

Annual report

2016–17



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 youth of past, current and future generations.

© Commission for Children and Young People 2017

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without prior written permission from the Commission for Children and Young People, Level 18, 570 Bourke Street, Melbourne 3000.

Suggested citation

Commission for Children and Young People, *Annual Report 2016–17*. Commission for Children and Young People, Melbourne 2017.

ISBN 978-0-9945296-5-7

Commission for Children and Young People

Level 18, 570 Bourke Street

Melbourne Victoria, 3000

Phone: 1300 78 29 78

(03) 8601 5884

Email: childsaf@ccyp.vic.gov.au

www.ccyp.vic.gov.au



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

17 October 2017

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 2017.

Yours sincerely

Liana Buchanan

Principal Commissioner

Contents

Definitions.....	1
Language in this report	1
Case studies.....	1
Abbreviations and acronyms	1
From the Principal Commissioner	2
From the Commissioner for Aboriginal Children and Young People	5
About the Commission for Children and Young People.....	8
Highlights: our year in review	9
Increasing oversight of youth justice	9
Advocating for Aboriginal children in out-of-home care	9
Ensuring children experiencing family violence are heard	10
Promoting children’s safety in organisations.....	10
Oversight and monitoring.....	11
Overview.....	11
Systemic inquiries	12
Recommendations	18
Monitoring action on the recommendations of ... <i>as a good parent would</i>	18
Completed individual inquiries 2016–17	20
Inquiries underway	20
Child death inquiries	21
Monitoring through on-site visits	30
Oversight of serious incidents	33
Approaches from the public	40
Influencing policy, programs and services	41
Overview.....	41
Youth justice.....	41
Highlighting the needs and experiences of children who experience family violence	43
Influencing the broader policy agenda for children and young people.....	43
Supporting and regulating organisations working with children	46
Overview.....	46
New regulatory schemes introduced to prevent and respond to child abuse.....	46
Child Safe Standards	47
Compliance support	48
Compliance activities.....	50
Compliance and education activities by relevant authorities.....	52
Reportable Conduct Scheme	54
Preparing for the scheme.....	54

Improving outcomes for Aboriginal children.....	56
Overview.....	56
Engagement work	56
The Aboriginal Children’s Forum.....	57
Aboriginal Children and Families Strategic Action Plan	57
Transferring parental responsibility for Aboriginal children from government to community	58
Transitioning Aboriginal children’s cases to ACCOs	58
Aboriginal Justice Forum	59
Phase 4 of the Aboriginal Justice Agreement.....	59
Aboriginal Inclusion Action Plan	60
Cultural safety training	60
Financial summary.....	61
Appendix 1. Disclosure index.....	62
Appendix 2. Governance and organisational structure	64
The Commissioners	64
Executive officers	64
Organisational structure chart	64
Audit and Risk Committee membership and roles.....	65
Occupational health and safety	65
Employment and conduct principles	66
Appendix 3. Workforce data	67
Public sector values and employment principles.....	67
Comparative workforce data	67
Executives and other non-executive senior staff.....	69
Executive officer data.....	69
Appendix 4. Other disclosures.....	70
Local jobs first – Victorian Industry Participation Policy	70
Advertising expenditure	70
Consultancy expenditure	71
Information and communication technology expenditure.....	71
Disclosure of major contracts.....	72
Freedom of information.....	72
Compliance with the <i>Building Act 1993</i>	73
Compliance with the <i>Protected Disclosure Act 2012</i>	73
Compliance with the <i>Carers Recognition Act 2012</i>	73
Additional Commission information available on request	73
Attestation for compliance with Ministerial Standing Direction 3.7.1	74

List of tables

Table 1.	Response to recommendations arising from public systemic inquiries in 2016–17.....	18
Table 2:	Child death notifications received by the Commission in 2016–17, by Aboriginal status and category of death	21
Table 3:	Child death notifications to the Commission in 2016–17, by Aboriginal status and age.....	22
Table 4:	Child death notifications received by the Commission 2012–17, by category of death	22
Table 5:	Child death notifications received by the Commission between 2012–17, by Aboriginal status.....	23
Table 6:	Child death inquiries completed by the Commission in 2016–17, by age, category and Aboriginal status.	24
Table 7:	Child death inquiries completed by the Commission in 2016–17, by living arrangements at death.	25
Table 8:	Category One client incident reports for children in out-of-home care 2015–17, by type of incident reported	35
Table 9.	Category One client incident reports for children in out-of-home care, by type of incident reported, by care type 2016–17.....	38
Table 10:	Number of youth justice Category One incidents reported to the Commission in 2016–17	39
Table 11:	Non-compliance concerns status as at 30 June 2017	51
Table 12:	Commission’s Child Safe Standards Compliance activities 1 January 2016 – 30 June 2017	51
Table 13:	Commission Expenditure for 2016–17	61
Table 14a:	Workforce data as at 30 June 2017.....	67
Table 14b:	Workforce data as at 30 June 2016	68
Table 15:	Annualised total salary, by \$20,000 bands, for executives and other senior, non-executive staff	69
Table 16:	Total number of EOs for the Commission, by gender.....	69
Table 17:	Reconciliation of executive numbers.	69
Table 18:	Details of advertising expenditure.....	70
Table 19:	Consultancies \$10,000 or greater	71
Table 20:	Commission ICT expenditure.....	71

List of figures

Figure 1.	Alleged physical assault incidents in out-of-home care reported to the Commission in 2016–17	36
Figure 2.	Alleged sexual assault incidents in out-of-home care reported to the Commission in 2016–17.....	37
Figure 3.	Rape incidents in out-of-home care reported to the Commission in 2016–17.....	37

Definitions

Language in this report

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

Case studies

Case studies have been included to illustrate the work of the Commission and key themes arising from our inquiries. Pseudonyms have been used and details of the cases have been altered to protect the privacy of the people to whom they refer. 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
AIAP	Aboriginal Inclusion Action Plan
AJF	Aboriginal Justice Forum
CCYP Act	<i>Commission for Children and Young People Act 2012</i>
CSO	Community sector organisation
CYF Act	<i>Children, Youth and Families Act 2005</i>
DELWP	Department of Environment, Land, Water and Planning
DET	Department of Education and Training
DHHS	Department of Health and Human Services
DJR	Department of Justice and Regulation
KAE	Koori Advisory and Engagement unit
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VRQA	Victorian Registration and Qualifications Authority

From the Principal Commissioner

The past year has seen significant reform across a range of policy areas affecting children and young people in Victoria. It has also been a year of change for the Commission, as we added to our existing oversight and advocacy functions, and assumed the role of regulator for two new schemes designed to safeguard children from harm and abuse.

Victoria's landmark *Betrayal of Trust* parliamentary inquiry outlined a range of reforms to prevent and respond to child abuse in organisations. The Child Safe Standards and the Reportable Conduct Scheme were among those recommendations.

The Child Safe Standards are principles-based requirements directed at ensuring organisations have child-centred policies, processes and practices that promote safety, and empower children and young people to exercise their right to have a say in matters that affect them. In 2016–17 we supported organisations to implement the standards through information sessions, awareness-raising campaigns, our dedicated helpline and resources. Over time, the standards will operate to ensure safe and accountable organisational cultures that prevent harm and abuse.

We also prepared for the commencement of the Reportable Conduct Scheme on 1 July 2017. The scheme introduces requirements for organisations that interact with children to report and investigate concerns or allegations of harm to the Commission. This will give us greater insight into how organisations manage known risks to children. We will be empowered to act

in a direct and systematic way to close existing loopholes, while reinforcing best practice. This will drive greater accountability and ensure children's interests are consistently prioritised.

Implementing these schemes has given us the opportunity to build relationships with a wide range of organisations that interact with children in the community, private and public sectors.

More broadly, we welcomed a number of reforms within the child protection and family violence systems. The Victorian Government's Roadmap to Reform seeks to address many of the shortcomings within the child protection and out-of-home care systems. We particularly welcome changes that reduce the number of children in residential care facilities and improve supports for children in home-based care. We also welcome the implementation of recommendations of the Royal Commission into Family Violence, which rightly found that children affected by family violence are often invisible and overlooked in current service systems.

It is our role to positively influence these reforms by ensuring the voices and experiences of children remain at the forefront of their design and implementation. This prevents a default focus on adults or an adult perspective of what children need. It is also our job to monitor responses to children here and now. Sadly, we see daily evidence that major room for improvement remains in how we respond to vulnerable children at risk of harm.

Not all areas of reform have been positive. The combination of a media focus on a small cohort of serious young offenders, with disturbances in a troubled and neglected youth justice system, placed a rehabilitative model for youth justice at risk. As Commissioner for Children and Young People I have opposed the calls for an end to a differentiated response to children in favour of more punitive approaches. The evidence clearly demonstrates punitive approaches are counterproductive and often entrench offending behaviour.

We highlighted our concerns over the treatment of children and young people held in a secure unit within the adult Barwon Prison. Our first-hand observation of conditions, and our direct engagement with the affected young people, resulted in improvements to their treatment during the six-month period the unit was used, and ultimately informed the Supreme Court's consideration of whether use of this unit was lawful.

Recent debate on youth offending has strengthened our resolve to educate the community about the causes of children's offending, the evidence that underpins a differentiated youth justice model, and Victoria's youth offending trends, which have been decreasing for successive years.

In the past year, we completed five major inquiries into systemic aspects of the child protection and youth justice systems, further strengthening our oversight and monitoring work. The four reports tabled during the past year reflect our key focus areas: family violence, youth justice and service responses to Koori children in out-of-home care.



Our inquiries highlighted systemic failures to identify and respond to risks of family violence and sexual abuse, non-compliance with requirements that ensure Koori children remain connected to their community and culture, and the mistreatment of young people in detention. We will continue to inquire into areas of concern to hold agencies accountable and drive continuous improvement.

Shortly after the end of 2016–17 my colleague Andrew Jackomos announced he would not seek reappointment when his term ends in June 2018. As the inaugural Commissioner for Aboriginal Children and Young People, Andrew has been instrumental in furthering our understanding of the plight of Koori children, who continue to be removed from their parents at an unacceptable rate and are routinely alienated from their family, community and culture when placed in out-of-home care.



Andrew is a persistent and passionate advocate who can bridge divides and facilitate genuine partnerships. These qualities have led to significant commitments from government, community service organisations and the Aboriginal community to work together to reverse these devastating outcomes. I am incredibly sad that Andrew will not be continuing beyond next year but look forward to working alongside him in coming months as he embeds a range of reforms to improve the safety, wellbeing and cultural connectedness of Koori children.

I thank all Commission staff for a year of hard work and incredible commitment. In the past year, we farewelled a number of longstanding staff, and I acknowledge their significant contribution to the Commission over the years. With the addition of new functions and responsibilities, the Commission has grown and changed. We welcomed many new staff members who bring a range of skills and experience, all of which will help continue to build our capacity as a strong, independent and rigorous organisation.

I look forward to working with all of the Commission's staff, our many valued stakeholders and, importantly, children and young people themselves as we defend, protect and realise the rights of children and young people in this state.

Liana Buchanan
Principal Commissioner

From the Commissioner for Aboriginal Children and Young People



Today in 2017, 20 years after the *Bringing them Home* report, we are still seeing record numbers of Victorian Koori children removed by Child Protection and placed in out-of-home care, away from their families. There is twice the number of Koori children in the Victorian out-of-home care system as there was when we commenced Taskforce 1000. As evidenced in *Always was, always will be Koori children* and *In the child's best interests*, together with good practice, we saw countless examples of institutional racism, cultural ignorance and a failure to comply with legislation to ensure the protection of our children's cultural rights.

I remain confident that with strong commitment across government, and within the Department of Health and Human Services (DHHS), mainstream community sector organisations (CSOs), and primarily driven by Aboriginal Community Controlled Organisations (ACCOs) and leadership, we are seeing an honest attempt and improved practices to keep our children home or to bring them and keep them safe in family, community and culture.

I applaud the commitment by the Minister for Families and Children, the Hon. Jenny Mikakos, and the work by all members of the Aboriginal Children's Forum (ACF) to ensure we have a system that is now working to protect the rights of our children and families, and to ensure full compliance with the Aboriginal Child Placement Principle (ACPP). There are Koori and non-Koori champions across sectors ensuring we achieve this objective.

Over and above the findings and recommendations from the Royal Commission into Family Violence, we have never before seen a level of commitment from government and community to stop family violence, which, along with alcohol and drug abuse are the primary drivers of child removal. As evidenced in Taskforce 1000, close to 90 per cent of Koori children are removed due to factors involving family violence, alcohol and drug abuse.

We must seize the moment to maximise this groundswell to make a generational change to the ever-increasing numbers of Koori children in Victoria being removed. We cannot lose this opportunity.

Over the past 12 months, we commemorated landmark anniversaries. This year marked the 50th anniversary of the passing of the 1967 Referendum, the 26th anniversary of the final report of the Royal Commission into Aboriginal Deaths in Custody, the 20th anniversary of the *Bringing them Home* report, and the 25th anniversary of the Mabo High Court Decision.

The referendum and the Mabo Court decision were milestones in the recognition of the rights of Aboriginal people in acknowledgement of their ancestral connection to Australia.

Bringing them Home and the Royal Commission's report detailed the sorry tale of exclusion, racism, injustice, disadvantage, and the impact of past government and social policies on our children, our families and our communities.

The ongoing incarceration of Russell Moore in a Florida prison is a continuing testament to the failures of past government practices and policies that were highlighted in these reports. The failure to implement these recommendations nationwide has seen lost opportunities to right the wrongs of the past and current circumstances. It is disappointing to think that Aboriginal people may have told their stories in vain, and we should not let them sit idle on shelves gathering dust.

The ongoing leadership shown by the ACF to drive policy and practice reform in the child protection and out-of-home care sectors demonstrates that government, ACCOs and CSOs can work in partnership with a focus on best outcomes for Koori children and young people by ensuring they grow up strong in community and culture.

The ACF continues to hold government and their commitment to self-determination to account. In 2017 it has set, in partnership with the DHHS, important targets and timeframes for the number of Koori children in care to be transitioned to case management by ACCOs.

The ACF has set a target of 30 per cent of Koori children and young people in care to be case-managed by ACCOs by the end of 2017. This will grow to 80 per cent by the end of 2018 and to

100 per cent by the end of 2021. These targets and timeframes are both realistic, long overdue and necessary if we are committed to self-determination, and better and safer outcomes for our children.

In the child protection and out-of-home care space, the Commission tabled two Koori-specific landmark reports in the Victorian Parliament in October 2016.

They were, Always was, always will be Koori children: A 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*.

Both these reports were informed by the extensive work of the landmark Taskforce 1000 project, a joint initiative of the department and the Commission that looked in-depth at the histories, case files and responses to 980 identified Koori children and young people in the care of DHHS.

I welcome the government's acceptance of all recommendations, either in full, in part or in principle and look forward to their full implementation in policy, legislation and practice. I applaud DHHS for establishing a committee, which the Commission co-chairs, to monitor the implementation of the recommendations.

While the last 12 months have seen promising and nationally-leading developments in our responses to Aboriginal children and young people in the child protection system, the same cannot be said about the state of the youth justice system and our Koori young people connected to the system.



Last year saw a significant number of disturbances and high-profile incidents across both Malmsbury and Parkville Youth Justice facilities. The causes of these disturbances have been complex and require nuanced and evidence-informed responses in operations and policy.

Unfortunately responses have been, in many cases, reactive and punitive and have created an atmosphere within the centres that led to an environment that has not been supportive, positive or rehabilitative for young people or youth justice staff.

I welcomed the decision by the Victorian Government to commission an extensive review of Youth Justice, to be undertaken by Penny Armytage and Jim Ogloff, and to transfer responsibility for Youth Justice from DHHS to the Department of Justice and Regulation (DJR). I have looked forward to the review being finalised, and the findings and recommendations being made public.

My hope is that the transfer to DJR and the review, together with a greater focus and oversight over next 12 months through the Aboriginal Justice Forum and key youth priorities within the Aboriginal Justice Agreement 4, will bring about a change in the rhetoric that dominated much of the discourse with regard to youth justice and young people.

I remain confident that these changes will create an environment that is focused on the rehabilitation, responsibility and development of our young people within youth justice facilities, and drive the enhancement and expansion of early intervention and prevention programs within ACCOs to begin to address the over-representation of Aboriginal young people in youth justice.

Two things the government can do to reduce the over-representation of Koori children and young people in the justice system would be to increase the minimum age of criminality and the maximum age of leaving care from 18 to 21 years of age. The socioeconomic arguments for these two changes are considerable and could have a lasting impact that could change current life projections for many of the children in care today.

I look forward to the year ahead with many positive challenges awaiting us to improve the youth justice and child protection systems, increasing self-determination and greater opportunities to bring our children home.

A handwritten signature in black ink that reads "Andrew M Jackomos". The signature is written in a cursive, flowing style.

Andrew M Jackomos PSM
**Commissioner for Aboriginal Children
and Young People**

About the Commission for Children and Young People

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

We are an independent statutory body established to promote improvement and innovation in policies and practices relating to the safety and wellbeing of vulnerable Victorian children and young people.

Our vision is that the rights of children and young people in Victoria are recognised, respected and defended.

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

EIGHT KEY PRIORITIES

In 2016–17 we established eight key priorities.

1. Advocating for Aboriginal self-determination to ensure Koori children and young people retain connection to family and culture.
2. Driving improvement and innovation across the out-of-home care service-delivery system.
3. Ensuring family violence reforms are focused on children and young people.
4. Promoting and regulating child safety in organisations.
5. Ensuring lessons learned from child death inquiries drive system improvement.
6. Increasing oversight of youth justice.
7. Enhancing the participation of children and young people in our work.
8. Building a strong, vibrant, high-impact and effective Commission.

Highlights: our year in review

Increasing oversight of youth justice

- This year we significantly expanded our oversight of youth justice centres. Through regular visits to youth justice centres by our Commissioners, staff and independent visitors, we raised concerns about conditions and the treatment of children and young people with youth justice management and the Minister for Families and Children. We increased our monitoring role when children were held in a unit within Barwon Prison, visiting at least weekly and raising issues of concern.
- We tabled our inquiry report, *The same four walls*, which made 21 recommendations to address the excessive use of isolation, separation and lockdowns in youth justice facilities. The Victorian Government accepted all our recommendations.
- Our work in youth justice occurred in the context of significant community concern about youth offending and disturbances in youth justice centres. Through our advice to government and our monitoring activities, we sought to ensure Victoria's youth justice system retains and strengthens its focus on rehabilitation and specialist, age-appropriate responses to offending by children and young people.

Advocating for Aboriginal children in out-of-home care

- This year we continued our close engagement with Victoria's Aboriginal community, listening to their stories and celebrating their work. Through the

“ 2016–17 was a year of change, growth and achievement ”

Commissioner for Aboriginal Children and Young People, we pushed for self-determination for Aboriginal communities around decisions about how to care for their children.

- We tabled two landmark reports about Aboriginal children in out-of-home care. Our inquiries, *In the child's best interests* and *Always was, always will be Koori children*, revealed widespread non-compliance in Victoria with laws designed to prevent Aboriginal children being disconnected from their families, culture and communities. We made 133 recommendations that were accepted by government and are on track to be implemented.
- Key actions that resulted from these recommendations will allow Aboriginal communities, rather than government agencies, to be responsible for decisions about Aboriginal children in out-of-home care. The government has also committed to transferring parental responsibility for Aboriginal children on protection orders to ACCOs, with the cases of all Aboriginal children on protection orders to be transferred to these organisations by 2021.

Ensuring children experiencing family violence are heard

- The recommendations of the Royal Commission into Family Violence featured prominently in this year's policy and legislative reform agenda in Victoria. Ensuring these vital reforms deliver change for children affected by family violence was a considerable focus of our work.
- The Commissioners, through their membership of the Social Services Taskforce, the Family Violence Steering Committee and several other forums, continued to highlight the experiences of children and young people as victims of family violence in their own right. They called on the government to ensure Victoria's response to family violence addresses children's specific needs.
- We finalised our inquiry *Neither seen nor heard*, which focused on children who had been involved with Child Protection and died having experienced family violence. Our findings echoed problems identified by the Royal Commission into Family Violence and revealed that further improvements must be made in a number of areas. These include Child Protection's response to family violence, responses to Aboriginal children and families affected by family violence, and strengthening the identification of and response to child sexual abuse. All our recommendations were accepted by the government.

Promoting children's safety in organisations

- This year we established two new functions: the Child Safe Standards and the Reportable Conduct Scheme. We are proud to be responsible for administering these two schemes, which represent a complementary approach to preventing child abuse by ensuring everyone takes responsibility for keeping children safe.
- The introduction of our new functions led to enormous change and growth in the skills and size of our workplace. In 2016–17, we grew from 31 to 53 staff.
- We worked hard to educate hundreds of organisations about their new obligations to create a child-safe culture and to prevent abuse. We delivered information sessions, ran a helpline, embarked on a digital campaign to spread our message about child safety, and developed resources for organisations covered by the schemes.
- There was also considerable internal activity to set up our new functions and prepare to administer the Reportable Conduct Scheme. In particular, we rebuilt our website and developed a new case management system to receive, manage and oversee allegations of reportable conduct from a range of organisations.

Oversight and monitoring

Overview

Our activity as an independent oversight and monitoring body continued to improve transparency, accountability and safety in services for children and young people, particularly across youth justice centres, out-of-home care and child protection.

Our inquiries into services provided to children help identify areas that need to be improved, so systemic failings are not repeated in the future.

Altogether, our public systemic inquiries gave rise to 167 recommendations. Each was accepted and many have been actioned or are in-train, leading to immediate improvements for children and young people. We continue to keep a close eye on the progress of recommendations from our inquiries this year and last year.

This year, we strengthened our monitoring of conditions in youth justice centres, seeking follow-up information about more than a third of incidents reported to us. We also implemented staff inspections when centres were especially unsettled, and while children were kept at the Grevillea unit in Barwon Prison.

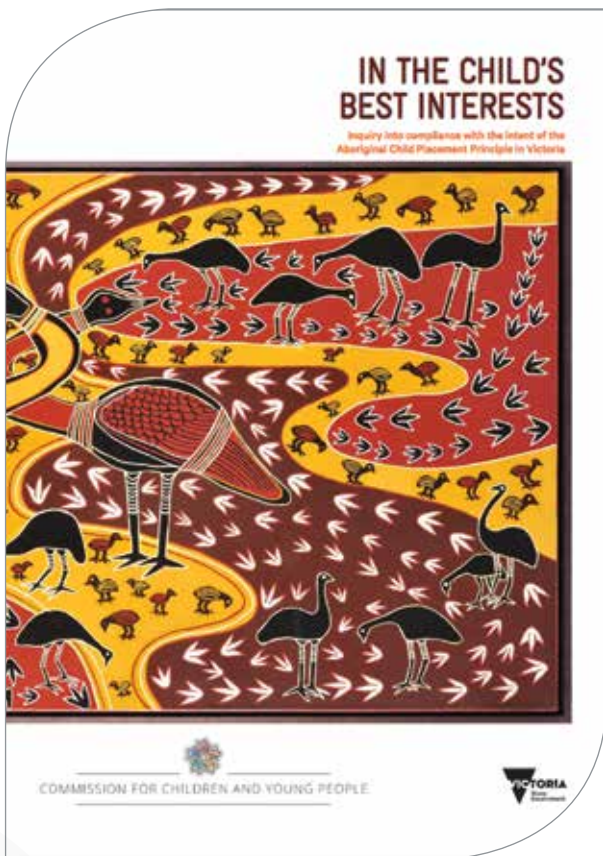
Our child death inquiries focused on improving systems and services for children in the child protection system. This resulted in 51 recommendations compared to 12 in the previous year.

OUR MOST ACTIVE YEAR

2016–17 was our most active year yet, with five systemic inquiries, which examined the following areas:

1. compliance with the Aboriginal Child Placement Principle in Victoria
2. the experience of Aboriginal children in out-of-home care
3. the use of isolation and related practices in youth justice centres
4. responses to children affected by family violence
5. the impact of permanency amendments to Victoria's child protection laws.

Our oversight and monitoring work this year reflects our steadfast commitment to ensuring the rights of Victorian children are upheld, by scrutinising services, holding government and providers to account, and driving improvements.



Systemic inquiries

We completed five systemic inquiries. The Commission initiated four, and the Minister for Families and Children recommended one.

In the child's best interests

We found Victorian child protection services were not complying with vital protections put in place across Australia to prevent a repetition of the impact of Stolen Generation policies. Our inquiry into compliance with the intent of the ACPP in Victoria was tabled in the Victorian Parliament in October 2016.

The inquiry found that little effort was being put into placing Aboriginal children in out-of-

home care with Aboriginal families or Aboriginal carers, or keeping them connected with culture and community as required by the ACPP.

In a sample of 65 cases of Aboriginal children, we did not find a single case where agencies had complied with all the requirements of the ACPP. Some systemic barriers to implementing the ACPP included:

- unclear legislation that does not sufficiently articulate the intent of the ACPP
- insufficient capacity and funding of agencies
- poor policy and practice guides
- lack of Aboriginal carers
- the failure of Child Protection to prioritise cultural connectedness when making placement decisions
- insufficient DHHS oversight and accountability to ensure compliance with the principle.

We made 54 recommendations to improve ACPP compliance and provide more opportunities for Aboriginal self-determination in child protection decisions.

A key recommendation was that the government develop a strategy and timeline to transfer parental responsibility for Aboriginal children and young people who are subject to a child protection order, from the Secretary of DHHS to ACCOs. The work being done to implement this recommendation is discussed in more detail in the section, Improving Outcomes for Aboriginal Children (page 56).

Always was, always will be Koori children

Our inquiry into services for Aboriginal children and young people in out-of-home care in Victoria was tabled in October 2016.

The inquiry was based on the landmark Taskforce 1000, an 18-month project co-chaired by the Commission and DHHS. Bringing together ACCOs, CSOs, government departments and the Aboriginal community, Taskforce 1000 examined the cases of 980 Aboriginal children in out-of-home care.

The inquiry found family violence, and alcohol and/or drug abuse by parents were the leading reasons Aboriginal children enter out-of-home care. Of the children reviewed, 88 per cent experienced family violence and 87 per cent had parents with alcohol or substance abuse issues. The inquiry also found the child protection system failed to preserve, promote and develop cultural safety and connection for Aboriginal children.

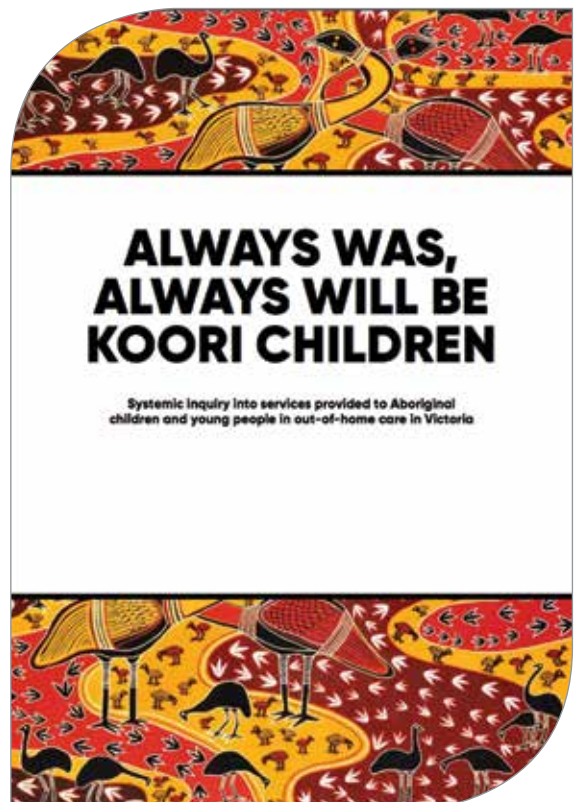
More than 60 per cent of the children reviewed during Taskforce 1000 were placed with a non-Aboriginal carer, 41 per cent were placed away from their extended family, and more than 40 per cent of children with siblings were separated from their brother or sister.

We made 79 recommendations to improve policies and practices for Aboriginal children in out-of-home care.

The recommendations included:

- that a strategy be developed, with timelines and an action plan, to transfer the case management of Aboriginal children and young people to ACCOs

- a range of measures to increase the inclusion of Aboriginal people in the Child Protection workforce, such as the establishment of Aboriginal Principal Practitioners and increased funding for the Aboriginal Child Specialist Advice and Support Service (ACSASS)
- policies and practices to ensure Aboriginal children and young people in out-of-home care maintain meaningful connections with their culture and community
- strengthening programs and services that help Aboriginal children and young people, and their families, address family violence and inter-generational trauma
- building cultural competency of organisations providing services to children.





- The government has allocated \$3.6 million over two years to expand ACSASS.
- A new cultural planning model has been developed, which is monitored by the Cultural Planning Monitoring Group, and mandates that cultural plans must be prepared for all Aboriginal children and young people in out-of-home care.
- The government has allocated funding for the development of an Aboriginal healing, care and culture service.
- A Return to Country Framework was launched on 1 March 2017.

Ongoing monitoring of recommendations of In the child's best interests and Always was, always will be Koori Children

With the assistance of the ACF, we will closely monitor the ongoing implementation of the recommendations from both inquiries through 2017–18.

The ACF is a representative group of ACCOs, the community sector and government. It was established to drive the safety and wellbeing of Aboriginal children and young people in, or at risk of, entering the out-of-home care system. Within the forum, a partnership between community organisations, government and the Commission has responsibility for overseeing, evaluating and verifying the implementation of recommendations arising from the inquiries.

The forum has assessed that 68 recommendations from both reports are on track or in progress, 18 are complete and three are the subject of ongoing monitoring.

The Victorian Government accepted all of the recommendations in full, in part or in principle. In response to the recommendations, the following initiatives have been started or completed.

- Case management of Aboriginal children and young people is being transferred from DHHS and CSOs to ACCOs, with a target to transfer 30 per cent of children by the end of 2017 and 100 per cent by 2021. This work is being overseen by a steering committee and supported by additional funding.
- DHHS has established the position of Principal Practitioner Aboriginal and Torres Strait Islander Children and Families, which will be supported by a senior cultural adviser.

Neither seen nor heard

Tabled in December 2016, this report examined a sample of child death inquiries involving children who had experienced family violence.

We found that Child Protection and other services:

- underestimated the impact of family violence on children, resulting in no meaningful intervention to keep them safe
- rarely engaged directly with child victims to fully understand their experience, meaning children were not provided the support they needed to address their trauma
- relied too heavily on parents' assurances that they could keep children safe while failing to offer support to mothers who were victims of violence
- did not fully investigate or provide adequate support to children following disclosures or suspicions of sexual abuse.

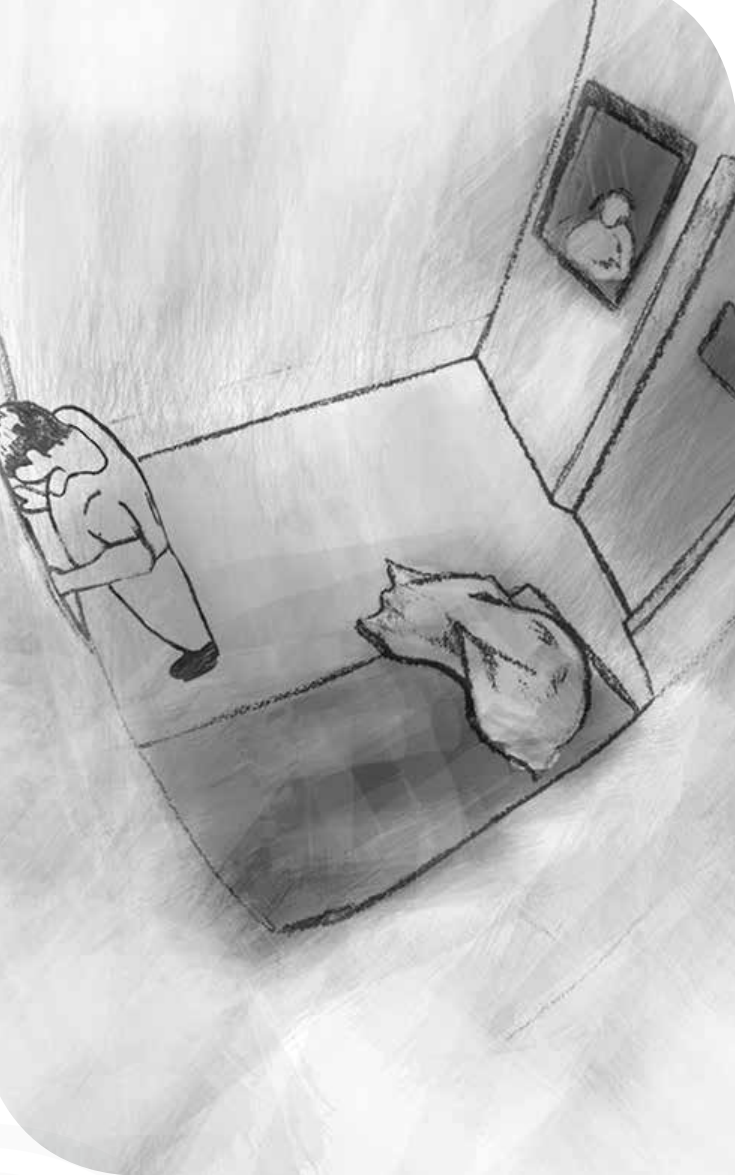
Through the report, we called on the government to ensure the current family violence reforms deliver genuine change for child victims of family violence. We made 13 recommendations calling on the Victorian Government to:

- address the findings of the inquiry when implementing the recommendations of the Royal Commission into Family Violence
- consult with Aboriginal services to ensure that where a report is made to Child Protection before an Aboriginal child is born, families are engaged in a culturally-appropriate way and receive early intervention and support



- implement a suite of measures to ensure that child sexual abuse affecting children who experience family violence is properly understood, identified and responded to
- establish a process to identify and improve the response to cases where multiple reports have been made to Child Protection, where family violence is a factor, and the child is in the care of parents or extended family.

Of the 13 recommendations, 10 were accepted in full and three in principle. Action on the recommendations was still in progress at 30 June 2017 and we continue to seek further detail.



As well as monitoring progress of these actions, we will also monitor other recommendations that were included in the government's response to the Royal Commission into Family Violence and our inquiry, *Always was, always will be Koori children*.

The same four walls

We initiated an 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.

Our inquiry found limited staff training, the absence of a clear or effective approach to behaviour management and poor compliance with legislation and policy were leading to widespread use of restrictive practices that resulted in confinement and isolation.

Longstanding issues of understaffing meant that, on average, at least one unit (up to 15 children and young people) was subjected to a lockdown each day during the 18-month period we reviewed.

These practices resulted in children and young people being enclosed with limited access to fresh air, human interaction, education, psychological support and, in some circumstances, basic sanitation. They formed part of the context to the incidents of unrest seen in Victoria's youth justice centres in 2016 and early 2017.

We made 21 recommendations to change policies, practices and infrastructure, strengthen legislation to safeguard rights, and improve the treatment of children in detention.

However, DHHS has committed to:

- establishing a working party with police, sexual assault services and relevant areas within the department to improve responses and intervention to disclosures of sexual abuse by children affected by family violence
- reviewing a sample of Child Protection cases that have been closed at intake four times or more to identify ways to improve the Child Protection response to children affected by family violence
- improving the treatment for young people who commit family violence
- reviewing, in consultation with Aboriginal services, the process of reporting family violence concerns before a child is born, to strengthen early intervention responses.

Of the 21 recommendations, 13 were fully accepted and eight were accepted in principle.

In April 2017, shortly after the tabling of our report, responsibility for youth justice transferred from DHHS to the DJR.

As at 30 June, as a result of the inquiry, DJR had developed an action plan and showed early signs of progress in the following areas:

- improved transparency and record keeping for isolations, with changes to how isolations are recorded, and records checked by management daily
- redeveloped training for new and existing staff to ensure isolation is only used when necessary and not as punishment – all staff had received training by August 2017
- a review of isolation practices for Aboriginal children and young people will begin in 2017–18, in consultation with Aboriginal community agencies and the Commissioner for Aboriginal Children and Young People
- works to upgrade sanitation in isolation rooms are being scoped
- separation plans will be replaced by Secure Care Plans, which outline how to manage behaviour and support children and young people through their time in custody
- targeted recruitment is underway to address staffing problems that were leading to excessive lockdowns, and the use of lockdowns has reduced.

Safe and wanted

The Minister for Families and Children recommended that we 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.

To achieve this we:

- analysed extensive sets of DHHS and Children's Court quantitative data
- reviewed case files
- held wide-ranging stakeholder consultations
- received public submissions and case studies
- spoke directly to children and young people about what matters to them in long-term care arrangements.

We provided *Safe and wanted*, with 40 recommendations for consideration, to the Minister for Families Children, and the Secretary of DHHS in June 2017. The decision to release all or part the report rests with the Minister.

Recommendations

The four systemic inquiries we tabled in Parliament in 2016–17 resulted in 167 recommendations (Table 1). We also continued to monitor the implementation of recommendations arising from last year’s inquiry, ... *as a good parent would*

Monitoring action on the recommendations of ... *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 and prompted DHHS to develop an 18-point plan to:

- urgently redevelop Victoria’s residential care system
- develop specialised care options
- provide ongoing funding for a statewide sexual exploitation prevention strategy
- improve data systems, departmental structures and processes.

Table 1. Response to recommendations arising from public systemic inquiries in 2016–17

Response	<i>In the child’s best interests</i>	<i>Always was, always will be Koori children</i>	<i>Neither seen nor heard</i>	<i>The same four walls</i>	Total
Accepted	35	31	10	13	95
Accepted in principle	17	38	3	8	69
Accepted in part	2	10	0	0	12
Not accepted	0	0	0	0	0
Total	54	79	13	21	167

As at 30 June, the Victorian Government had made progress on many aspects of the recommendations including:

- the development of the ‘Keeping children safe from sexual exploitation strategy’, which involves a number of measures including assigning specialist child abuse investigators to work with children who are at risk of exploitation, establishing sexual exploitation Child Protection practice leaders, and providing training and resources to the workforce
- \$9.4 million to renew or replace up to 24 residential care properties; as at 30 June, four of these properties had been built or renovated
- \$2.3 million over two years for repairs of almost 230 residential care properties, along with a program of unannounced audits to review the condition of residential care properties and responsiveness to maintenance issues
- an 8 per cent decrease in the number of children in residential care, from 453 in July 2016 to 416 in June 2017
- \$62 million funding over four years for ‘Targeted care packages’ to transition children out of residential care or prevent them from entering care – 386 packages have been provided (83 to Aboriginal children) as at 30 June 2017
- a trial of the Treatment Foster Care Oregon program to assign professional foster carers to transition children out of residential care or prevent them from entering residential care



- a trial of the Mentoring, Learning and Support program began in April 2017 to support 10 young people with complex needs to transition out of residential care.

We look forward to the introduction of an intensive support service in 2017 for young people with complex trauma who are in or about to enter residential care. This should help to address our concerns about the capacity of staff in residential care units to meet the complex and challenging needs of many children in care. We remain concerned that there is no specialist independent body to which children and young people in residential care can make complaints. We also remain concerned that there has been limited response to our recommendation to improve placement matching.

Completed individual inquiries 2016–17

Inquiry concerning services provided to a young person in youth justice

This inquiry followed an incident where restraint by a staff member resulted in serious injuries to a child, and was extended when the same child suffered another serious injury in similar circumstances, at the same facility.

The inquiry revealed that in both cases the physical restraints imposed were inconsistent with good practice. Staff did not attempt to de-escalate the situation before resorting to restraint and, in one case, used physical restraint when there was no physical threat by the child. The inquiry highlighted the importance of staff understanding how to respond to challenging behaviours, and children and young people with medical conditions. Another problem that we identified was a lack of communication between staff when a child is transferred between units.

The inquiry highlighted the need for children and young people in youth justice to have facilities where they can recover from health and medical problems, and the importance of a thorough process for reviewing incidents where young people have been restrained by staff.

The inquiry made nine recommendations, including:

- improvements to staff training to modify staff responses to challenging behaviour by children and young people
- improvements in communication processes and the transfer of information about children and young people between units and among unit staff

- that policies be developed to guide unit staff on how to respond and restrain children and young people suffering medical conditions or injuries
- that the new youth justice centre include infrastructure to accommodate children and young people returning from hospital and recovering from physical injuries
- improvements to the department's internal 'Restraint review' process.

Inquiry concerning services provided to an Aboriginal child in out-of-home care

We initiated an inquiry into the circumstances that led to a child being de-identified as Aboriginal on the DHHS Client Relationships Information System (CRIS) database. During the course of this inquiry, Child Protection developed policies and procedures on de-identifying children as Aboriginal. The new policy requires endorsement from the Commissioner for Aboriginal Children and Young People before a child can be de-identified.

Inquiries underway

In 2016–17 we initiated some inquiries that are still in progress. These include inquiries into services provided to:

- a group of vulnerable children in Grevillea Youth Justice Centre, prior to, during and following an incident on 13 February 2017
- children known to Child Protection who have died from suicide
- children known to Child Protection who have complex medical needs or disabilities.

Child death inquiries

Under the CCYP Act 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. We identify service improvements even where the services had no connection to the child's death. This year these inquiries produced 51 recommendations.

Child deaths reported to the Commission 2016–17

We were notified of the deaths of 36 children in 2016–17; four of those children were Aboriginal. The category of death in the following tables is based on information available to the Commission, such as Child Protection files, medical reports, autopsy reports, forensic reports and, when available, coronial findings. This categorisation is indicative; only the Coroner determines the cause of death. For the deaths that we have categorised this financial year the majority appear to have resulted from illness or accident (Tables 2 and 3).

Table 2. Child death notifications received by the Commission in 2016–17, by Aboriginal status and category of death

Category of death ¹	Aboriginal	Non-Aboriginal	Total	Per cent
Illness	1	12	13	36.1
Accident		6	6	16.4
Suicide/self-harm		3	4	11.1
Pending determination ²	1	3	3	8.3
Sudden unexpected death in infancy (SUDI)		3	3	8.3
Drug/substance related		3	3	8.3
Non-accidental	2	1	3	8.3
Unascertained ³		1	1	2.8
Total	4	32	36	100
Per cent	11.1	88.9		

1. The category of death is based on information available to the Commission in the child's Child Protection client files, medical examination reports and coronial findings (when available). Cause is determined by the Coroner's Court Victoria.

2. 'Pending determination' refers to deaths where the cause of death is not yet clear. This includes cases for which there is an ongoing coronial investigation.

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

Table 3. Child death notifications to the Commission in 2016–17, by Aboriginal status and age

Child's age at death	Aboriginal	Non-Aboriginal	Total	Per cent
0–5 months	1	12	13	36.1
6–11 months	1	1	2	5.5
1–3 years	0	5	5	13.9
4–12 years	0	5	5	13.8
13–17 years	2	9	11	30.6
Total	4	32	36	100
Per cent	11.1	88.9		

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

Consistent with previous years, most children who died after being involved with Child Protection were infants aged 0–5 months (36 per cent) or adolescents aged 13–17 years (31 per cent) (Tables 4 and 5).

Table 4. Child death notifications received by the Commission 2012–17, by category of death

Category of death ⁴	2012–13	2013–14	2014–15	2015–16	2016–17	Total
Illness	12	12	15	13	13	65
Accident	6	3	3	7	6	25
Suicide/self-harm	1	4	4	5	4	18
Non-accidental trauma	2	5	1	6	3	17
Unascertained ⁵	3	7	0	2	1	13
Sudden unexpected death in infancy (SUDI)	1	2	0	4	3	10
Drug/substance related	1	3	0	0	3	7
Pending determination ⁶	0	1	1	1	3	6
Total	26	37	24	38	36	161

4. The category of death is indicative only; it is based on information available to the Commission in the child's Child Protection client files, medical examination reports and coronial findings (when available). Cause of death is determined by the Coroner's Court Victoria.

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

6. 'Pending determination' refers to deaths where the cause of death is not yet clear. This includes cases for which there is an ongoing coronial investigation.

Table 5. Child death notifications received by the Commission between 2012–17, by Aboriginal status

Status	2012–13	2013–14	2014–15	2015–16	2016–17	Total	Per cent
Aboriginal	3	2	4	4	4	17	10.6
Non-Aboriginal	23	35	20	34	32	144	89.4
Total	26	37	24	38	36	161	100

Child death inquiries completed

We finalised 34 child death inquiries in 2016–17 (Tables 6 and 7). The issues we identified in these child death inquiries prompted us to make 51 recommendations this year. These inquiries related to children who died between 2015 and 2016.

Six inquiries related to Aboriginal children and 28 inquiries related to non-Aboriginal children. Three-quarters of the children in our finalised inquiries were living at home, and illness accounted for more than one-third of child deaths reviewed (38 per cent).

Seventy per cent of children in our finalised inquiries had been subject to between one and three reports to Child Protection, with two children being subject to 10 or more reports. For Aboriginal children, the average number of reports to Child Protection was two.

Thirteen (38 per cent) of our inquiries related to children whose cases had been closed by Child Protection.

Five of the six Aboriginal children were younger than one year old when they died.

Table 6. Child death inquiries completed by the Commission in 2016–17, by age, category of death and Aboriginal status

Category of death ⁷	Aboriginal	Non-Aboriginal	Total
<i>Illness</i>	3	10	13
0–5 months	3	4	7
1–3 years		1	1
4–12 years		2	2
13–17 years		3	3
<i>Accidental</i>		6	6
6–11 months		1	1
1–3 years		2	2
4–12 years		1	1
13–17 years		2	2
<i>Non-accidental</i>	2	3	5
0–5 months		1	1
6–11 months	2		2
1–3 years		1	1
13–17 years		1	1
<i>Suicide/self-harm</i>	1	2	3
13–17 years	1	2	3
<i>Sudden unexpected death in infancy (SUDI)</i>		3	3
0–5 months		2	2
6–11 months		1	1
<i>Unascertained</i> ⁸		2	2
6–11 months		1	1
13–17 years		1	1
<i>Drug/substance related</i>		1	1
13–17 years		1	1
<i>Pending determination</i> ⁹		1	1
0–5 months		1	1
Total	6	28	34

7. The category of death is indicative only; it is based on information available to the Commission in the child's Child Protection client files, medical examination reports and coronial findings (when available). Cause of death is determined by the Coroner's Court Victoria.

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

9. 'Pending determination' refers to deaths where the cause of death is not yet clear. This includes cases for which there is an ongoing coronial investigation.

Table 7. Child death inquiries completed by the Commission in 2016–17, by living arrangements at death

Child's living arrangements at time of death	Aboriginal	Non-Aboriginal	Total
With a parent	4	21	25
Did not leave hospital	2	2	4
Kinship care	0	1	1
Unknown	0	1	1
Hospital	1	0	1
Residential care	0	2	2
Total	7	27	34

Practice themes

In the child death inquiries we conducted in 2016–17 we identified a number of recurring issues that prompted recommendations for improvements to services. These included:

- identification of risks to children before they are born
- information gathering, information sharing and collaboration between services
- responses to children who experience family violence
- culturally-appropriate responses to Aboriginal children
- planning supports for infants who are at high risk of harm.

Unborn child reports

The CYF Act allows Child Protection to receive unborn child reports. These reports allow people to make a report to Child Protection when they have a significant concern about the wellbeing of a child before birth. The purpose of these reports is to prevent harm to the child and provide support to the parents of a child at risk.¹⁰ This financial year, eight of the 34 finalised child death inquiries (26 per cent) involved children who were the subject of unborn child reports.

In some of our inquiries we found that reports were not made despite evidence of risks to an unborn child. We also found that there were often gaps in practice in cases where an unborn child report had been made. In particular, practitioners failed to convene case conferences, which meant professionals missed the opportunity to engage with families and collaborate for an earlier, coordinated response prior to the birth of the child.

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

CASE STUDY

Tom

Tom died at six weeks of age. His mother had been involved with Child Protection, as a victim of emotional abuse. The hospital was concerned about his mother not attending ante-natal appointments and about Tom's parents' living arrangements, health and drug use. However, it did not make an unborn child report and Child Protection was not involved until after Tom was born.

We found that the absence of an unborn child report meant that services did not have an opportunity to plan the appropriate support for Tom and his family.

We recommended that DHHS work with the hospital to ensure that workers understood the importance of unborn child reports. We also recommended that Child Protection strengthen its monitoring of high-risk infants.

In many cases we also found that, following the child's birth, services had not prepared clear intervention plans, which left vulnerable infants without adequate support and, in one case, without appropriate housing.

We have recommended practice guidelines be strengthened so that services involved with the parents consistently make unborn child reports. We have also continued to make recommendations aimed at ensuring that case conferences with relevant professionals are consistently held following receipt of an unborn child report.

The department has considered our concerns and is reviewing its practice for unborn child reports.

Information gathering, information sharing, and service collaboration

Victoria's Child Protection Manual has extensive guidance on what workers need to do to ensure services have all the information they need to form an accurate picture of a child's needs. This includes meeting to share information and plan any interventions needed.

When services do not share information, they do not have all the necessary background to make a robust assessment that considers all the risks to a child. In addition, when services do not meet and plan interventions, their responses can be uncoordinated and less effective. In 21 out of the 34 child death inquiries we finalised, we found that information was not shared or services did not collaborate.

A strong theme in these cases was that services are often unsure about whether, and if so when, they are permitted to share information to protect the safety and wellbeing of a child or young person.

This year we have called for the progression of legislative reforms and training that will promote appropriate information sharing between health services, human services, schools, and other service providers for the purpose of ensuring the health and wellbeing of vulnerable children and young people.

Our advocacy has also influenced the *Healthcare that Counts* framework, which should ensure that health services, including mental health services, are clear about when and how information can be shared to protect and support vulnerable children and young people.

CASE STUDY

Maddie

Child protection received two reports when Maddie was aged 15. Both related to a conflict between Maddie and her parents, and both were assessed as wellbeing reports, meaning that they were not investigated.

Maddie had an extensive involvement with services for mental illness and addiction. She made multiple suicide attempts after she began abusing substances at 14. After taking a combination of substances, she presented to the emergency department expressing suicidal ideation.

Mental health services did not share this information with other services. In particular, Maddie's school knew nothing of her circumstances because she would not consent to share this information. Although the law allows information to be shared when there is a serious and imminent threat to a child's life, health, safety or welfare, services told us they were unsure if privacy legislation permitted them to share information about Maddie, because consent had been refused.¹²

CASE STUDY

Olivia

Olivia was 15 years old when she died in an accident. Although she appeared to be popular and happy, she did not attend school regularly.

The school was not aware that Olivia had been reported to Child Protection 13 times since her birth — eight of these reports were made when she was 12. Although many of these reports raised concerns about family violence, seven were closed without a full investigation.

This meant that Olivia's experience of family violence was never well understood, nor was she adequately supported. Each report about Olivia should have been reviewed in light of new information.

Family violence

Child death inquiries continued to present the same problems we identified in our inquiry report *Neither seen nor heard*.

In the 34 cases reviewed in 2016–17, at least 21 of the children had experienced family violence.¹¹ However, there was little evidence of services engaging with them about their experiences. Child Protection sometimes closed cases without direct contact with the child or young person, at times despite repeated reports of family violence. In six child death inquiries

involving family violence, the child had limited or no direct contact with services. We have urged DHHS to implement the recommendations of *Neither seen nor heard* and the Royal Commission into Family Violence, particularly given that we continue to find intervention has not focused on the needs of children and young people, and they were not provided with meaningful support to address the impact of family violence on their development.

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

12. On 13 June 2017, the Family Violence Protection (Information Sharing) Act 2017 was passed. Among other things, that act amended the Privacy and Data Protection Act 2014 so that it is no longer necessary for a threat to life, health, safety or welfare to be imminent. These changes will take effect on 1 July 2018.

CASE STUDY

Elliot

Elliot, an Aboriginal infant, passed away from illness after several stays in hospital. Child Protection became involved with Elliot after an episode of family violence between his parents and because of concerns for their mental health.

Our inquiry found that the hospital had not originally identified Elliot and his parents as Aboriginal. This delayed Elliot and his family being connected with Aboriginal services, which could have supported Elliot and his mother in a culturally-appropriate way. We also found that when Elliot was ready for discharge, Child Protection did not properly assess the risks to him, including the risk of family violence that he and his mother were facing.

Some of the issues we identified in Elliot's case are being addressed through the implementation of recommendations made by the Royal Commission into Family Violence, which we monitor closely. In addition, since Elliot's death, and in response to a similar case, DHHS has developed a practice advice about identifying Aboriginal children and families, which outlines why collecting this information can support them and how it can ensure appropriate services are engaged at the right time.

Experience of Aboriginal children

Across the six child death inquiries relating to Aboriginal children and young people we conducted this year, we found that an ongoing issue was a lack of understanding of Aboriginal inter-generational trauma and its impact on children and their families. Services must better understand the importance of culture and identity in an Aboriginal child's life. We uncovered missed opportunities to respond to complex issues in a culturally-appropriate way. For example, consultation with the ACSASS did not consistently occur. Sometimes this was due to the service not being proactive, other times it was a lack of staff or lack of follow-up by Child Protection. In addition, services rarely came together, which limited opportunities for collaboration, information sharing and the development of cultural plans.

High-risk infants

Victoria's Child Protection Manual provides guidance to workers about the steps to take to ensure the safety of children under two years who are deemed to be at particular risk of harm. It lists indicators of risk factors, appropriate responses and information that should be gathered.

Our child death inquiries found Child Protection staff did not follow guidelines about infants with a high-risk status. In particular, contrary to practice guidelines, Child Protection practitioners failed to hold case conferences with other services and so did not have vital information necessary to assess risks and respond to the needs of high-risk 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.

Our recommendations about high-risk infants have contributed to practice improvements. Training and education materials have been improved, and measures have been put in place to enhance the supervision provided to Child Protection practitioners working with high-risk infants. Recommendations in our child death inquiries are also being considered as part of a review of maternal and child health service practice guidelines.

CASE STUDY

Aisha

Aisha was a vulnerable infant, born with complex medical needs, who lived for only 30 days. She was the subject of an unborn child report due to concerns about her mother's ability to care for her. Child protection supported Aisha's mother during the pregnancy and made referrals to support development of her parenting skills.

Hospital files showed that after Aisha was born, Child Protection was not invited to hospital and family meetings. This meant Child Protection workers were not fully aware of Aisha's complex needs, and weren't able to comprehensively assess the risks to Aisha or her mother's capacity to care for her.

This case highlights that, even where legislation specifically permits information to be shared with Child Protection, practice and culture can stop information being shared.

CASE STUDY

Kurt

Kurt was a vulnerable infant who was born into a complex family with a significant history of involvement with Child Protection. An unborn child report was made about Kurt, which raised concerns about whether his parents could safely care for him and referred to past allegations of parental substance abuse and family violence. Child Protection assessed Kurt to be at high risk and referred his family to support services in the community.

We found no evidence that services engaged with Kurt or his family either before or after he was born. The absence of a case conference and/or hospital discharge planning meeting after Kurt was born meant services that could have helped his family did not have a full understanding of the family's issues or the risks he faced. Services that received referrals were unable to engage with Kurt's parents, who would not allow them to come into their home. Despite the concerns raised about Kurt's parents, his sleep and home environment were not monitored after discharge from hospital.

We found that more robust information sharing would have enabled a range of services to plan and act to increase the parents' capacity to care for their baby, their awareness of these issues and their preparedness to engage with services.

Monitoring through on-site visits

We also performed our monitoring and oversight function through on-site visits to youth justice, and secure and community residential care.

Children and young people in these settings are often among the most vulnerable in our society.

Our visits to Grevillea Youth Justice Centre (Barwon Prison)

On 17 November 2016, following a riot at Parkville Youth Justice Precinct, the state government established the Grevillea Youth Justice Precinct within Barwon Prison.

Commission staff, independent volunteer visitors, and the Commissioners visited children and young people at Grevillea once or twice per week until it was de-commissioned in May 2017. During these inspections, we spoke to young people about conditions in the unit and services provided to them. Their concerns were then raised with local managers and significant matters were brought to the attention of the Minister for Families and Children. Much of our correspondence with the Minister about these issues and the government's response were documented in a Victorian Ombudsman report published in February 2017.¹³

Some problems that were resolved as a result of our advocacy for the children and young people in Grevillea included:

- regular access to fresh air and the unit's exercise yard
- adequate bedding and clothing
- improving children and young people's access to fans in their cells in extremely hot temperatures

- substantially reducing the amount of time children and young people spent locked in their cells, in effective seclusion (often for 23 hours per day).

Grevillea was decommissioned as a youth justice facility, and all children and young people were transferred to other facilities in May 2017.

Independent Visitor Program to youth justice

Our Independent Visitor Program (IVP) conducts regular visits to Victoria's youth justice centres. The IVP was introduced into Victoria's youth justice centres five years ago. During this financial year, it continued to visit the Parkville and Malmsbury Youth Justice Precincts and was extended to the Grevillea Youth Justice Precinct while it operated.

The IVP involves regular visits by independent volunteer visitors who go to centres, observe conditions and talk to children and staff about services and issues. They 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. Examples of the issues raised and our follow-up work are set out below.

Reports by independent visitors also inform our systemic work. For example, we established our systemic inquiry, *The same four walls*, which examined the use of isolation, seclusion and lockdowns in Victoria's youth justice centres, partly due to reports provided by independent visitors. (See page 12 for information on our inquiries and recommendations.) The Commission is very grateful for the important

13. Victorian Ombudsman, Report on youth justice facilities at the Grevillea Unit of Barwon Prison, Malmsbury and Parkville. February 2017.

work done by independent visitors. Their commitment to children and young people in youth justice centres is outstanding, as are the invaluable insights they provide us.

Issues raised

This year, children and young people raised 952 issues across the three locations. This included 439 issues at Malmsbury, 389 issues at Parkville and 124 issues at GreVILLE. The nature of the issues raised varied, with children and young people reporting concerns about their physical environment, and the health and education services they receive.

Children and young people at Parkville raised 61 issues about health services to independent visitors this year. We received complaints about long waiting times to see a health professional (many related to dental treatment) and requests to have medication reviewed. We provide reports of the matters raised by young people to Youth Health and Rehabilitation Service (YHaRS), to ensure that it provides the best possible health service to children and young people.¹⁴

There were 69 concerns raised about programs and education at Malmsbury, and we are particularly concerned about the limited access to programs and education at the centre. We have raised our concerns with Youth Justice, who have committed to increasing access to educational programs.

Issues related to environment were broad ranging, and concerned infrastructure, furniture, maintenance, cleanliness, and placement in units. There were 61 issues raised about environment at Parkville and 52 at Malmsbury.

Some of the observations and reports that caused concern included a lack of chairs and tables for children and young people to eat meals, poor cleanliness and damage to physical infrastructure. We have raised these concerns with Youth Justice.

CASE STUDIES

Use of handcuffs at Parkville

During a visit to Parkville in early 2017, independent visitors saw children and young people being moved across the precinct in handcuffs, with one bleeding from the wrist as a result.

We raised this issue with the General Manager, who reviewed how rules about the use of handcuffs were being applied. This reinforced the policy that staff must conduct an individual risk assessment before using handcuffs when moving young people within a precinct.

Poor access to showers at Parkville

Independent visitors talked to a boy who had not showered since he had arrived at Parkville five days earlier.

We reported this to the General Manager and the boy was immediately given the chance to shower. The matter was addressed with staff to ensure proper access to showers for everyone.

¹⁴ We note that since April 2017, YHaRS has been overseen by Justice Health, within DJR.



Secure welfare and residential care services

During 2016–17 we concluded pilot visitor programs to secure welfare services and residential care services. Both pilots aimed to monitor these services and give children and young people an avenue to raise issues.

During the pilots, we commissioned an independent review to find out their effectiveness. The review found that the programs were valuable and had led to

changes to specific issues children and young people raised. At the same time, the review made recommendations to improve the focus of our objectives, particularly when it came to hearing from children and young people, and monitoring the services effectively.

As a result, we will be developing a new statewide monitoring strategy that builds on our youth justice IVP, and extends the strategy to residential care, secure welfare services, kinship care and foster care.

Oversight of serious incidents

We also monitor the safety and wellbeing of vulnerable children and young people by receiving information about serious incidents in Victoria's youth justice and child protection systems.

The information we receive comes in the form of 'client incident reports'. In March 2016, we began monitoring incident reports related to children and young people in youth justice. This became possible following amendments to the CCYP Act in March 2016.¹⁵ This amendment has greatly increased our capacity to independently monitor these services.

How we monitor serious incidents

We receive and read all 'Category One' client incident reports that are generated by staff in the out-of-home care and youth justice systems.

We compile and analyse data about the incident reports we receive, which helps inform the focus of our policy and advocacy work, and our systemic inquiries. We may also follow-up on behalf of an individual child or young person in certain circumstances. When deciding whether we will follow-up we consider a wide variety of factors, such as:

- whether the incident report discloses information about a systemic failing
- whether the incident report relates to a particularly vulnerable child or young person
- the adequacy of the service provider's response and the seriousness or significance of any remaining risks to the child or young person.

Our follow-up may involve requesting further information or documents or asking for a briefing from DHHS or DJR about what action has been taken in response to the incident.

CASE STUDY

Sexual exploitation

In late 2016, we noted a high frequency of 'behaviour – sexual exploitation' incidents involving two young people, reported from the same residential care unit. We asked the relevant DHHS office to advise us about the support they were providing to each young person, particularly to avoid their ongoing involvement in these incidents. DHHS provided us with an overview of the risks to the young people, the support services and agencies involved (which included Victoria Police) and the strategies they put in place to reduce each young person's risk of sexual exploitation. DHHS also reviewed the co-placements of the young people.

After our follow-up and DHHS actions, we received information that both young people had been involved in significantly fewer Category One incidents.

15. Commission for Children and Young People Act 2012, s.60A. This amendment came into effect on 16 March 2016 and requires the Secretary of DHHS to, 'disclose to the Commission any information about an adverse event relating to a child in out-of-home care or a person detained in a youth justice centre or a youth residential centre if the information is relevant to the Commission's functions'.

CASE STUDIES

Conditions in residential care home

We received an incident report of a residential care home in very poor condition with faeces on the floor, in the kitchen and on the table. We raised our concerns with the DHHS division, asking that the issue be addressed and for assurance that the risk of the issue arising again was being managed. Local Child Protection staff visits were increased and the site was cleaned up including repainting the entire house and replacing the kitchen flooring. This was confirmed by photographic evidence and a follow-up inspection by the Child Protection area manager.

Sexual assault allegation

We received an incident report about an allegation of the sexual assault of a young person by another young person in a residential care unit. We raised the incident with DHHS, and asked for information about their response to the victim, including what support was provided and what they were doing to make sure their placement was appropriate.

DHHS reported the assault to Victoria Police and offered the alleged victim therapeutic support. The unit was double-staffed with an active member every evening while an alternative placement was being explored. The alleged perpetrator was moved three days after the alleged incident.

We have also taken a number of steps to maximise our ability to monitor the child protection and youth justice systems through incident reports. Most notably, we entered into Memorandum of Understanding with DHHS to give effect to the 2016 legislative amendment. When responsibility for youth justice transferred from DHHS to DJR on 3 April 2017, responsibility for providing these incident reports transferred to the Secretary of DJR. We will work with DJR to develop a Memorandum of Understanding to ensure we receive information about all serious incidents in youth justice facilities.

We have also contributed to the development of a new DHHS client incident management system, which will begin in 2017–18. Our feedback sought to improve our visibility of a broader range of serious incidents. We will continue to work closely with the department to ensure we are notified about serious and significant incidents that affect children and young people in out-of-home care, and secure welfare services.

Incident reports in out-of-home care

We receive Category One incident reports for children in foster care, kinship care, residential care, lead-tenant settings and secure welfare services. This year, DHHS provided us 2,623 Category One incident reports, representing a 7.5 per cent decrease compared to the previous financial year (2,833 incident reports) (Table 8). Some of the reports we receive may relate to alleged incidents that occurred in previous financial years.

Table 8. Category One client incident reports for children in out-of-home care between 2015–17, by type of incident reported¹⁶

Incident type ¹⁷	2015–16	2016–17	Per cent change
Behaviour – sexual exploitation	412	394	↓ 4
Physical assault	337	352	↑ 4
Behaviour – dangerous	345	314	↓ 9
Absent/missing person	286	299	↑ 5
Sexual assault – indecent	200	222	↑ 11
Behaviour – sexual	269	202	↓ 25
Sexual assault – rape	138	132	↓ 4
Poor quality of care	134	127	↓ 5
Illness	176	122	↓ 31
Suicide attempted	69	83	↑ 20
Self harm	76	77	↑ 1
Medical condition (known) – deterioration	43	64	↑ 49
Breach of privacy/confidentiality matters	71	62	↓ 13
Injury	96	60	↓ 38
Drug/alcohol	40	40	– 0
Community concern	93	38	↓ 59
Property damage/disruption	14	10	↓ 29
Possession	1	8	↑ 700
Behaviour – disruptive	8	5	↑ 38
Death – other	5	5	– 0
Medication Error	2	4	↑ 100
Death – client	15	1	↓ 93
Escape from centre	3	1	↓ 67
Escape from temporary leave	0	1	↑ 1
Total	2833	2623	↓ 7

16. In the 2015–2016 Annual Report, categories of incidents that recorded less than five incidents were aggregated into similar incident categories (Escape from Centre was included in Absent/Missing, Possession was included in Drug/Alcohol, Medication Errors were included into Medical condition (known – deterioration)).

17. For a full explanation of each category, see Department of Human Services, Incident type categorisation table 2011, last updated December 2012, online: <http://www.dhs.vic.gov.au/_data/assets/pdf_file/0009/684711/critical-client-categorisation-table-12-2012.pdf>, accessed 29 August 2017.

Type of incidents reported

This year, the most reported incident in out-of-home care was 'behaviour – sexual exploitation', representing 15 per cent of all incidents reported (394 incident reports).

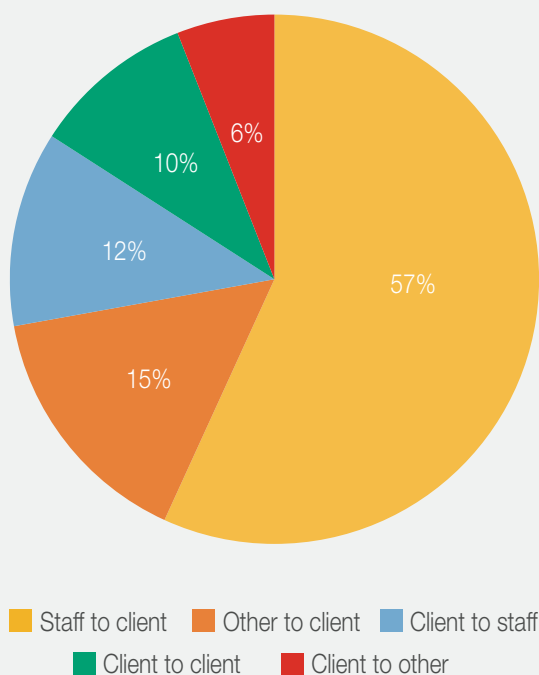
This was followed by 'behaviour dangerous' (12 per cent, 314 incidents). Behaviour by a child or young person that puts themselves or others at risk of harm is considered 'dangerous'.¹⁸

These figures show that there has been a small decrease in the number of incidents involving sexual exploitation or dangerous behaviour. However, the proportion of both incident types out of the total reports from out-of-home care remains the same compared to 2015–16.¹⁹

We remain concerned about these figures, in particular the high proportion of reports of sexual exploitation in residential care. We continue to monitor the government's implementation of recommendations we made in our 2015 report ... *as a good parent would* ... to address this issue. This is discussed in more detail on page 18.

In 2016–17, 352 incidents related to alleged physical assaults, comprising just over 13 per cent of all incidents. As Figure 1 shows, more than half (200 in total) related to reports of alleged staff assaults on children and young people.²⁰

Figure 1. Alleged physical assault incidents in out-of-home care reported to the Commission in 2016–17



18. See Department of Human Services, *Incident type categorisation table 2011*, last updated December 2012, online: <http://www.dhs.vic.gov.au/_data/assets/pdf_file/0009/684711/critical-client-categorisation-table-12-2012.pdf>, accessed 29 August 2017.

19. In 2015–2016, the most reported Category One incident in out-of-home care was behaviour – sexual exploitation (412, 15 per cent), followed by 'behaviour – dangerous' (345 incidents, 12 per cent).

20. 'Staff' can also include home-based carers.

In addition, 222 reports related to ‘sexual assault – indecent’. Reports in this category comprised 7 per cent of all incident reports. More than two-thirds (143 of 222) of ‘sexual assault – indecent’ incident reports were about alleged sexual assaults by people outside of the out-of-home care setting against children (Figure 2).

Four per cent (132) of all incident reports related to alleged rape, of which three-quarters (104) were recorded as being from people outside of the out-of-home care setting against children and young people (Figure 3). These are deeply troubling figures and we will monitor actions taken to reduce them.

These figures should be considered in the context of increasing numbers of children and young people in out-of-home care. Meanwhile, the number of children in residential care, which typically reports the highest number of Category One incidents, has reduced.

Figure 2. Alleged sexual assault incidents in out-of-home care reported to the Commission in 2016–17

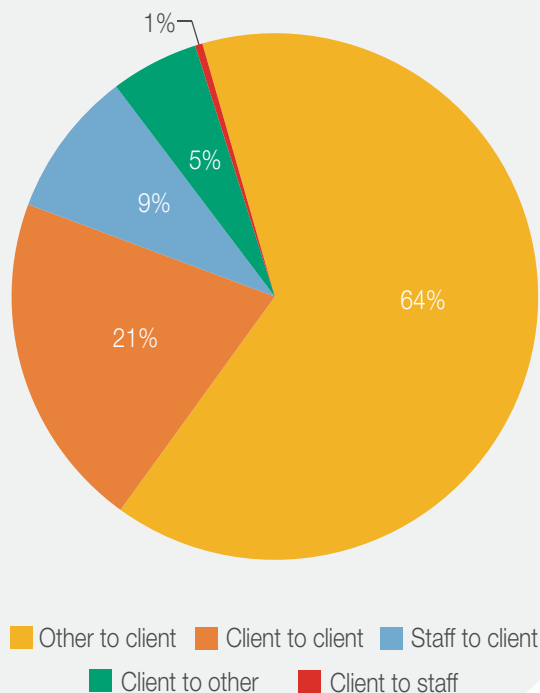
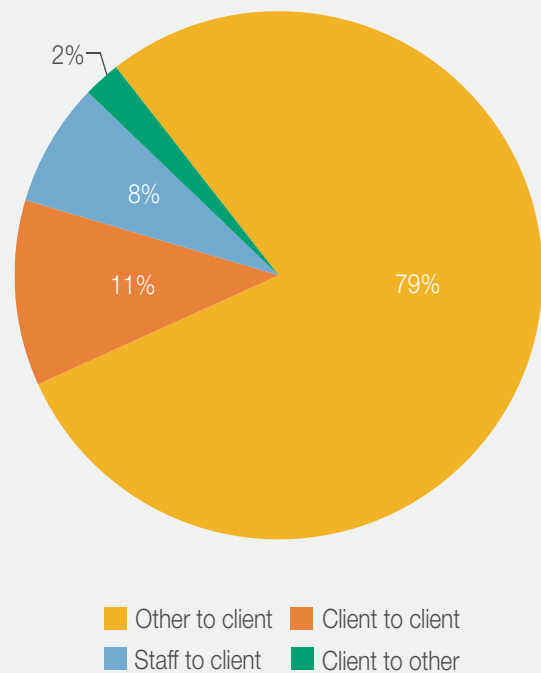


Figure 3. Alleged rape incidents in out-of-home care reported to the Commission in 2016–17



Incident reports by placement type

Although almost 5 per cent of children in out-of-home care were in residential care, more than 70 per cent of the Category One incident reports related to children in residential care. This is an increase compared to 2015–16, when 62 per cent of all Category One incident reports were about children in residential care (Table 9).

We remain concerned about the disproportionately high number of incidents being reported about children and young people in residential care. We are monitoring the work done by DHHS to better support, and reduce the number of, children and young people in residential care placements.

Table 9. Category One client incident reports for children in out-of-home care, by placement type²¹

Placement type	2015–16		2016–17	
	Proportion in OOHC (%)	Proportion of Cat. 1 incidents (%)	Proportion in OOHC (%)	Proportion of Cat. 1 incidents (%)
Kinship care	60	12	61	8
Home-based care	17	20	17	21
Permanent care ²²	17	–	17	–
Residential care	5	62	5	70
Other	1	5	<1	1

Incident reports from youth justice custody in 2016–17

During the 2016–17 financial year, we received 115 Category One youth justice reports (Table 10).²³ Seventy-three were assault related, of which 33 related to allegations of assault against children and young people by youth justice staff. We are concerned about the number of allegations of assault by staff and will continue to monitor this.

A further 13 reports (18 per cent) related to alleged sexual assault between children and

young people and 10 involved alleged physical assaults between children and young people (14 per cent).

This year we followed up 37 incidents from Youth Justice. More than half (53 per cent) of our queries involved requesting CCTV footage or copies of internal reviews. We also asked questions about children and young people's access to lawyers, therapeutic support, or offence-specific programs.

21. Population figures were calculated by averaging the 'end of month' figures provided by DHHS for each month in 2016–17.

22. We do not receive Category One incident reports for children and young people subject to a permanent care order because they are not DHHS clients.

23. DHHS advises that incident reporting data undergoes routine validation and as such is subject to minor changes over time. Total numbers contained in this report may not be directly comparable to subsequently released incident reporting information, <https://www.dhhs.vic.gov.au/publications/quarterly-incident-data>, accessed 21 June 2017.

Table 10. Number of youth justice Category One incidents reported to the Commission in 2016–17

Incident category	Total
<i>Assault</i>	73
Physical assault – client to client	10
Physical assault – client to staff	7
Physical assault – other to client	3
Physical assault – staff to client	33
Sexual assault – indecent – client to client	13
Sexual assault – indecent – client to staff	1
Sexual assault – indecent – other to client	5
<i>Behaviour</i>	20
Behaviour – dangerous	7
Behaviour – disruptive	1
Behaviour – sexual	12
<i>Other incident types</i>	23
Breach of privacy/confidentiality matters	1
Escape from centre	3
Illness	2
Injury	4
Medical condition (known) – deterioration	1
Medication error – other	2
Poor quality of care	1
Possession	1
Property damage/disruption	6
Self-harm	1
Suicide attempted	1
Total	115



Approaches from the public

We are not a formal complaints body, and do not have legislated complaint-handling functions. However, we often receive calls or emails from members of the community raising concerns about the welfare and safety of children and young people, or the actions of a government department or other agencies.

Depending on the nature of the call, we can provide the caller with alternate avenues to raise their concerns, or we can raise the issue with the relevant department or agency on the caller's behalf.²⁴

This financial year, we received 626 contacts from parents, carers, professionals, children and young people who approached us for information, advice or support. This number is slightly lower than last year, when we received 652 formal contacts. A sample review of the approaches we received showed that almost 25 per cent of people contacted us with concerns about the case management of children in out-of-home care. We referred the majority of callers to an appropriate area that could address the complaint, such as DHHS.

24. Raising issues on behalf of callers only occurs rarely, with the caller's permission, and when the issues raised are either considered significant and serious or the caller has exhausted all internal complaints mechanisms or the caller is considered particularly vulnerable.

Influencing policy, programs and services

Overview

An important part of our role is to advocate to improve policies, programs and services for children and young people.

Our advice and advocacy is based on input from children and young people combined with the specialist knowledge we gain through our oversight activities. This gives us unique access to information about the experiences of children and young people, particularly those in the child protection, out-of-home care and youth justice systems, to inform decision makers and drive change.

Our advocacy takes various forms. We provide advice directly to government as well as making public submissions on specific policies or laws. The Commissioners and Commission staff participate in ministerial and other government advisory and oversight groups across a range of policy areas central to children's lives.

We also raise awareness of issues affecting 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 40 speeches and the Commissioner for Aboriginal Children and Young People shared his knowledge at 20 events. In addition to authoring comment pieces and giving interviews, the Commissioners' advocacy for children featured in more than 200 mentions in the media this year.

While our policy and systemic advocacy for children and young people covered a range of topics in 2016–17, much centred on two key areas:

- promoting the rights of children and young people in Victoria's youth justice system and ensuring that it retains and strengthens its focus on rehabilitation
- ensuring that reforms to address family violence in Victoria deliver genuine change for children and young people affected by family violence.

Youth justice

Youth justice became a significant focus of our advocacy efforts this year. Community and media concern about trends in youth offending and disturbances in youth justice centres increased. Commentators called for more punitive responses and to erode a specialist approach for children who offend.

Through the media and a range of speaking engagements, the Commissioners argued for all commentators to have regard to the evidence, which shows that a very small number of children and young people offend and the overall number of young offenders is falling. They also called for evidence-based, age-appropriate responses to children and young people who offend, and more opportunities to divert children and young people from the criminal justice system. They urged against counterproductive but politically popular responses.

Drawing on our monitoring activity and the findings of our systemic inquiry report, *The same four walls*, the Commissioners also advocated for a broader understanding of recent disturbances in youth justice centres. They pointed to serious concerns about excessive use of isolation, separation and lockdowns, and deficiencies in infrastructure, staffing levels, staff training and incident response capacity.

Parliamentary inquiry into youth justice centres

Both Commissioners gave evidence to Victoria's Parliamentary Inquiry into Youth Justice Centres in Victoria.

The Principal Commissioner gave evidence about our oversight and monitoring of youth justice centres, highlighting concerns about the treatment of children and young people resulting from long-term staff shortages, poor training, and the lack of a clear and consistent approach to working with children and young people in custody.

The Commissioner for Aboriginal Children and Young People gave evidence that focused on the importance of early intervention, prevention and diversion for Aboriginal children and young people at risk of becoming involved in the criminal justice system, and the value of community-based and community-led interventions.

Submissions on youth justice

We made three public submissions on youth justice issues and two confidential submissions on proposed reforms to Victoria's youth justice laws.

We provided a submission on the draft terms of reference for the Australian Law Reform Commission's (ALRC) Inquiry into the Incarceration Rate of Indigenous Australians, recommending that the terms expressly consider the following as factors that affect incarceration rates of children and young people:

- the impact of existing laws, such as the minimum age of criminal responsibility
- the impact of family violence
- institutional racism and systemic bias.

We recommended that in conducting the inquiry, the ALRC be required to engage directly with Aboriginal and Torres Strait Islander people and organisations, including children and young people.

We also submitted to the National Children's Commissioner's *Review of the Optional Protocol to the Convention Against Torture (OPCAT) in the Context of Youth Justice Detention Centres*. This review examined how the special needs of children and young people in detention should be considered and monitored under OPCAT. Drawing on our extensive experience monitoring Victoria's youth justice detention centres, we highlighted the importance of inspections and monitoring being performed by a body that has specialist expertise regarding the needs and rights of children, including Aboriginal children, in detention. We welcomed the Federal Government's announcement in February 2017 that it will ratify OPCAT, which should strengthen independent monitoring of youth justice centres.

We provided a submission to the federal Joint Standing Committee on Migration: Inquiry into Migration Settlement Outcomes, which was tasked with giving ‘particular consideration to social engagement of youth migrants including involvement of youth migrants in anti-social behaviour such as gang activity, and the adequacy of the *Migration Act 1958* (Migration Act) character test provisions as a means to address issues arising from this behaviour’. We submitted that changing the Migration Act would not be effective in reducing anti-social activity by young people from refugee and migrant backgrounds. Instead, governments should invest in programs and services to reduce offending and improve the social engagement of young people.

Highlighting the needs and experiences of children who experience family violence

The recommendations of the Royal Commission into Family Violence featured prominently in this year’s policy and legislative reform agenda in Victoria, and were a considerable focus of our advocacy work.

As members of the Victorian Government’s Social Services Taskforce and Family Violence Steering Committee, the Commissioners worked to ensure children’s issues were addressed across all aspects of the family violence reform process. They also participated in other forums such as the Chief Magistrate’s Family Violence Taskforce and the Indigenous Family Violence Partnership Forum.

The Commissioners also used their contribution to numerous public forums to advocate for the needs of child survivors of family violence, reaching a broad range of legal, government, health and community sector audiences.

We also made confidential submissions on a range of family violence-related reforms.

Influencing the broader policy agenda for children and young people

Media and public appearances

The Commissioners made numerous public appearances on a range of different topics, including child protection and out-of-home care, the delivery of social and family services, and social inclusion and empowerment for young people.

The Commissioner for Aboriginal Children and Young People authored a number of comment pieces highlighting the alarmingly high number of Victorian Aboriginal children in out-of-home care and calling for an urgent policy response. He has also appeared at a range of public forums, including the Royal Commission into the Protection and Detention of Children in the Northern Territory, where his evidence focused on the role of a Commissioner for Aboriginal Children and Young People, and the work being done to improve outcomes for Aboriginal children in the child protection and youth justice systems.

The Principal Commissioner gave more than 40 speeches including to the Royal Children's Hospital and Monash Children's Hospital, the ANZATSA (Australian and New Zealand Association for the Treatment of Sexual Abuse) Symposium, and spoke at the launch of the Home Stretch campaign.

Advisory groups and committees

The Commissioners also influenced policy through their involvement in advisory groups and committees that cut across a range of reform areas. Both sit on the Roadmap Implementation Ministerial Advisory Group, where they advise government about implementing system-level changes to Victoria's service system to meet the needs of and improve outcomes for vulnerable children and families.

We proudly participate in the Australian Children's Commissioners and Guardians (ACCG), which comprises national, state and territory commissioners, guardians and advocates for children and young people. The ACCG, which meets bi-annually, aims to promote and protect the safety, wellbeing and rights of Australian children by giving them a voice, and ensuring their best interests are considered in policy and program development.

Our advocacy efforts are also advanced through the Culturally and Linguistically Diverse (CALD) Strategic Partnership Advisory Committee, which is a partnership between the Commission and the Ethnic Communities Council of Victoria (ECCV). It includes decision-makers from key government departments and non-government agencies, who collaborate to identify strategic responses that improve the lives of vulnerable children and families from CALD and refugee backgrounds.

Submissions

We made seven public submissions about issues impacting vulnerable children and young people in 2016–17, and made six confidential submissions to inform legislative reform.

Our submissions covered a range of topics, including education, youth justice, family violence and information sharing.

Education

We made a submission to the Victorian Ombudsman's investigation into expulsions from Victorian government schools. We argued that certain groups of children are disproportionately excluded or disengaged from education, particularly children in residential care and Aboriginal children. We recommended collecting detailed demographic data on students subject to suspension and expulsion, stronger policy and procedures to make expulsion a last resort, and a better appeals process to prevent a disproportionate impact on vulnerable students and their families. The Ombudsman's report, released in August 2017, reflected most of our recommendations.

We contributed to the review of the Education and Training Reform Regulations 2017 to ensure the safety and wellbeing of children who are at greater risk of being marginalised. Our submission supported the idea of principals consulting the school community and council to develop a student behaviour policy, with an expectation that the proposed evaluation framework would address the risk of inconsistency between schools. We recommended integrating work around challenging behaviours, and the use of restraint and seclusion, with other work in youth justice and mental health.



We also proposed stronger registration processes, and ongoing monitoring, assessment and visibility of children who are home schooled.

Adoption

Our submission to the Victorian Law Reform Commission's (VLRC) review of Victoria's *Adoption Act 1984* recommended training and education on applying the 'best interests' principle to decisions about children and young people, and ensuring children and young people are involved in decisions about adoption. We also urged the VLRC's review to consider historical and current adoption issues for Aboriginal and Torres Strait Islander children, and the findings and recommendations of our own inquiries into compliance with the ACPP and Taskforce 1000 when formulating our recommendations.

Royal Commission into Institutional Responses to Child Sexual Abuse

We made two submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse, one on forced marriage and one on criminal justice responses to child sexual abuse. Our submission on forced

marriage provided an overview of the legal and service context of forced marriage in Australia, highlighted trends in forced marriage, and made a range of suggestions about improving funding, services and the government's response.

Our submission on criminal justice highlighted the importance of making sure children are heard in the criminal justice system. We recommended that specialist police responses to child sexual abuse be developed, alongside information-sharing protocols and practices, with attention to information barriers and the experience of vulnerable groups. We also urged the Royal Commission to support a national training approach, and an appropriately-funded research program for justice responses to child sexual abuse.

Supporting and regulating organisations working with children

Overview

We work to create safe, positive environments for children and young people to thrive.

We are proud to be tasked with overseeing the new Child Safe Standards and administering the Reportable Conduct Scheme. Together, these complementary schemes operate to prevent the abuse of children in organisational settings and to support organisations to respond appropriately when allegations of abuse are made.

The Child Safe Standards describe in legislation the minimum that organisations must do to build child-safe systems, policies and culture. The standards have applied to government-funded and regulated organisations since January 2016, and covered a broader range of organisations from January 2017. From that date, we assumed a legislated role in educating organisations about the standards and overseeing organisations' efforts to implement them.

The Reportable Conduct Scheme requires some organisations to report allegations of abuse by staff or volunteers to us so we can support thorough, effective investigations and oversee organisations' responses. The scheme will also allow us to share information where appropriate, including with Victoria Police and the Working with Children Check unit, to better prevent child abuse. During the first half of 2017 we worked hard to make sure we had the right systems, processes and people to operate this exciting and important new scheme.

New regulatory schemes introduced to prevent and respond to child abuse

Betrayal of Trust, the report of the inquiry into the handling of child abuse by religious and other non-government organisations was tabled in the Victorian Parliament in 2013. In response to the report, the Victorian Government has introduced significant legislative changes in 2016–17 including:

1. new powers to oversee and enforce compliance with the Child Safe Standards from 1 January 2017
2. the new Victorian Reportable Conduct Scheme from 1 July 2017.

The schemes require organisations to have a child-safe culture, as well as systems and processes to prevent child abuse and effectively respond to allegations of child abuse by their workers and volunteers. We are responsible for administering the schemes. Our role includes:

- promoting and supporting organisations to implement the standards
- supporting and guiding organisations that receive allegations to conduct fair, effective, timely and appropriate investigations into workers or volunteers who have engaged in child abuse
- independently overseeing, monitoring and, where appropriate, making recommendations to improve investigations of those organisations



- referring substantiated findings of child abuse or misconduct to the Working With Children Check unit to determine an individual's suitability to work with children
- referring allegations of child abuse to regulators to take appropriate action and determine the suitability of individuals to remain accredited in some professions
- supporting and working with regulators to promote awareness and compliance.

Both schemes have resulted in significant change and restructure for Commission staff including:

- expanded functions
- a new program of engagement to reach organisations now subject to the schemes, and working closely with those who co-regulate organisations subject to the schemes
- developing, testing and implementing operational procedures
- designing, building and testing business systems to capture the new case management functions
- engaging and training new operational and support staff.

Child Safe Standards

On 15 November 2016 legislation was passed to amend the Child Wellbeing and Safety Act. From 1 January 2017 the Commission has had the power to oversee and enforce organisations' compliance with the standards, and other regulators and funders have shared responsibility to oversee and promote compliance.

The standards cover a broad range of organisations that provide services and facilities to children, and call for minimum requirements to be met with a continuous improvement approach to safety, preventing child abuse and properly responding to allegations.

Our focus so far has been on educating organisations about how to comply. We have undertaken some compliance-related activities following concerns being brought to our attention. Other regulators and funders also undertook compliance activities.



Compliance support

To help organisations understand and comply with the standards we:

- ran a digital awareness campaign
- held information sessions throughout the state
- published a range of information material
- funded training partnerships with community-based peak bodies
- developed a new website.

We joined other regulators and peak bodies to reach as many relevant businesses and organisations about the standards as possible.

Getting our message out there

We launched a three-month digital campaign in September 2016, raising public awareness, alerting organisations to the need to meet the Child Safe Standards and informing people about available support from the Commission. The digital campaign aimed to get as broad a reach as possible.

The campaign gained more than two million views across apps, websites, YouTube, Facebook, and Google. Our Google ads resulted in almost 4,000 additional visits to our website and our promotion on Facebook gained almost 700,000 views. We also reached CALD communities by placing banners on websites in several languages visited by Victorian users including websites in Hindi, Traditional/Simplified Chinese and Vietnamese.

From mid-July 2016 we emailed over 14,000 entities and peak-body organisations about the standards, and the support available to raise awareness, promote our new site and highlight educational activities. Web traffic increased as a result, making our site the key source for information and resources about the standards.

Our new website

We completely redeveloped our website to help us educate organisations about the Child Safe Standards and to allow organisations and the public to make notifications to the Reportable Conduct Scheme.

Our new site, launched in May 2017, houses all the resources we have created for organisations including fact sheets, videos, frequently-asked questions and our *Guide to Creating a Child-safe Organisation*.

The website also covers information about our powers, inquiries, submissions, monitoring work and media releases.

Education activities

Information sessions

In the lead up to the introduction of the standards, we conducted 23 information sessions across metropolitan Melbourne and six cities in regional Victoria. These were attended by almost 800 representatives from in-scope organisations and businesses, government departments, peak body organisations and local councils.

The sessions covered an overview of the standards, strategies to create a child-safe organisation and the compliance requirements for organisations. The sessions were a valuable tool to raise awareness of the standards, and to understand organisations' support needs and common questions. Feedback from the sessions is helping us to further develop our education and communication efforts in the future.

Training partners

As well as our own information sessions, we commissioned sector-specific education and awareness programs. These were developed and delivered under our guidance by the following peak bodies:

- Australian Nanny Association
- Australian Tutoring Association
- Centre for Excellence in Child and Family Welfare
- Our Community
- Victorian Aboriginal Child Care Agency (VACCA)
- Victorian Council of Churches
- VicSport
- VICSEG New Futures.

These training partners allowed us to reach more than 2,000 organisations through a range of materials:

- online resources, such as training modules, webinars, videos and social media discussion groups
- statewide face-to-face training, including information sessions, train-the-trainer courses, and workshops
- resources such as newsletters, information packs, sample presentations, policy templates, risk assessment guides, posters, fact sheets and case studies.

Resources

We developed a series of information sheets for organisations on the principles that underpin the standards. We also developed some fact sheets for parents about what to look for in a child-safe organisation.

We updated and reprinted our guide for creating a child-safe organisation, distributing more than 4,000 copies to organisations and businesses that need to comply with the standards.

A dedicated enquiry line

We fielded almost 1,000 queries via our dedicated telephone enquiry line from businesses and organisations seeking information and advice about the Child Safe Standards and Reportable Conduct Scheme. The enquiry line proved to be an invaluable source of information and assistance across a broad range of sectors, and was an important complement to our information sessions, training partnerships and broader communication.

Learning from national and international experts

In May 2017 we held two half-day seminars for peak bodies and regulators led by Dr Keith Kaufman, a Psychology Professor from Portland State University.

Dr Kaufman, author of the Royal Commission into Institutional Responses to Child Sexual Abuse research report *Risk profiles for institutional child sexual abuse*, took co-regulators through the situational risk prevention approach to risk management. He also took peak bodies through different peer-to-peer models to enable community-based organisations to benefit from shared learning.

The seminars included a session led by experts from Ombudsman NSW.

Deputy Ombudsman Steve Kinmond and Assistant Ombudsman Juliana Demetrius shared their experiences and reflections about the NSW reportable conduct scheme, which has been operating for 17 years.

Compliance activities

While we focused on educating organisations on the requirements of Child Safe Standards, we also conducted some compliance activities where we received information about compliance concerns.

When community members raise concerns about an organisation's compliance with the standards we usually make enquiries with the organisation or, where relevant, work with the its regulator to assess whether the organisation is meeting the standards or on track to do so within a reasonable time.

In 2016–17 we conducted compliance activities for 12 organisations. Eight of those were conducted in collaboration with other regulators. Tables 11 and 12 provide a summary of our compliance activities.



Dr Keith Kaufman, author of Risk profiles for institutional child sexual abuse, leading a seminar for peak bodies and regulators, which focused on risk prevention and shared learning.

Table 11. Non-compliance concerns status as at 30 June 2017

Sector	Cases opened	Referred to a relevant authority	Activities	Cases closed
Community – Disability	1	Yes – DHHS	Support to regulator	0
Local government	1	Yes – DELWP	Support to regulator and entity	1
Early childhood education	1	Yes – DET (QARD)	Regulator supported entity to achieve compliance	1
Schools	4	Yes – VRQA	Regulator supported one entity to achieve compliance Regulator currently assessing compliance in three entities	1
Government	2	No	Supported the development of action plans to achieve compliance	0
Religious organisations	2	No	Supported one entity to develop action plan Assessed one entity as exempt from standards under s.22(1)	1 1
Sports clubs	1	Yes – DHHS	Triage assessment commenced	0

Table 12. Commission’s Child Safe Standards compliance activities 1 January 2016 – 30 June 2017

Sector	Number
The number of notices to produce issued by the Commission in the reporting period	0
The number of notices to comply issued by the Commission in the reporting period	0
The number of section 33 court declarations (did not comply with notice to produce) issued by the Commission in the reporting period	0
The number of section 33 court declarations (did not comply with notice to comply)	0
The number of civil penalties for failure to comply with notice to produce	0
The number of civil penalties for failure to comply with notice to comply	0

Compliance and education activities by relevant authorities

Implementing the Child Safe Standards has been done in close partnership with ‘relevant authorities’, which are co-regulators, agencies and departments that fund or regulate organisations providing services and facilities to children and young people. Relevant authorities undertook a range of activities to promote the standards including training, promotional material, updated policies and compliance checks.

This whole-of-government approach has allowed us to collectively reach a wide variety of sectors including education, health, youth justice, out-of-home care and sport.

In 2016–17 we received reports from the following departments:

- Department of Health and Human Services
- Department of Education and Training
- Department of Justice and Regulation
- Victorian Registration and Qualifications Authority
- Department of Environment, Land, Water and Planning
- Department of Economic Development, Jobs, Transport and Resources.

Department of Health and Human Services

DHHS has provided funding to peak bodies and other organisations to deliver workshops, presentations, and training sessions.

Sporting associations received funding to support an industry forum, workshops and presentations. DHHS also provided assistance to sporting associations to develop a guide, and for policy development.

The standards became part of all Victorian health services’ objectives for 2016–17, with inclusion in both the Statement of Priorities and in *Healthcare that Counts*, a framework for improving health care to vulnerable children.

DHHS also put in place an awareness-building campaign, which included online information, posters and fact sheets. Articles about the standards appeared in several sector-specific newsletters.

The department has developed its own internal action plan to support staff at all levels to access training in the standards, and compliance is part of funded organisations’ performance targets.

DHHS conducted one intervention as a relevant authority.

Department of Justice and Regulation

In 2016-17 DJR undertook a project to implement the processes and policies required to be compliant with the standards, and informed staff of their obligations. The department established a working group to develop and distribute information, held presentations, produced brochures and sent direct communications to all staff.

A risk management framework and compliance guide tailored to the department were developed, and an interim Child Safety Officer was appointed to oversee internal compliance with the standards.

The department worked with youth justice by holding presentations for senior staff and will continue to work with youth justice to ensure their compliance with the standards.

Department of Education and Training

DET tapped into the vast network of schools, training providers and early childhood services to ensure all these sectors were aware of their responsibilities under the standards.

To do this, it launched its web portal, PROTECT, which includes resources and guidance on how to implement the standards across early childhood services, schools and higher education. It reinforced this information through regular electronic communication, face-to-face meetings and articles in sector-targeted newsletters.

Regional department staff were trained in the Child Safe Standards to allow them to undertake compliance checks and provide support to schools in their areas throughout 2017. The department has also trained accredited external school reviewers.

Each government school in Victoria will now have their compliance with the standards assessed through the school review process, at least every four years. Early childhood services' compliance is monitored through the Quality Assessment and Regulation Division (QARD).

Victorian Registration and Qualifications Authority

The Victorian Registration and Qualification Authority (VRQA) shares co-regulatory responsibility of Child Safe Standards with us. It promotes the standards and monitors

compliance across all schools, non-school senior secondary providers and overseas secondary student exchange organisations.

The VRQA added a range of materials to its website for organisations it regulates including videos, a self-assessment tool for schools, tip sheets and other resources.

Between 1 January and 30 June 2017, the VRQA and its approved school review bodies conducted reviews of 156 schools' compliance with the standards. It conducted 21 registration activities, which included an assessment of compliance against the standards. It also conducted five investigations and handled 12 complaints. More information on these compliance activities can be found in the VRQA's annual report.

Department of Environment, Land, Water and Planning

Department of Environment, Land, Water and Planning (DELWP) worked in partnership with us to ensure that knowledge and implementation of the Child Safe Standards and the Reportable Conduct Scheme were communicated across the local government sector.

Local Government Victoria shared information with the sector through its regular *Thinking Local* newsletter, and worked with one shire to support putting in place new organisational systems and policies to implement the standards. In addition, DELWP held a well-attended information session for Landcare, Catchment Management Authorities and other DELWP-funded volunteer groups.

Department of Economic Development, Jobs, Transport and Resources

The Department of Economic Development, Jobs, Transport and Resources (DEDJTR) engaged providers and services in sectors such as creative arts, agriculture, fisheries, and transport, as well as entities that employ children. To increase their knowledge of the standards, it held industry and stakeholder forums, information sessions, published web information, sent mail outs and incorporated the standards into staff training and policies.

State-owned creative institutions (Arts Centre Melbourne, Australian Centre for the Moving Image, Geelong Performing Arts Centre, Melbourne Recital Centre, Museums Victoria, National Gallery of Victoria and State Library of Victoria) participated in two creative industry forums. DEDJTR has ensured that these organisations have adopted the standards with endorsement from their governing boards and are promoting them on their websites. Altogether, these institutions provide education programs for almost 500,000 children in Victoria every year.

Organisations that employ children and young people received information through an email campaign to all employers in its Child Employment permit database. DEDJTR also distributed information to this sector via peak bodies and published guidance about the standards on the business.vic.gov.au website.

Other sectors that were engaged to ensure they adopted the standards included fisheries, transport services and the Responsible Pet Ownership Education Program.

Reportable Conduct Scheme

The Victorian Parliament passed further amendments to the Child Wellbeing and Safety Act in February 2017.

These amendments came into effect on 1 July 2017 and outline our oversight and monitoring role for the Reportable Conduct Scheme. The scheme will:

- ensure organisations respond to allegations of child abuse (and other child-related misconduct) against their workers and volunteers, and notify us of any allegations
- allow us to independently oversee the organisation's investigations and responses to these allegations
- make it easier to share information between organisations, their regulators, Victoria Police, the DJR's Working With Children Check unit and the Commission.

Preparing for the scheme

Preparing for the scheme's introduction was one of our proudest achievements of 2016–17. It involved ensuring that we had the right resources and systems in place to administer the scheme, and engaging with many organisations and regulators to ensure those in-scope were aware of their obligations.

Resourcing and systems

We built a case management system to ensure we can gather and act on allegations we receive. The system integrates with our newly-launched website so organisations and members of the public can notify us of allegations via a secure webform.

We also hired more staff to develop policies and procedures, educate organisations, raise awareness and manage cases. Our staff visited Ombudsman NSW to learn from their expertise in running a reportable conduct scheme.

Education and communication

We published comprehensive information about the scheme's scope and requirements on our new website. This included a series of information sheets, frequently asked questions and videos.

We partnered with other regulators and government departments to ensure that in-scope organisations across education, health and child protection services were prepared for the scheme. This included information sessions and content for internal communications channels.

Co-regulation

We worked closely with key stakeholders to develop operational relationships.



The Commission-initiated information sessions to prepare agencies for the introduction of the new Child Safe Standards and the Reportable Conduct Scheme attracted many participants.

Improving outcomes for Aboriginal children

Overview

We work to ensure Aboriginal children, young people, their families and carers can access quality services that are inclusive and culturally safe.

While most Aboriginal children and young people in Victoria thrive in culturally-rich and loving homes, many others are not experiencing the same positive outcomes from programs and services as other Victorians.

Aboriginal children and young people continue to suffer from a legacy of disadvantage and trauma caused by past government policies and broader community attitudes. They are over-represented in our youth justice and out-of-home care systems and under-represented in early years schooling and the broader economy. Their experiences within those systems has often been one that reinforces that disadvantage, by failing to maintain the vital cultural connections they need to grow up strong.

We connect daily with the community to advocate for Aboriginal children in Victoria, listen to their stories and the issues that affect them. We celebrate and support the good work that is being done by communities to determine the best way to care for their children and uphold their best interests.

We believe in leading by example and, to that effect, we are continuously building cultural capacity among our staff. Our Aboriginal Inclusion Action Plan (AIAP) reaches all areas of the Commission and promotes inclusion of and respect for Aboriginal and Torres Strait Islander people in everything we do.

Engagement work

Our Koori Advisory and Engagement (KAE) unit works to:

- engage with the Koori community in Victoria on issues that affect Koori children and young people
- monitor conditions for Koori children and young people in out-of-home care, and the child protection and the youth justice systems
- provide policy advice to government and conduct inquiries to improve services to Koori children and young people
- build cultural competency and provide cultural advice to the Commission as a whole.

In 2016–17 the KAE unit continued to engage Aboriginal children, young people and families, government departments, CSOs, Koori community organisations and advisory bodies, Ministerial advisory bodies and Royal Commissions.

The Commissioner for Aboriginal Children and Young People spoke at forums to promote continuous improvement and innovation for vulnerable Aboriginal and/or Torres Strait Islander children in child protection, youth justice and out-of-home care. The Commissioner spoke at state and national forums including:

- Healing our Future: Caring for Koori Kids Forum, Portland and Geelong, Victoria
- Mungabareena Aboriginal Corporation, Wodonga Victoria

- Child Aware Approaches Conference – Family Matters, Brisbane Queensland
- MacKillop Family Services National Conference, Melbourne Victoria
- Launch of the Reconciliation Action Plan of the Centre for Excellence for Child and Family Welfare, Melbourne Victoria
- Royal Commission into Institutional Responses to Sexual Abuse, Sydney New South Wales
- Royal Commission into the Protection and Detention of Children in the Northern Territory, Darwin Northern Territory.

The Aboriginal Children’s Forum

The quarterly ACF is convened by the Hon. Jenny Mikakos, Minister for Families and Children, and co-chaired with a nominated CEO from an ACCO. It brings together key players from DHHS, ACCOs and other relevant organisations to address the over-representation of Aboriginal children in out-of-home care. These deficits were highlighted in Taskforce 1000 and identified in the *Koori kids: Growing strong in their culture* submission. In late 2013, the Commissioner for Aboriginal Children and Young People lobbied for the establishment of the ACF and an Aboriginal Children’s Strategy. This advice stemmed from outcomes of *Koori kids: Growing strong in their culture*, and was based on the Commissioner’s experience with the Aboriginal Justice Forum (AJF) at the Department of Justice and Regulation.

The most significant outcome for the Commission was the government’s response and action plan to address the recommendations from our two inquiries,

Always was, always will be Koori children and In the child’s best interests. Accountability and reporting mechanisms for this action plan were tabled at the ACF, and a forum sub-committee co-chaired by the Commissioner was established to monitor the progress of the plan.

The ACF is only one aspect of the government’s commitment to Aboriginal self-determination and involvement of the Victorian Aboriginal community in decisions about children’s needs.

Some of the topics that have been discussed at the ACF include:

- innovations in programs and services aimed at keeping Aboriginal children connected to culture and Country
- funding announcements to support Aboriginal services to help families and prevent children from entering out-of-home care
- the findings of our inquiry reports, Taskforce 1000 and other data gathered through our monitoring functions
- progress reports on the transition of case management of Aboriginal children in out-of-home care from government to ACCOs.

Aboriginal Children and Families Strategic Action Plan

This year we enjoyed working with the ACF to develop a strategic action plan and agreement for Aboriginal children and families. The plan brings us together with the DHHS, ACCOs and CSOs. By working across organisations and keeping the plan consistent with the Victorian Government’s principles of self-determination, we can deliver a sustainable and successful action plan.

Transferring parental responsibility for Aboriginal children from government to community

We strongly support work being done by government and community organisations in progressing the self-determination goal of implementing section 18 of the CYF Act under a program called Aboriginal Children in Aboriginal Care. The program enables the Secretary of DHHS to authorise an Aboriginal principal officer of an appropriately trained, supported and resourced ACCO to make decisions about Aboriginal children on protection orders that would normally be made by DHHS. This is a shift in the role of ACCOs, from advisors to decision makers, allowing them to become responsible for case planning and support that matches the plan. The ACCOs work collaboratively with professionals, family and community to implement the case plan and provide culturally safe support.

Aboriginal Children in Aboriginal Care aims to meet the following objectives:

- maintain Aboriginal children's cultural identity by preventing loss or disconnection from family, community and culture
- develop culturally safe responses for Aboriginal children to reunify with parents or extended family
- maintain and develop connection to Country for Aboriginal children
- improve support and decision making for Aboriginal children.

The Commissioner for Aboriginal Children and Young People, and the Manager of the KAE unit are members of the program implementation

steering group. Their participation ensures that one of the key recommendations we made in our report *In the child's best interests* is addressed.

Work on Aboriginal Children in Aboriginal Care implementation is being progressed by the following organisations, through the steering group:

- DHHS
- VACCA
- Bendigo and District Aboriginal Cooperative
- Victorian Aboriginal Children and Young People Alliance
- Centre for Excellence in Child and Family Welfare.

We continue to promote ongoing and bipartisan commitment, support and resourcing between government and ACCOs.

Transitioning Aboriginal children's cases to ACCOs

We are actively involved in the steering committee and working group for transitioning the case management of Aboriginal children on child protection orders and out-of-home care from government to ACCOs. At the end of 2016, 14 per cent of Aboriginal Children in out-of-home care were case managed by ACCOs. With this as a starting point, the working group is aiming for 30 per cent of Aboriginal children transitioned to ACCOs from CSOs and DHHS case management by the end of 2017, 80 per cent by the end of 2018 and 100 per cent by the end of 2021. We will contribute to monitoring achievement of these targets through the DHHS steering committee and the ACF.



Commissioner for Aboriginal Children and Young People Andrew Jackomos with delegates at the Indigenous Youth Parliament.

Aboriginal Justice Forum

Our Commissioner for Aboriginal Children and Young People is an AJF partner. This year his work included:

- highlighting the need for cultural support planning for kids in youth justice custody
- bringing a focus to complaints about police behaviour made by Aboriginal children and young people to prompt partners to review the issues raised and explore ways to address any problems that are identified
- briefing the AJF on the findings of Taskforce 1000 regarding the intersection between out-of-home care and the youth justice system
- advocating to raise the minimum age of criminal responsibility to 14.

At each AJF the Commissioner strongly advocated the need for the next phase of the Aboriginal Justice Agreement to have a focus on

children and young people. This will be achieved through the development of an Aboriginal Youth Justice Strategy, which was announced at the final AJF for 2016–17.

Our Commissioner looks forward to continuing our collaboration with ACF partners and representing the interests of Aboriginal children and young people to achieve better outcomes for them through this forum.

Phase 4 of the Aboriginal Justice Agreement

In 2016–17 the Commissioner for Aboriginal Children and Young People and members of the KAE unit helped develop Phase 4 of the Aboriginal Justice Agreement, which is due to be completed in 2018. We want 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.



Commissioner for Aboriginal Children and Young People Andrew Jackomos at the launch of the Aboriginal Inclusion Action Plan.

Aboriginal Inclusion Action Plan

Our AIAP aligns with the Victorian Aboriginal Inclusion Framework, developed in consultation with Victoria's Koori community.

The framework strengthens inclusion of Aboriginal people and culture in the workplace, and promotes participation of Aboriginal staff in the design, implementation and assessment of policies and programs.

Our AIAP will be implemented over 2016–19. Staff contribute to implementing actions, and are encouraged to incorporate AIAP principles into their daily activities.

We aim to operate in a culturally-safe way, and are determined to influence others to include Aboriginal children, young people and families in their decision making.

The AIAP has six focus areas:

- leadership and governance
- policy and research
- programs, inquiries and reviews
- workplace diversity
- communications
- Reportable Conduct Scheme and Child Safe Standards.

AIAP Working Group

We have established a working group to help implement and monitor actions from our AIAP, and provide safe leadership. It will seek relevant, and culturally-appropriate advice from the KAE unit and our Commissioner for Aboriginal Children and Young People.

Monitoring, reporting and evaluation

We will be transparent and accountable with the AIAP's progress, and commit to monitoring, reporting and evaluation. Our executive group will assess the implementation and progress, monthly and quarterly. An independent evaluation of the AIAP's implementation and outcomes will occur in the final stages, in mid-2019, just in time for its next iteration.

Cultural safety training

All our staff received cultural safety training this year in response to:

- staff wanting to improve confidence in their own and the Commission's cultural competency
- a defined action within our AIAP.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was engaged and consulted by the Aboriginal Strategy and Policy unit within the Commission to develop a four-hour cultural safety training program for staff.

Feedback was generally very positive and the evaluations have been reviewed in collaboration with VACCHO trainers.

Our cultural training plan for the coming 12 months will be based on identifying ongoing learning needs, particularly as we grow through our expanded functions.

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 13 provides a summary of the Commission's expenditure for 2016–17.

Table 13. Commission expenditure for 2016–2017

Expenditure	2016–17 (\$)	2015–16 (\$)
Salaries and on costs	5,847,138.77	4,350,560.29
Grants and other transfers	185,720.60	356,260.46
Operating expenses	3,170,709.80	1,736,657.06
Depreciation	10,156.23	10,156.32
Total expenditure	9,213,725.40	6,453,634.13

Appendix 1. Disclosure index

Ministerial Directions and Financial Reporting Directions – Report of operations

Legislation	Requirement	Page reference
Charter and purpose		
FRD 22H	Manner of establishment and the relevant Ministers	8
FRD 22H	Purpose, functions, powers and duties	8
FRD 22H	Key initiatives and projects	9–60
FRD 22H	Nature and range of services provided	8
Management and structure		
FRD 22H	Organisational structure	64
Financial and other information		
FRD 10A	Disclosure index	62
FRD 12B	Disclosure of major contracts	70
FRD 15D	Executive officer disclosures	69
FRD 22H	Employment and conduct principles	66
FRD 22H	Occupational health and safety policy	65
FRD 22H	Summary of the financial results for the year	61
FRD 22H	Significant changes in financial position during the year	NA
FRD 22H	Major changes or factors affecting performance	NA
FRD 22H	Subsequent events	NA
FRD 22H	Application and operation of <i>Freedom of Information Act 1982</i>	72
FRD 22H	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	73
FRD 22H	Statement on National Competition Policy	NA
FRD 22H	Application and operation of the <i>Protected Disclosure Act 2012</i>	73
FRD 22H	Application and operation of the <i>Carers Recognition Act 2012</i>	73
FRD 22H	Details of consultancies over \$10,000	71

Ministerial Directions and Financial Reporting Directions – Report of operations (cont)

Legislation	Requirement	Page reference
FRD 22H	Details of consultancies under \$10,000	71
FRD 22H	Disclosure of government advertising expenditure	70
FRD 22H	Disclosure of ICT expenditure	71
FRD 22H	Statement of availability of other information	73
FRD 24C	Reporting of office-based environmental impacts	NA
FRD 25C	Victorian Industry Participation Policy disclosures	70
FRD 29B	Workforce data disclosures	67
SD 5.2	Specific requirements under Standing Direction 5.2	1–74
Compliance attestation and declaration		
SD 3.7.1	Attestation for compliance with Ministerial Standing Direction	74
SD 5.2.3	Declaration in report of operations	i
Legislation		
<i>Freedom of Information Act 1982</i>		72
<i>Building Act 1983</i>		73
<i>Protected Disclosure Act 2012</i>		73
<i>Carers Recognition Act 2012</i>		73
<i>Victorian Industry Participation Policy Act 2003</i>		70
<i>Financial Management Act 1994</i>		61

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.

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

Andrew Jackomos was appointed as the inaugural Commissioner for Aboriginal Children and Young People in July 2013. He is responsible for leading the functions of the Commission relating to Aboriginal children and young people.

Executive officers

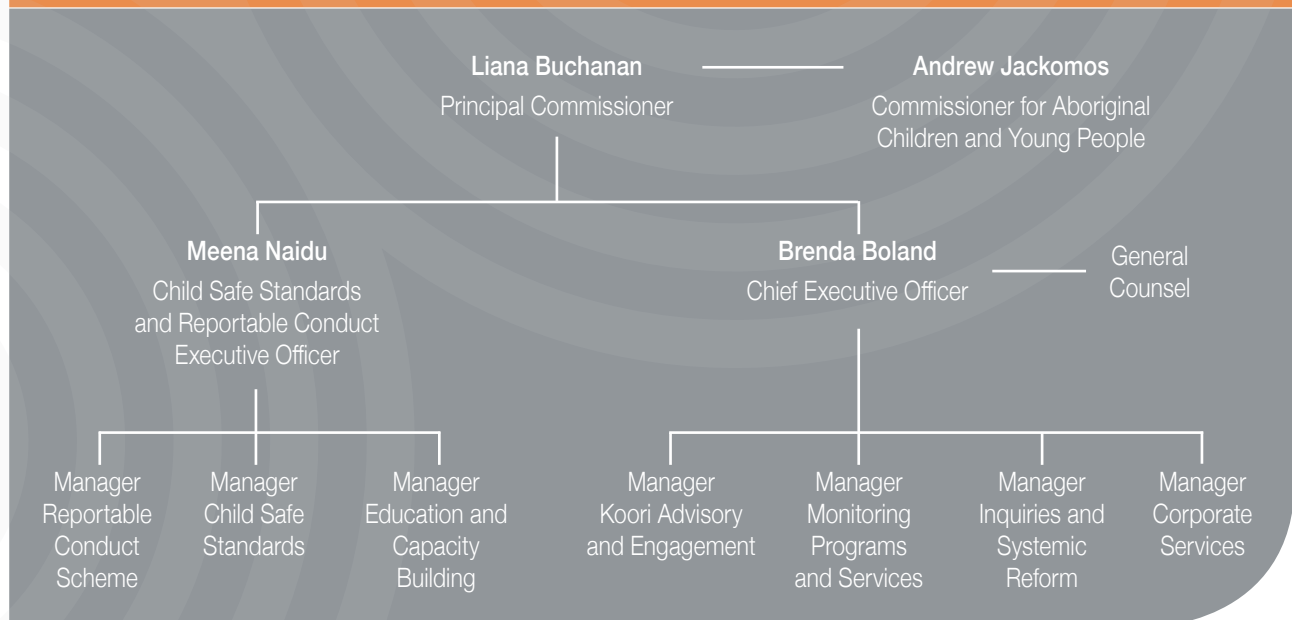
Brenda Boland

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

Meena Naidu

Meena Naidu is Executive Officer, Child Safe Standards and Reportable Conduct. She is responsible for planning, establishing and implementing the operational components of the Reportable Conduct Scheme and Child Safe Standards.

Organisational structure as at 30 June 2017



Audit and Risk Committee membership and roles

The Audit and Risk Committee consists of the following members:

- David Gibbs, Chairperson
- Sue Crook, 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, both internal and external
- development, operation and implementation of the Commission's risk management framework
- charter, scope of work, performance and independence of the Commission's internal audit function
- scope of work of the Commission's external auditor
- 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 2016–17 we continued our ongoing internal safety reporting process, workplace inspections, ergonomic assessments for staff and an Employee Assistance Program.

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

Injuries and incident management

During 2016–17 there were no reported injuries.

There were two recorded major incidents:

- In January 2017, staff were exposed to an incident in Bourke Street in which a driver intentionally hit pedestrians. Group debriefing was offered to all staff on the day of the incident and in the week following. Individual counselling was available to staff in the weeks following the incident.
- In January 2017, staff and volunteers were on site at a youth justice facility during a lockdown caused by an escape incident. Group debriefing and individual counselling were provided to staff and volunteers who were affected.

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 53 people as at 30 June 2017, a 70 per cent increase from the same time last year (Tables 14a and 14b).

This increase was due to work in establishing our new functions, the Child Safe Standards and Reportable Conduct Scheme. During this transition, we also increased the number of employees on fixed-term contracts.

Table 14a. Workforce data as at 30 June 2017

	June 2017							
	All employees		Ongoing			Fixed term and casual		
	Number*	FTE	Full-time*	Part time	FTE	Number*	FTE	
Demographic data	<i>Gender</i>							
	Male	7	7	3	0	3	4	
	Female	46	42.9	20	8	25.4	18	
	<i>Age</i>							
	15–24	1	1	1	0	1	0	
	25–34	8	8	1	0	1	7	
	35–44	16	14.8	5	2	6.3	9	
45–54	12	11.3	5	2	6.3	5		
55–64	16	14.8	11	4	13.8	1		
65+	0	0	0	0	0	0		
Classification data	<i>VPS grade 1–6</i>	53	49.9	23	8	28.4	22	
	VPS 3	5	4.6	3	1	3.6	1	
	VPS 4	5	5	1	0	1	4	
	VPS 5	25	23.4	11	5	14.4	9	
	VPS 6	16	14.9	7	2	8.4	7	
	<i>Senior employees</i>	2	2	1	0	1	1	
	Executives	2	2	1			1	
Total employees	53	49.9	23	8	28.4	22		

Table 14b. Workforce data as at 30 June 2016

		June 2016						
		All employees Number*	FTE [§]	Ongoing Full-time*	Ongoing Part time*	FTE	Fixed term and casual Number*	FTE
Demographic data	Gender							
	Male	3	3	3	0	3	0	0
	Female	28	23.6	16	10	21.6	2	2
	Age							
	15–24	0	0	0	0	0	0	0
	25–34	2	2	1	0	1	1	1
	35–44	8	5.9	4	3	4.9	1	1
45–54	11	9.3	8	3	9.3	0	0	
55–64	11	10.4	6	5	10.4	0	0	
65+	0	0	0	0	0	0	0	
Classification data	VPS grade 1–6	31	26.6	18	11	24.6	2	2
	VPS 3	3	2.6	2	1	2.6	0	0
	VPS 4	3	3	2	0	2	1	1
	VPS 5	15	13.0	8	6	12	1	1
	VPS 6	9	8.01	5	4	8	0	0
	Senior employees	1	1	1	0	1	0	0
	Executives	1	1	1	0	1	0	0
	Total employees	31	26.6	19	10	24.6	2	2

The figures in Tables 14a and 14b 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*.

* Headcount

§ Full-time staff equivalent

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 15 discloses the annualised total salary for senior employees of the Commission, categorised by classification. 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 16, and Table 17 provides a reconciliation of executive numbers in 2016–17 and 2015–16.

Table 15. Annualised total salary, by \$20,000 bands, for executives and other senior non-executive staff

Income band (\$)	Executives	Other
180,000 – 199,999	–	1
200,000 – 219,999	2	–
220,000 – 239,999	–	1
Total expenditure	2	2

Table 16. Total number of EOs for the Commission, by gender

Class	All		Male		Female	
	No.	Var.	No.	Var.	No.	Var.
EO-3	2	1	0	–	2	1
Total	2	1	0	–	2	1

Table 17. Reconciliation of executive numbers[^]

Type	2016–17	2015–16
Executives	2	1
Non-executive senior staff	1	2
Accountable Officer	1	3
(Less) Separations	–	(3)
Total as at 30 June	4	3

[^] Table 17 lists the actual number of EOs 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 2016–17 we commissioned one advertising campaign to the value of \$122,000 (Table 18).

Table 18. Details of advertising expenditure

Campaign name	Summary	Start/end date	Media \$ (ex GST)	Concept/ creative \$ (ex GST)	Research/ evaluation \$ (ex GST)	Total \$ (ex GST)
Child Safe Standards	Digital campaign to promote awareness of and readiness for Victoria's Child Safe Standards legislation, which came into effect on 1 January 2017.	09/16 –12/17	54,815	52,991	14,960	122,766

Table 19. Consultancies valued at \$10,000 or greater

Consultant	Purpose	Total approved project fee \$ (ex GST)	Expenditure 2016–17 \$ (ex GST)	Future expenditure \$
Dwycon Pty Ltd	Inquiry into provision of services to children and families where family violence is a factor	38,250	38,250	–
Jenny Dwyer	Contribution to inquiry report into isolation, separation and lockdowns	31,500	31,500	–
Ernst & Young	The 2016 assessment of the <i>Working with Children Check Act 2005</i> for 2015 and 2016	28,500	28,500	–
PWC	Inquiry into Aboriginal Child Placement Principle	27,273	27,273	–
Total		125,523	125,523	

Consultancy expenditure

Consultancies \$10,000 or greater

In 2016–17 we engaged four consultancies with individual costs greater than \$10,000. The total value of those consultancies was \$125,523 (Table 19).

Consultancies less than \$10,000

In 2016–17 we engaged one consultancy in this category, for a value of \$6829.

Information and communication technology expenditure

For the 2016–17 reporting period we had a total ICT expenditure of \$413,783,

the details of which are shown in Table 20. Our non-business as usual expenditure was focused on developing a new case management system to capture and report on Child Safe Standards and Reportable Conduct Scheme cases, as well as other Commission functions. We also rebuilt our website.

Table 20. Commission ICT expenditure

Business as usual ⁺ (\$)	Non-business as usual [#] (\$)	Operational expenditure (\$)	Capital expenditure (\$)
3,292.00	410,491.00		410,491.00

⁺ Total

[#] Total equals 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.

Pursuant to s. 7 of the FOI Act, the Commission is required to publish the following information in its annual report.

About the Commission

The details required to be published in relation to the Commission, the information and documents in its possession, and the material that is available for publication is contained elsewhere in this report.

Applications made under the FOI Act

For the period 1 July 2016 to 30 June 2017 we received one application under the FOI Act. This application was a request for personal information, and partial access to the documents was granted.

In the period 1 July 2016 to 30 June 2017 there were no decisions reviewed by the Freedom of Information Commissioner and no appeals were made to the Victorian Civil and Administrative Tribunal.

Making a freedom of information request

An application to the Commission under the FOI Act should be made in writing and should include the following information and documentation:

- the personal details of the applicant
- a description of documents or information sought
- the application fee or a written request that the application fee be waived.

Applications 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 Street
Melbourne Victoria 3000

This year the application fee was \$27.90 and can be waived in certain circumstances, such as financial hardship. Applications may also be subject to charges to access documents. These costs are set by the Freedom of Information (Access Charges) Regulations 2014 and will vary depending on the nature of the request.

Further information regarding freedom of information can be found at www.foi.vic.gov.au.

Compliance with the *Building Act 1993*

The Commission does not own or control any government buildings and is exempt from notifying its compliance with the building and maintenance provisions of the *Building Act 1993*.

Compliance with the *Protected Disclosure Act 2012*

The *Protected Disclosure Act 2012* encourages and assists people in making disclosures of improper conduct by public officers and public bodies. The Act provides protection to people who make disclosures in accordance with the 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 the Independent Broad-based Anti-corruption Commission (IBAC):

Level 1, North Tower

459 Collins Street

Melbourne VIC 3000

Phone: 1300 735 135

Website: www.ibac.vic.gov.au.

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 department and are available on request, subject to the provisions of the FOI Act.

- 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.

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
