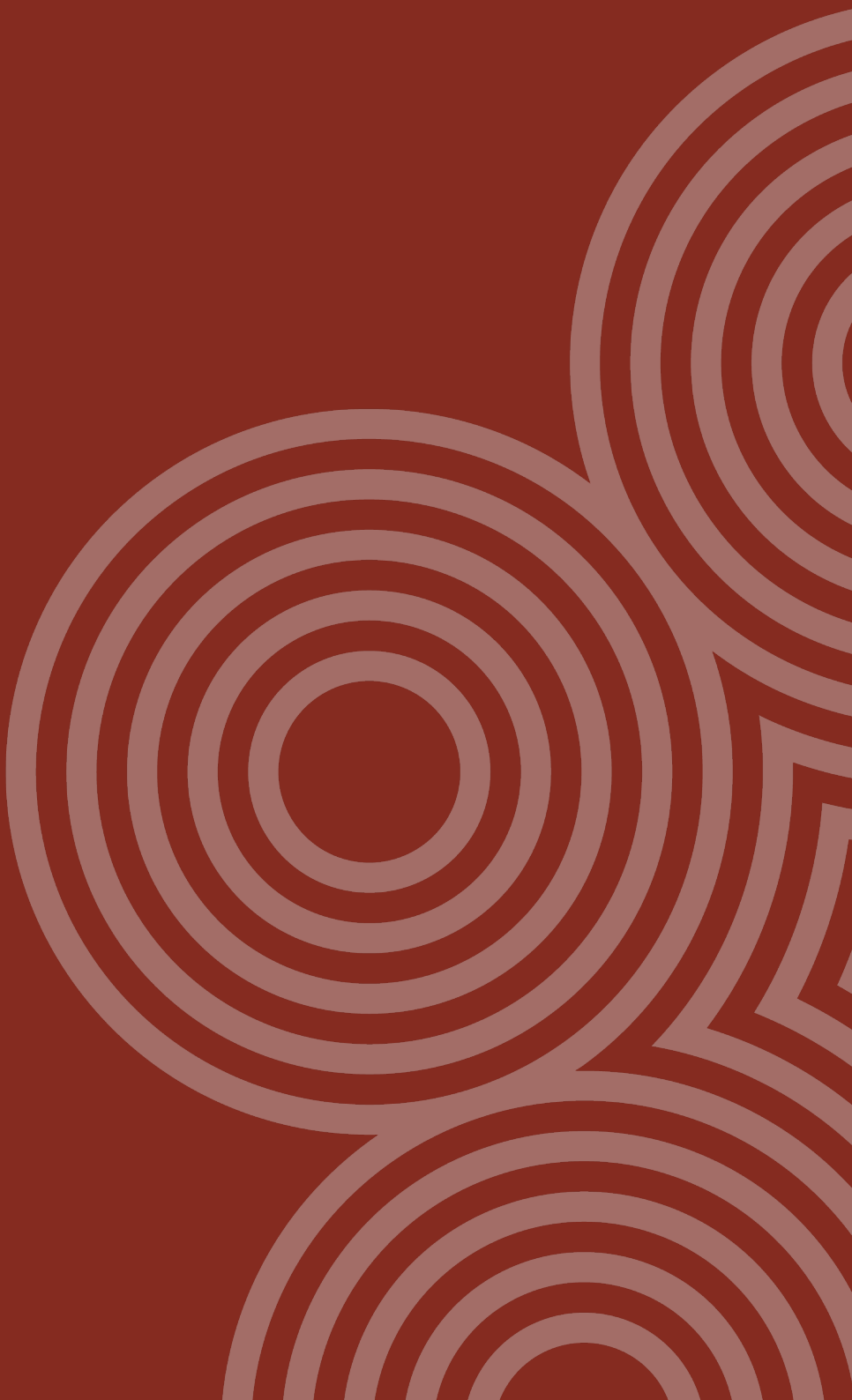

COMMISSION FOR CHILDREN
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