



Commission for Children
and Young People

Annual report

2023–24



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

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

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The cover artwork is taken from the Commission's *Let us learn* inquiry, for which children and young people were invited to submit artworks about their experiences of education. We have not included the name of the artist for reasons of confidentiality. However, the Commission again thanks our annual report cover artist, and all contributors to the *Let us learn* inquiry, for their work.

'This painting represents the ups and downs of life for me'
(Artist: 12, Aboriginal young person, residential care)



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

10 October 2024

The Hon Lizzie Blandthorn MP
Minister for Children
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 2024.

Yours sincerely

Liana Buchanan
Principal Commissioner

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Definitions

Language in this report

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

Case studies and thematic studies

Case studies and thematic studies have been included to illustrate the work of the Commission for Children and Young People and key themes. Pseudonyms have been used, and details have been altered to protect personal privacy.

Rounding

In tables and figures in this report, rounding may result in percentages not adding up to 100.

Abbreviations and acronyms

ACCO	Aboriginal community-controlled organisation
AJF	Aboriginal Justice Forum
ANZCCGA	Australian and New Zealand Children's Commissioners, Guardians and Advocates
CCYP Act	<i>Commission for Children and Young People Act 2012</i>
CE Act	<i>Child Employment Act 2003</i>
CIMS	Client Incident Management System
Commission	Commission for Children and Young People
CoP	community of practice
CRIS	Client Relationship Information System
CWSA	<i>Child Wellbeing and Safety Act 2005</i>
CYFA	<i>Children, Youth and Families Act 2005</i>
DE	Department of Education
DFFH	Department of Families, Fairness and Housing
DGS	Department of Government Services
DJCS	Department of Justice and Community Safety
DH	Department of Health
FOI Act	<i>Freedom of Information Act 1982</i>
FRD	Financial Reporting Directions
IVP	Independent Visitor Program
MDAS	Mallee District Aboriginal Services
MoU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
OC spray	oleoresin capsicum spray
QARD	Quality Assessment and Regulation Division

Definitions

continued

RTO	registered training organisations
SAFER	SAFER Children Framework
Scheme	Reportable Conduct Scheme
SEO	student exchange organisations
SIDS	Sudden Infant Death Syndrome
SUDI	sudden unexpected death in infancy
Standards	Child Safe Standards
VCEA	Victorian Catholic Education Authority
VIT	Victorian Institute of Teaching
VRQA	Victorian Registration and Qualifications Authority

From the

Principal Commissioner



Liana Buchanan
Principal Commissioner

As Principal Commissioner, it is my great privilege to work with so many inspiring young people every year. The 2023–24 financial year was no exception, with children and young people sharing their lived experience, wisdom, strength and ideas to make Victoria a better place. These young people made it abundantly clear that our work to promote the rights of children and young people is as critical as ever.

Last year's landmark Australian Childhood Maltreatment Study gave a sobering picture of the scale of harm and abuse that children and young people endure in Australia. It found over 60 per cent of Australians had experienced some form of maltreatment as children. Among young Australians, 44 per cent experienced family violence in childhood, 29 per cent experienced physical abuse, and over a quarter had been sexually abused.

At the Commission, we find these figures confronting but unsurprising. They are consistent with what we see across all of our work. And they affirm the need for all services in contact with children to be well-placed to identify and respond to the impacts of maltreatment in the children they work with.

This need was evident in our most recent systemic inquiry, *Let us learn*, tabled in late 2023. The inquiry examined the educational experiences of children in care and exposed a

staggering disparity in educational outcomes between children and young people in care compared to other students. Students in care were far more likely to have chronic absences, be expelled or suspended, disengage from school and perform poorly in standardised testing. We found a range of factors contributed to this – unstable care arrangements, a lack of trauma-informed practice within schools, stigma and low expectations of students in care, and failures to prioritise learning in care planning.

We made 47 recommendations for change, some of which are intended to improve how all schools understand and respond to trauma in students, not just those schools working with students in care. While the high-level response from government has been positive, we are yet to see the detail on planned steps and timeframes to implement recommendations. At the Commission, we will continue to press government to drive change across the entire education system so that children in care, and others who have experienced trauma, benefit equally in this, the 'Education State'.

In addition to systemic reviews, we can also initiate inquiries into how Child Protection and other agencies have responded in specific cases. One of the individual inquiries we conducted this year exposed some of the most profound service system failures I have seen. The



We see the increased notifications as a sign that organisations are getting better at identifying and acting on reportable allegations. The numbers also suggest that organisations must redouble their efforts to embed the Child Safe Standards.

case of 'WD' reflected the extreme manifestation of so many of the problems we have seen across systemic inquiries from the last few years, with devastating consequences. For the first time, I decided to share an individual inquiry with the Premier of Victoria, as I am determined that WD's experience prompts real change – starting with the 19 recommendations we made in this inquiry. Too often, the suffering and harm that results from pressured, ill-equipped service systems is invisible, even to many in government.

Over the past year, we completed 45 child death inquiries, which examine the experiences of children who died after having Child Protection involvement. While these inquiries show efforts by many committed individuals and some instances of good practice, we also continue to see persistent failures. Poor responses to children at risk, including child victims of family violence and children impacted by cumulative harm, reflect shortcomings in Child Protection itself but equally in broader service systems such as The Orange Door, mental health services and other community services. Our child death inquiries led to 17 new recommendations and 56 occasions where we reiterated previous recommendations for improvements in service responses.

We have seen some important improvements in response to our recommendations. This includes investment in one-on-one teaching supports for young people in residential care, improved analysis and planning to respond to demand in the child protection system, and training and development for child protection staff, including in risk assessment. A focus on children and young people has, appropriately, been foreshadowed in

the government's consultations on its next family violence rolling action plan.

In the youth justice system, our monitoring reveals some improvements as well as a continued struggle to meet the rehabilitation needs of children and young people in detention. We note with concern that the practice of isolating young people has increased for the first time in years. In addition, staff absences are still preventing young people from accessing education and programs.

Progress in the area of youth justice is fragile. Small steps can be quickly unravelled by unbalanced narratives about children that fail to place offending rates or the circumstances of these children into context. We were disappointed that the Victorian Government reversed its commitment to ultimately raise the age of criminal responsibility to the age of 14 – a decision that is inconsistent with our human rights obligations and the evidence about what works to change a child's behaviour.

After years of contributing to the Youth Justice Bill, however, we welcomed its introduction into Parliament this year. While several elements depart from best practice, the legislation includes many positive features. It enshrines differentiated justice responses to children and embeds diversionary practices as well as a presumption against custodial sentences for younger children. It introduces stronger regulation of restrictive practices in custody and raises the age of criminal responsibility to the age of 12. These steps to entrench evidence-based responses are important to acknowledge; I commend the Victorian Government for taking them.



While there is much progress for us to be proud of, I am painfully aware of how much work there is ahead to ensure every Victorian child and young person is safe, healthy, loved and happy.

We continue to refine our approach to regulating organisations to make sure they are child safe and respond to risks to children quickly and effectively. We feel the momentum of our efforts to raise awareness and encourage compliance with requirements through a record number of notifications under the Reportable Conduct Scheme, with even more expected in the next financial year. Around 30 per cent of reportable allegations we received were substantiated and 383 people were flagged to have their working with children check reassessed.

We see the increased notifications as a sign that organisations are getting better at identifying and acting on reportable allegations. The numbers also suggest that organisations must redouble their efforts to embed the Child Safe Standards. Our regulatory approach reflects this; after many years of guiding and supporting organisations to implement the Standards, we are increasingly taking enforcement action when organisations are resistant to act. This will continue.

Meanwhile, we continue to look for ways to improve the way we work at the Commission. This year we appointed new Youth Council members and created a *Youth Voices* platform to share children and young peoples' articles, poetry and recordings. We had the benefit of two new youth project officers, who bring their expertise and lived experience to inform our everyday work. I am increasingly co-presenting with young people in speeches, presentations, when giving evidence and as part of our public advocacy. Their contributions strengthen our work and drive us to be better at what we do, for which I am incredibly thankful.

Like other agencies, we feel the tension between Victoria's reform ambitions and its budgetary realities. I have previously referenced significant demand pressures in our Reportable Conduct Scheme, which grew worse again this year. In 2023, we celebrated legislation to introduce long-awaited and much needed individual advocacy powers to enable us to help individual children in the care or child protection systems. These new legislated functions commenced in July 2024 but, sadly, have not been funded for their first year of operation – limiting the extent to which we can take up matters on behalf of children in need of help. We trust this will change in 2025.

Finally, I want to acknowledge the expertise, skill and tireless efforts of my colleagues. Our staff are passionate, courageous and values-driven. They will always work above and beyond to make a difference for children and young people and I want to thank them for their dedication and professionalism. I also wish to thank my fellow commissioner, Meena Singh and our small executive team led by the indefatigable Leanne Barnes as CEO. We would not have the impact we achieve without the contribution of each and every one of them.

As I reflect on the year ahead, I am conscious of the urgency of our work and its ability to lead to real-world improvements to the lives of Victoria's most traumatised and disempowered children and young people. While there is much progress for us to be proud of, I am painfully aware of how much work there is ahead to ensure every Victorian child and young person is safe, healthy, loved and happy. We remain steadfast and determined in making this a reality.

From the

Commissioner for Aboriginal Children and Young People



Meena Singh

Commissioner for Aboriginal Children and Young People



The enthusiasm of many organisations to understand and establish culturally safe environments that will be of benefit to all children and young people has been a great source of hope for me.

This year, the Commission has continued to centre Aboriginal children and young people's voices and be guided by their lived experience and priorities in our advocacy for their human rights. In Aboriginal culture every child is sacred and valued; this has been a way of life for us for thousands of generations and integral to the continuation of the oldest culture in the world. In my role, I am privileged to uphold these cultural values as I advocate for Aboriginal children and young people.

This year began with the lead-up to the Voice to Parliament referendum campaigns, and the devaluing experience of our community yet again being talked about but never talked to. I heard from community the growing racism that was experienced by many while 'living blak'. The referendum result left many, including myself, reeling and needing time to heal. I'm grateful always to work alongside Liana Buchanan, our governance group and staff at the Commission, but their support and care during this time was especially appreciated.

Unfortunately, the success of the 'No' campaign, and the failure to see Aboriginal and Torres Strait Islander people recognised in the Constitution have only served to embolden racist attitudes. There is no denying the impact of racism on the lives of Aboriginal children and young people. Experiences of racism, personal and systemic,

can mean the difference in engagement with education and services necessary to address needs and fulfill aspirations, or being isolated from the broader society without the chance of participation. Our consultations with Aboriginal children and young people in out-of-home care as part of our *Let us learn* inquiry told us they often experienced school as a racist and culturally unsafe space, a space where they don't see themselves valued or encouraged.

In May, I met with 50 Aboriginal young people on Ladjiladjil Country in the Mallee region, as well as community members and Elders. The outcome of the referendum showed this area to have the highest concentration of 'No' votes in Victoria. Their stories and suggestions for social change motivated me for the fight ahead. At times, the path forward post-referendum felt heavy, but I was uplifted by direct engagement like this which displayed the resilience and strength of Aboriginal communities. In 2024–25, we will continue our engagement with young people about these experiences.

With the tabling of *Let us learn* in November, there have been many opportunities for advocacy alongside Liana and our Commission Youth Council members. One of these was the opportunity for Liana and I to give evidence at the Yoorrook Justice Commission's social justice



In Aboriginal culture every child is sacred and valued; this has been a way of life for us for thousands of generations and integral to the continuation of the oldest culture in the world. In my role, I am privileged to uphold these cultural values as I advocate for Aboriginal children and young people.

hearings. We were honoured to give evidence alongside Elias Jarvis, a proud Djab Wurrung, Kirrae Wurrung, and Gunditjmara man and Commission Youth Council member. Elias testified powerfully about his educational experience. He opened with expressing how the Aboriginal community values education in Victoria but also made the poignant observation ‘Why would I report racism to a racist system?’ We spoke about the educational experiences of Aboriginal children and young people, drawing on learnings from our systemic inquiry into the educational experiences of children and young people in out-of-home care.

Disappointingly, the response this year from the Victorian Government to the Yoorrook for Justice report was that only four of the 46 recommendations were accepted in full. Recommendations still under consideration include enshrining the role of the Commissioner for Aboriginal Children and Young People in legislation. Aboriginal children and young people were virtually absent in the government’s response.

We continue to see an increase in the numbers of Aboriginal families engaged with the child protection system, and Aboriginal children and young people removed from their families. Victoria still has the highest rate of Aboriginal children in out-of-home care in Australia. The Commission advocates for a system that drives prevention and early intervention strategies as we monitor and oversight all children in out-of-home care and advocate for Aboriginal community initiatives to reduce the number of children removed from their families. In the past year, the Victorian Government has continued to progress its commitment to transition all Aboriginal children to

Aboriginal care. I recognise this as a positive step towards culturally appropriate care and self-determination which could be life-changing for many children.

In 2024, the Commission released new cultural safety guidance and tools to assist organisations to meet their legal obligations under the Child Safe Standards to keep Aboriginal children and young people safe from abuse. Child Safe Standard 1 is about restoring Aboriginal cultural ways of viewing and valuing the child. Standard 1 requires organisations to establish a culturally safe environment in which the diverse and unique identities and experiences of Aboriginal children and young people are respected and valued. The enthusiasm of many organisations to understand and establish culturally safe environments that will be of benefit to all children and young people has been a great source of hope for me.

We know that Aboriginal children and young people are our future and hope for the oldest continuing culture in the world. The value placed on our children for thousands of generations prior to colonisation saw healthy, happy, safe and connected Aboriginal children and young people. Prior to colonisation Aboriginal babies were kept safe from the harsher elements of Country when wrapped in the love and warmth of the possum skin cloak. Our babies were born into the safety of the land, of Country, of connection, and raised not separate from but a part of Country. It is with these cultural values that I work to elevate the voices of Aboriginal children and young people, and I look forward to another year of being guided by and fighting for them.

About the

Commission for Children and Young People

We are an independent statutory body that promotes improvements in policies and practices affecting the safety and wellbeing of Victorian children and young people.

We have a particular focus on Aboriginal children and young people and all children and young people in the out-of-home care and youth justice systems.

What we do

At the Commission we:

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

Our vision

That children and young people in Victoria are supported to live safely and thrive, and their rights are respected and upheld.

Our values

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

Legislation

Our objectives, 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* (CWSA).

Our priorities

The Commission's work focuses on the five outcomes set out in our *Strategic Plan 2022–2025*.

Outcome 1

Impacts for children and young people are understood and prioritised when government designs services, makes decisions and creates new laws.

Outcome 2

The Commission leads by example in ensuring the views and lived experiences of children and young people are sought, heard and acted on.

Outcome 3

Organisations keep children and young people safe, well and free from child abuse.

Outcome 4

Children and young people live free from systemic and institutional racism.

Outcome 5

There are fewer children and young people in out-of-home care and youth justice, and those in contact with these systems have their rights upheld.

Highlights: our year in review

Amplifying the voices of children and young people

The voices of children and young people were at the core of the Commission's work in 2023–24. As well as seeking their ideas, knowledge and experience on the important issues affecting them, the Commission included their views and perspectives in the fabric of our work.

The creation of a new youth project officer role and recruitment of new Youth Council members were integral in shaping and delivering the Commission's workplan. A new *Youth Voices* platform on the Commission's website was among the expanded platforms the Commission developed to ensure the voices of young people were heard. Young people were also directly involved in creating social media content for the Commission.

Youth project officers and Youth Council members jointly presented and delivered speeches with our commissioners. They also advocated jointly with commissioners in calling for improvements to the education system recommended by the Commission's *Let us learn* inquiry. As a result of this work, decision-makers and other leaders heard directly from children and young people on the issues affecting them (see page 28).

This year, a Youth Advisory Group supported by the Commission continued to guide the work of the South Sudanese Australian Youth Justice Expert Working Group. The Commission also convened four youth forums to better understand the experiences of South Sudanese

Australian young people, which were reflected in the first Youth Forums report published this year.

Shining a light on the systems impacting children

In our role as an independent oversight body, the Commission this year continued to shine a light and call for action on issues critically impacting children and young people in the child protection, out-of-home care, education and youth justice systems.

We recommended government action to improve these systems, with inquiries this year focusing on education, and service responses to the needs of three individual children and young people.

Let us learn examined the education experiences of children and young people in care, identifying deeply inequitable experiences in schooling, and ongoing racism directed at Aboriginal children in the education system. The inquiry recommendations called for change to ensure all schools apply a trauma-informed approach and provide a fairer, more inclusive opportunity for children and young people in care to learn.

Children and young people were involved in every stage, including advocating for the inquiry recommendations and giving evidence with commissioners to a Victorian Parliamentary inquiry and to the Yoorrook Justice Commission (see page 29).

An individual inquiry completed by the Commission this year concerned a vulnerable child with complex needs. The inquiry made 19 recommendations, including calling

for improved oversight and reduced reliance on contingency placements, and a coordinated cross-agency response to sexual exploitation of children in residential care.

To ensure ongoing safeguarding of this child, the Commission intervened as a 'friend of the court' in Supreme Court proceedings, resulting in an ongoing monitoring role with obligations to report back to the court (see page 56).

More broadly, the Commission continued to provide visibility and increased accountability regarding implementation of the Commission's past inquiry recommendations – urging investment and action where critical reform remains needed to protect and improve outcomes for children and young people (see pages 48, 63 and 81).

Learning from the deaths of children known to Child Protection

An important part of the Commission's work is carrying out inquiries into the deaths of children known to the child protection system to help improve services for children in future. This year we completed 45 child death inquiries, making 17 recommendations for change and reiterating past recommendations for change on 56 occasions.

Of eight recommendations to receive a response this year, seven have been accepted and one has been accepted-in-principle.

A further 29 recommendations from past child death inquiries were closed this year, of which 26 were fully implemented.

As in previous years, the Commission this year examined particular themes common to the deaths of children known to Child Protection. Key concerns to emerge included assessment of risk, particularly from family violence; coordination and collaboration between, and access to, services; the response of services outside of child protection; and responses to Aboriginal children (see page 37).

This year, the Principal Commissioner gave evidence before a coronial inquest into four children who died between 2015 and 2017. The inquest examined opportunities for improvement with respect to Child Protection and relevant service agencies working with families in these cases.

Supporting cultural safety for Aboriginal children

The Commission this year delivered communication and education activities to support organisations to implement the Child Safe Standard on cultural safety. The Standard, which came into force on 1 July 2022, requires that organisations establish a culturally safe environment in which the diverse and unique identities and experiences of Aboriginal children and young people are respected and valued. The Standard targets barriers, including racism, in seeking to provide cultural safety within organisations working with Aboriginal children and young people.

To progress implementation of the Standard, the Commission developed extensive resources and carried out engagement with stakeholders, including through a community of practice led by the Commissioner for Aboriginal Children and Young People, Meena Singh, together with members of the Commission's Youth Council.

While the Commission's focus is on supporting organisations to comply, the Standard creates a legal obligation on organisations working with children and young people to put in place policies and practices to achieve cultural safety.

The Standard also aims to have a broader effect in creating cultural safety for all children whose cultural identity is central to their wellbeing (see page 83).

Key activities

Providing scrutiny and recommending system improvements

Child death inquiries and recommendations

45

completed inquiries into deaths of children known to Child Protection

17

new child death inquiry recommendations made

56

occasions where past recommendations reiterated

Other inquiries and recommendations

47

recommendations made to improve the educational experiences of children and young people in out-of-home care through the *Let us learn* inquiry

3

individual inquiries completed – relating to children who experienced significant harm as a result of service system failings

Youth justice centres

29

independent onsite visits to youth justice centres – to amplify the voices of children and young people in youth justice detention

559

issues raised by children and young people

Out-of-home care

12K+

12,394 incidents involving children in out of home care reviewed

Supporting and regulating child-safe organisations

Commission website and publications

1M+

web page views

59K+

59,575 child safety video views

100K

child safe publication downloads

Child Safe Standards

129

organisations with active Child Safe Standards compliance cases

8

Child Safe Standards Notices to Comply issued

7

Child Safe Standards Notices to Produce issued

Reportable Conduct Scheme

1,892

Reportable Conduct Scheme notifications received

30%

of reportable allegations substantiated

1,412

notifications closed

996

allegations reported to Victoria Police

383

people referred for Working With Children Check reassessment

New powers driving compliance with Child Safe Standards

In the first full year of increased compliance and enforcement powers under the Child Safe Standards (Standards), the Commission continued to focus on supporting organisations to comply. In addition, the Commission issued eight Notices to Produce and seven Notices to Comply to compel the provision of information about child safety in organisations, and to enforce compliance action. An official warning was also issued to spur action on non-compliance (see page 133).

The Commission also trained and appointed additional Authorised Officers to support implementation of the Commission's broader powers to carry out onsite inspections without consent, and with or without a warrant.

Across the Standards, 2023–24 saw the Commission initiate compliance action with respect to 43 organisations, and complete compliance action with respect to 67 organisations.

In administering the Standards, the Commission again identified the theme of sporting and religious organisations struggling to identify and manage risks in their organisation. This included organisations where workers or volunteers were being investigated over, or charged with, criminal offences against children but were still participating fully in their roles with no strategies in place to manage this risk.

In sporting organisations in particular, poor screening practices of volunteers resulted in increased risk of harm and abuse to children by allowing alleged perpetrators of abuse to move between organisations.

Overall, organisations providing children with cultural, sporting or recreational services dominated the organisations against which new compliance action was initiated (67 per cent), as well as organisations with current action in progress (50 per cent).

Managing surging demand in the Reportable Conduct Scheme

In 2023–24, the Commission again saw a significant increase in mandatory notifications and public notifications under the Reportable Conduct Scheme (Scheme).

The 1,892 notifications of reportable allegations received by the Commission across the year represented a 30 per cent increase on 2022–23, and a 136 per cent increase since the first year of the Scheme. This record number of annual notifications is anticipated to grow in the coming year.

With no additional funding for the Scheme despite increased notifications, the Commission has progressed a risk-based strategy to manage demand. These measures have seen us significantly reduce our oversight of a high number of investigations. Our efforts will continue to be focused on the cases of highest risk, however resourcing for the Scheme has started to impact on the Commission's ability to run the Scheme in a way that maximises child safety.

This year, we closed 1,412 notifications. A total of 383 unique individuals were found to have committed substantiated reportable conduct and referred to the Working with Children Check Unit in relation to 1,135 substantiated allegations of reportable conduct. Consistent with previous years, 30 per cent of reportable allegations were substantiated in 2023–24.

Notably, the substantiation rate for sexual offence allegations substantially increased, rising from 15 per cent in 2018–19 to 38 per cent in 2023–24. The substantiation rate for sexual misconduct allegations also increased in each of the last five years, rising from 21 per cent in 2018–19 to 38 per cent in 2023–24 (see page 119).

This year saw significant work to prepare for the inclusion of new workers in the Scheme from 1 July, including workers or volunteers provided by labour hire agencies, companies or other providers.

Strengthening the engagement and participation of children and young people

Strengthening the engagement and participation of children and young people

Children have a right to be heard and involved in decisions that affect them. Throughout 2023–24, the Commission continued to challenge itself and build on approaches to embedding and amplifying children and young people's voices and influence in our work. We are dedicated to promoting children's rights and understand that for children and young people to live healthy and safe lives, they must be visible and have their voices and lived experiences heard and acted upon.

This year, our work in this area has included:

- developing a new youth project officer role and recruiting new Youth Council members
- creating a new platform to share children and young people's experiences, ideas and hopes – *Youth Voices*
- further embedding child and youth engagement throughout the Commission's operations
- empowering children and young people to directly influence our work
- centring the lived experiences of South Sudanese Australian young people to guide youth justice reforms
- amplifying the voices of children and young people to advocate for improvements to education.

Youth project officers

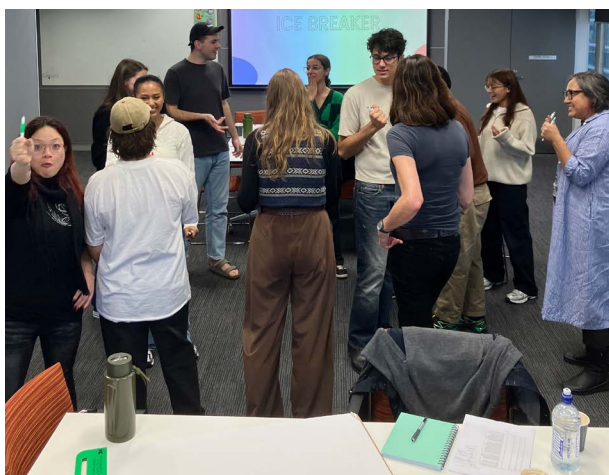


Commission youth project officers Amelia and Conor delivering one of the Commission's youth engagement workshops

The Commission's processes for involving children and young people to shape and deliver our workplan have evolved over time. One of the steps we took this year was to create an identified staff role for a young person. The role expands opportunities for young people to be embedded in our work. The position has been filled as a job share between two young people, Amelia and Conor, who each work part-time with crossover days.

'Over the past few months, we have continued to learn about all of the work the Commission undertakes. We continue to translate our lived experience into expertise to support the Youth Council and enhance the Commission's engagement with children through the youth engagement workshops. We are excited to continue our collective work to build upon our engagement with children and young people across Victoria.'
– Amelia and Conor, youth project officers

Commission Youth Council



Commission Youth Council members, youth project officers and commissioners engaging in a workshop activity at the Commission's office

Onboarding new members and planning workshops

In the second half of 2023 we welcomed new members to the Youth Council, bringing the group's membership to 14 young people, each with their own diverse lived experience, identity and aspirations. In November 2023, after getting to learn more about the functions of the Commission, the group held its first planning workshop alongside the Principal Commissioner and the Commissioner for Aboriginal Children and Young People. This workshop uncovered a range of ideas for the Youth Council and Commission to work on, to further our aim that every child in Victoria has their rights upheld.

Reflections from new Youth Council members

'Joining the CCYP's Youth Council in November 2023 has been a transformative experience for me. One of the standout moments has been attending the in-person workshops at the Commission's office. These sessions have allowed me to meet and speak with members of the Commission, who shared insights into their work and inspired me with their dedication to child protection and safety. Engaging with other council members has been equally enriching. Hearing their diverse experiences and perspectives has broadened my understanding of the issues young people face across Victoria.'

– Wana

'Settling in this year with the Youth Council has been beyond awesome. Everyone on the council is really kind and super passionate about making change for young people!'

– Allegra

'Joining the Youth Council this year has been an empowering experience, and I am grateful to be part of a team dedicated to shaping a better future by creating tangible change and advocating for collective action from stakeholders.'

– Riya

Spotlight: The Youth Council opening new doors – Samrawit

I was introduced to the Youth Council at a youth forum about the over-representation of South Sudanese Australian young people in youth justice in Victoria and wanted to be involved. So, I've been involved in the Youth Council for over a year now.

The Youth Council has allowed me to meet such incredible young people who strive for better systems around them, for both present and future generations. It has been great to work with adults who don't take advantage of our participation but instead open a space where we can be open-minded and speak up in matters where you normally don't hear the inputs of children and young people. The Youth Council has opened up an opportunity for me to work with the South Sudanese Australian Youth Justice Expert Working Group as a project support officer.

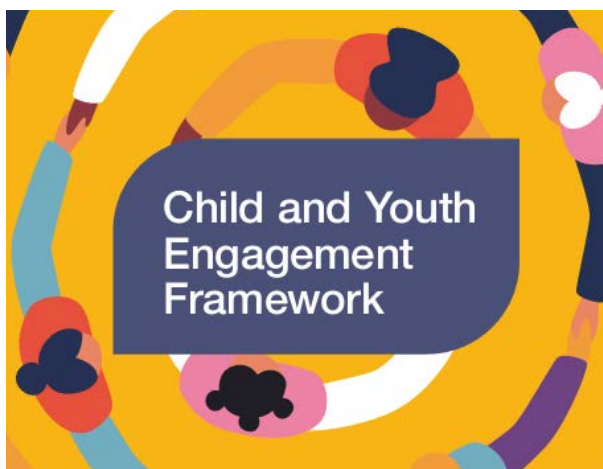
I was privileged to have managers who would explain the project and underlying issues without any judgement or criticism of my lack of knowledge. I did not expect to work in an amazing group of people who have taken time to not only encourage me and make me feel safe but also push me to cultivate skills while being in such a work environment.

Youth Voices

Our new platform – *Youth Voices* – was developed after the Youth Council workshopped their ideas with the commissioners in late 2023. Members expressed their ambition to have an outlet where young people's stories, experiences, ideas and hopes for the future could be amplified to make meaningful change. So far, members have created four pieces, which are all linked to the systemic challenges young people face. The pieces have been promoted through social media and the Commission's website to raise awareness of the lived experiences of children and young people. This Youth Council-led initiative generated almost 4,000 views on the first three articles alone.

The platform will evolve over time and allows members to express themselves in any way that feels best for them – written, spoken and visual modes are all welcome. We hope to also connect with the broader community of young people so they too can use the platform to share their experiences.

Bringing our *Child and Youth Engagement Framework* to life



Our *Child and Youth Engagement Framework* has been developed over many years, with the purpose of providing our staff with clear expectations, principles, theories and practical resources to ensure the Commission provides

meaningful opportunities for children and young people to influence issues that affect them.

This year, we developed a dedicated process for Commission staff to engage with the Youth Council, continuing our work to involve young people in our operations. Our youth project officers, alongside our Youth Council, also developed and ran a series of youth engagement workshops to bring the framework to life for all staff. Modelling genuine, positive engagement, these workshops provided an environment for staff to hear from young people directly, and to engage with the framework and relate it to the day-to-day work of the Commission.



Youth Council member Sakshi facilitating an activity at the Commission's *Child and Youth Engagement Framework* staff workshop

Some reflections from staff after the workshops:

'I feel energised and ready to keep challenging myself about how we do things.'

'The content was fantastic. The delivery was really inclusive. There wasn't a dull moment. Huge congratulations to all involved. The way the training was delivered, modelling of engagement, is worthy of going out to other organisations. The quality was great. And that you brought into it the tools of the framework for youth engagement, made that document "live" and practical.'

'It was fun and engaging, great to be in person and great to be led by the Youth Council, it makes it more powerful.'

Youth Council directly influencing our work

Influencing our monitoring of residential care

Over the past year the Youth Council has informed our monitoring work, assisting the team to plan series six of our residential care monitoring program. Members were involved in choosing the topic of the series and developing the questions that we asked children and young people living in residential care during our monitoring visits.

Advocacy function

The Commission's new advocacy function for children and young people interacting with the child protection and out-of-home care systems began on 1 July 2024. In preparation for this new responsibility, our youth project officers and some Youth Council members developed ideas to inform how the advocacy function can be made accessible and effective for children and young people.

Working with the policy team

This year the Youth Council continued to work with the policy team on policy submissions and longer-term pieces of work. The policy team attended workshops with the Youth Council to discuss mental health reform, unpacking steps the government has taken towards implementing Royal Commission into Victoria's Mental Health System recommendations and workshopping areas of advocacy.

Youth Council members also worked alongside the policy team to prepare a submission to the Victorian Parliament inquiry into the state education system in Victoria, highlighting elements of our *Let us learn* inquiry as well as their lived experience.

Strengthening the engagement and participation of children and young people *continued*

Child Safe Standards – helping organisations be safe places for children and young people

As the Commission further developed our approach to assessing organisations' compliance with the Child Safe Standards, the Youth Council provided input into the questions our authorised officers might ask children and young people to help us understand compliance issues in an organisation.

The Commission held a community of practice for Child Safe Standard 1 – establishing a culturally safe environment – in which the diverse and unique identities and experiences of Aboriginal children and young people are respected and valued. Elias from the Youth Council presented a live question and answer session alongside the Commissioner for Aboriginal Children and Young People.

South Sudanese Australian young people guiding improvements to youth justice

The Commission continued to work in partnership with the Department of Justice and Community Safety (DJCS) on the Victorian Government's South Sudanese Australian Youth Justice Expert Working Group (Expert Working Group) project. The project began in May 2022 and is tasked with reducing the over-representation of South Sudanese Australian young people in Victoria's youth justice system.

The Expert Working Group is led by Dr Santino Deng as Chair, with our Principal Commissioner as Deputy Chair. The Expert Working Group is supported by staff from DJCS and the Commission. The Commission is leading aspects of the project related to youth engagement and youth voice.

Over the past 12 months, the Commission led work to ensure the voices of South Sudanese Australian young people were embedded in and directly informed the work of the Expert Working Group. This included:

- establishing and administering a youth advisory group comprising 15- to 25-year-old South Sudanese

Australian and African Australian young people with lived experience of the youth justice system

- holding a series of youth forums with 188 participants across more than 12 local government areas in Victoria
- publishing a report on the issues and challenges facing South Sudanese Australian young people, including their ideas for potential reform
- consulting and engaging with young people in custody through a youth justice custody consultation initiative
- shaping and building an evidence base to understand the driving factors behind the over-representation of South Sudanese Australian and other African Australian young people in youth justice.

Youth Advisory Group

Recommendations to better support South Sudanese Australian young people and prevent their contact with youth justice must be informed by young people with lived experience. To support this, the Commission appointed 12 young people, selected for their lived experiences and commitment to driving change, to the project's Youth Advisory Group.

The Youth Advisory Group, hosted by the Commission, continued to operate alongside an advisory group convened by DJCS. Together, these groups are responsible for advising on all aspects of the project and its recommendations to government.

Over the past 12 months, the Youth Advisory Group actively guided the Expert Working Group by:

- participating in the first formal project meeting in December 2023, where they met the deputy chair and senior executives of the project to establish a foundational understanding of the project's goals and expectations
- providing advice on data reports, design of consultations and key themes for discussions
- engaging in strategic brainstorming sessions with the Expert Working Group and executives from the Commission and DJCS in May 2024, contributing valuable insights and strategic input to guide the project's direction

- meeting online once a week to discuss emerging criminal justice issues and receive regular project updates
- providing feedback on the Commission's 2023–24 *Youth Forum Report 1*
- providing feedback on the Expert Working Group project's custody consultations initiative.

The Commission looks forward to continuing this important work with the Youth Advisory Group to develop strong, impactful recommendations for change.

Youth forums

This year the Commission delivered four more youth forums in Melton, Springvale, Richmond and Wyndham Vale. At these forums, 188 South Sudanese Australian and African Australian young people had the opportunity to meet the Expert Working Group's chair and deputy chair to understand more about the project and to share their thoughts and experiences on relevant issues.

These youth forums were proudly held in partnership with local, South Sudanese or African youth-led organisations in Melbourne's western, northern and south-eastern suburbs. A final forum is also planned for regional Victoria.

To bring awareness to the experiences shared by young people, the Commission launched the [2023–24 Youth Forums Report 1](#) in May 2024. The report provides a snapshot of themes emerging from the first three forums, covering issues and challenges facing South Sudanese Australian and African Australian young people and their ideas for reform.

The youth forum report summarised what young people told us about their experiences of racism and discrimination, school and work, poverty and financial hardship, parental expectations and competing cultural norms, mental health and wellbeing, and alcohol and other drugs. This knowledge provided important context to help understand why some young people might get involved in criminal offending. Some participants also shared their lived experiences of the Victorian youth justice system to inform the Expert Working Group.

'We are blocked out of opportunities, I always have to prove my worth to white people. I have to be the smartest, stand up straight – it is such a heavy burden.'
– Youth forum participant

'He kept reoffending and they kept missing that it was his environment. He kept going into the continuous cycle of crime and now he's an adult, but you can see it had an effect on him. If you're going to change the person you also have to focus on the environment.'
– Youth forum participant

The most recent youth forum took place on 21 April 2024 in the western metropolitan suburb of Wyndham Vale. The Commission partnered with South Sudanese Australian leaders and community members from the newly founded West Youth Connect, supported by the African Youth Initiative. More than 20 young people of South Sudanese Australian and other African Australian heritage took part.

Forum participants had the privilege of hearing from esteemed young members of the South Sudanese community in a panel discussion. Panel members included Wardell Lual, Mary Daw and Shaggy Bol, who are highly regarded as pillars in western Melbourne's football community.

In smaller discussion groups, South Sudanese Australian and African Australian young people also bravely shared with members of the Expert Working Group and the Commissioner for Youth Justice, their personal and lived experiences of youth crime, mental health, employment, education, and alcohol and other drugs. These discussions were robust and brought together extremely powerful insights into the challenges and issues that South Sudanese Australian and African Australian young people face living in Victoria. Some of their powerful words are captured over the page.

Strengthening the engagement and participation of children and young people

continued

'At the end of the day, [you should] see that young person as a young person. Not colours. The first thing they see is the colour.'

– Youth forum participant

'There is a lack of community spaces for people to drop-in or come to. We need to make spaces for people to have ongoing support.'

– Youth forum participant

'[Teachers] have no faith in African students accomplishing anything. Teachers aren't understanding of their student's circumstances at home, [for example] babysitting siblings or working a job outside of school. We have a lot of responsibilities to help our parents too.'

– Youth forum participant



Members of the Expert Working Group project's Youth Advisory Group with project Chair, Santino, Deputy Chair, Liana, and the project team from the Commission and DJCS

Consulting young people in custody

In addition to the youth forums, the Commission began the design and preparation for the second phase of consultations with young people. Youth Justice custody consultations will directly engage with young people who have current contact with the youth justice system, particularly those remanded or sentenced to a youth justice custodial centre.

Since April 2024, the Commission has regularly visited youth justice custodial centres to engage with South Sudanese Australian young people sentenced or remanded in Parkville or Cherry Creek. These visits provided an opportunity for the Commission to discuss the project with young people and to build an understanding of young people's unique experiences and challenges after having contact with the criminal justice system.

Amplifying the voices of children and young people to improve education

On 16 November 2023 the Commission tabled the report of our inquiry *Let us learn: Systemic inquiry into the educational experiences of children and young people in out-of-home care* in the Victorian Parliament. Children and young people were involved in all aspects of the inquiry, including drafting the terms of reference, designing methods of engagement with children and young people to share their lived experience, consulting with children and young people in care, and working with the commissioners to develop recommendations for change.

Since the Commission tabled the report, the Youth Council has been instrumental in promoting the report and advocating for its recommendations. Members of the Youth Council have been involved in more than 15 presentations highlighting the report to key stakeholders and various peak bodies in the education and community sectors.

Youth Council members also gave evidence about *Let us learn*, alongside the commissioners, at public hearings for the Victorian Parliament inquiry into the state education system in Victoria and the Yoorook Justice Commission. We highlighted the substantial disparities in the educational outcomes for students in care compared with the general student population, and advocated for systemic reforms to achieve an education system that genuinely meets the needs of all students.

The Youth Council has also highlighted some of its own experiences related to *Let us learn* in our new *Youth Voices* platform. Missi and Julia each penned articles outlining some of the challenges they faced and how recommendations made in our inquiry would have changed things for them.

Spotlight: Promoting *Let us learn* – Missi



Youth Council members Missi, Kita, youth project officer Amelia, and commissioners Liana and Meena at the LOOKOUT conference

Since we tabled *Let us learn* in November 2023, the inquiry has made quite an impact on me. Presenting about the inquiry and giving my own personal experience at events such as the LOOKOUT state education conference and meetings with the Department of Families, Fairness and Housing and the Department of Education has been extremely rewarding.

However, giving evidence for the parliamentary inquiry into the state education system stuck with me the most. I was fortunate enough to join with Youth Council member Jas, as well as Liana and Meena, where we presented *Let us learn* in front of a board of politicians and spoke about the challenges we faced with the education system.

Was it daunting? Absolutely. Would I do it again? In a heartbeat. To present something like that to those who I've sought to talk to since day one was incredible. And to watch the same people who seemed somewhat responsible for the chaos in my life sit there and cry was a reward I never thought would happen.

Spotlight: Giving evidence at the inquiry into state education – Jasmine



Principal Commissioner Liana, Youth Council members Jasmine and Missi, and Commissioner for Aboriginal Children and Young People Meena at the inquiry into the state education system public hearing in Shepparton

Being able to sit at the table of the parliamentary inquiry into state education with politicians facing me was remarkable, although awfully nerve-racking. As a person who grew up in foster care, it was a healing experience to be able to finally tell my story of what it was like for me as a kid in the education system, and seeing the emotional impact it had on the politician in front of me. I hope it makes them realise that if hearing about it can bring tears to their eyes then I hope they're able to take some time to reflect on what it would be like for a child going through what I did and knowing that I am one of many, many kids who have experienced if not the same then very similar experiences.

I am so grateful for this opportunity to voice my lived experience and even more grateful to have the Commission members right beside me as well as my fellow Youth Council member Missi. The support really shows and cultivates a safe space for all of us to speak our truth, proudly.

Spotlight: Giving evidence at the Yoorook Justice Commission – Elias



Youth Council member Elias giving evidence at a Yoorook Justice Commission public hearing on 7 June 2024

It has been a massive year for the Youth Council. My personal highlight was giving evidence at the Yoorook Justice Commission alongside Meena and Liana, sharing insights and findings on the experiences of Indigenous children and young people in education settings. Yoorook is delivering such important work in documenting and showcasing the true history and current state for Indigenous people in Victoria. As a panel, we presented the themes and findings of our systemic inquiry, *Let us learn*, emphasising the need for reimagined approaches to supporting Indigenous children and young people in school.

Giving evidence alongside the commissioners was such an empowering moment in bringing to light the truths and experiences of Indigenous children and young people, including myself. Specifically, being a young person sharing spaces, like Yoorook, where Elders and leaders in my community have shared their truths, created such a sentimental and special moment in the context of my own advocacy and role within my community.

Oversight and monitoring of child protection

Oversight and monitoring of child protection

The Commission is responsible for monitoring and oversight of the child protection care system. We do this by:

- reviewing the services provided to every child who was involved with Child Protection in the year prior to their death
- conducting inquiries into service responses to individual children
- initiating inquiries into systemic issues affecting children in child protection.

In 2023–24, our work in this area included:

- completing 45 child death inquiries, making 11 new recommendations for action by Child Protection and six new recommendations directed to other government agencies and community service organisations, and reiterating 56 past recommendations
- conducting an individual inquiry into services provided to a child known to Child Protection
- identifying common themes and issues that arose from our child death inquiries
- monitoring the progress of recommendations from our child death inquiries and systemic inquiries.

Completed inquiries

Individual inquiries

In 2024, the Commission conducted individual inquiries relating to three children: WD, Jamal and Georgia.¹ The individual inquiry relating to Georgia is discussed in this chapter. The individual inquiry in relation to WD relates primarily to out-of-home care services and can be found in the *Oversight and monitoring of out-of-home care* chapter. The individual inquiry in relation to Jamal can be found in the *Oversight and monitoring of youth justice* chapter.

Georgia

The Commission conducted an inquiry into services provided to a young person, Georgia. The Commission became aware of Georgia's case in the course of conducting a child death inquiry. It became known that Georgia had experienced sexual abuse within the family, and the focus of the inquiry was on Child Protection's awareness and assessment of the risks to Georgia.

From a very young age, Georgia and her siblings were exposed to violence, neglect and abuse that triggered reports to Child Protection and Victoria Police, as well as referrals for support through family support services, mental health services, and sexual assault services. More than a dozen reports were made to Child Protection about Georgia, raising a range of concerns including the children's violent, threatening and sexualised behaviours.

The Commission found that although Child Protection progressed a small number of the reports to investigation, most were closed at intake despite recurring family concerns. Child Protection's responses were episodic and incident-focused and did not adequately consider the cumulative impact of all the relevant risk factors in relation to Georgia and her siblings. Child Protection did not separately assess the risks for each of the children, and this meant that Georgia and the risks she faced were largely invisible.

¹ Pseudonyms have been used, and details have been altered to protect personal privacy.

While reported behaviours over many years indicated sexual and physical abuse within the family, the Commission found that there were missed opportunities for early service intervention to address harmful behaviour and the risks to Georgia.

On several occasions, Child Protection consulted with Victoria Police about allegations of inappropriate physical discipline/abuse and the children's sexualised behaviours. However, this did not result in a joint investigation.²

The inquiry highlighted the need to always keep the child in focus and visible, and for further professional education and development to enhance the capacity of Child Protection practitioners to:

- recognise and respond to concerns of inappropriate physical discipline/abuse and sexual abuse, and early warning signs that indicate a child or young person may be developing harmful sexual behaviours
- ensure appropriate mental health and therapeutic supports are provided to both the child exhibiting inappropriate sexualised behaviours and to the victim as early as possible.

The Commission recommended that the department strengthen Child Protection practitioners' knowledge and understanding in recognising and responding to warning signs indicative of familial sexual abuse.

The Commission also recommended that the department lead a reflection with Victoria Police to identify improvements in collaborative practice to improve recognition of and responses to likely physical and sexual abuse and warning signs that a child or young person may be developing harmful sexual behaviours, including any risks they may pose to others.

Child death inquiries

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

Child deaths reported to the Commission in 2023–24

The Commission was notified of the deaths of 43 children in 2023–24, including eight Aboriginal children (Table 1). This represents an increase of three in the number of deaths involving Aboriginal children from the previous year, reflecting the significant over-representation of Aboriginal children in child deaths where the child was known to Child Protection.

² Sections 5.1 and 5.2 of the *Protecting children: Protocol between the Secretary of the Department of Families, Fairness and Housing, Aboriginal Children in Aboriginal Care providers and Victoria Police* (January 2023) provides guidance to Child Protection, Aboriginal Children in Aboriginal Care providers and Victoria Police for effective and collaborative responses to child abuse and neglect to children. The protocol outlines that the Sexual Offences and Child Abuse Investigation Team (SOCIT) is the primary recipient of child protection intake reports relating to allegations of physical or sexual abuse of children. SOCIT assesses reports to determine the need for a police response. The protocol also states that not all cases of child abuse lead to a criminal investigation by Victoria Police.

Table 1. Child death notifications received by the Commission by Aboriginal status 2019–20 to 2023–24

Aboriginal status	2019–20	2020–21	2021–22	2022–23	2023–24
Non-Aboriginal	44	32	33	31	35
Aboriginal	7	13	4	5	8
Total	51³	45	37⁴	36	43

The category of death identified in the following tables is based on information available to the Commission through Child Protection files and is indicative only. Only a coroner can determine the formal cause of death.

In 2023–24, the largest category of death was illness, with a substantial number unclear from the file at the time of notification (Table 2). The Commission will continue to examine any themes that have arisen in these cases as inquiries are finalised.

Table 2. Child death notifications received by the Commission by Aboriginal status and category of death 2023–24

Category of death	Aboriginal		Non-Aboriginal		Total	
	No.	%	No.	%	No.	%
Accident	5	63	5	14	10	23
Drug/substance-related	0	–	2	6	2	5
Illness	0	–	14	40	14	33
Non-accidental trauma	0	–	1	3	1	2
SIDS/SUDI ⁵	1	13	0	–	1	2
Suicide	0	–	2	6	2	5
Unascertained (by coroner)	0	–	1	3	1	2
Unclear from file	2	25	10	29	12	28
Total	8	100	35	100	43	100

³ The Commission's 2019–20 annual report identified nine children as Aboriginal and 42 as non-Aboriginal. These have subsequently been corrected because they had been misidentified either by services or family members.

⁴ The Commission's 2021–22 annual report identified two children as Aboriginal and 35 as non-Aboriginal. These have been subsequently corrected because they had been misidentified either by services or family members.

⁵ SIDS – Sudden Infant Death Syndrome; SUDI – Sudden Unexpected Death in Infancy.

Tables 3 and 4 provide further detail about category of death, Aboriginal status, and age of children at death. Of note this year is that the largest number of notifications fall into the birth to five-month grouping (15) and the 13–17 year or adolescent grouping (14).

Table 3. Child death notifications received by the Commission by Aboriginal status and age 2023–24

Age	Aboriginal		Non-Aboriginal		Total	
	No.	%	No.	%	No.	%
0–5 months	3	38	12	34	15	35
6–11 months	0	–	1	3	1	2
1–3 years	2	25	2	6	4	9
4–12 years	1	13	8	23	9	21
13–17 years	2	25	12	34	14	33
Total	8	100	35	100	43	100

Table 4. Child death notifications received by the Commission by category of death 2016–17 to 2023–24

CCYP category of death	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24
Accident	6	2	8	7	9	9	8	10
Drug/substance-related	3	0	0	2	0	0	1	2
Illness	13	11	7	20	9	6	9	14
Non-accidental trauma	3	1	3	5	1	7	2	1
SUDI	3	7	6	2	8	3	1	1
Suicide/self-harm	5	1	3	5	4	1	6	2
Pending determination/ unascertained/unclear from file	3	4	7	10	14	11	9	13
Total	36	26	34	51	45	37	36	43

Completed child death inquiries

In 2023–24, the Commission completed 45 child death inquiries (Table 5). These inquiries related to children who died between November 2019 and March 2024. Based on these inquiries, we made 17 new recommendations – 11 to the Department of Families, Fairness and Housing (DFFH) and six directed to other departments or services.

As in previous years, most children were living at home with their parent or parents when they died (Table 7). The children whose lives we reviewed through our child death inquiries had been the subject of, on average, four reports to Child Protection, with 12 children (27 per cent) having only one report. The highest number of Child Protection reports made in relation to a child who subsequently died was 24. In 17 of the completed child death inquiries, the Child Protection case was still open when the child or young person died.

Table 5. Completed child death inquiries by age and Aboriginal status 2023–24

Age	Aboriginal	Non-Aboriginal	Total
0–5 months	1	13	14
6–11 months	0	1	1
1–3 years	2	1	3
4–12 years	1	6	7
13–17 years	2	18	20
Total	6	39	45

Table 6. Category of death in child death inquiries completed by the Commission by Aboriginal status 2023–24

CCYP category of death	Aboriginal	Non-Aboriginal	Total
Accident	1	11	12
Drug/substance-related	0	1	1
Illness	2	8	10
Malnutrition ⁶	0	1	1
Non-accidental trauma	0	2	2
SIDS/SUDI	1	0	1
Suicide	1	7	8
Unascertained (by coroner)	0	6	6
Unclear from file	1	3	4
Total	6	39	45

⁶ Malnutrition in the setting of complex disability.

Table 7. Child death inquiries completed by the Commission by living arrangements at death 2023–24

Placement type	Aboriginal	Non-Aboriginal	Total
At home with parent	6	30	36
Kinship care	0	4	4
Never left hospital	0	4	4
Hospital (by court order)	0	1	1
Total	6	39	45

Practice themes and issues of concern

This year our child death inquiries highlighted both good practice and significant concerns across the following areas:⁷

- assessment of risk – with particular concerns where there is risk of family violence or the child is exposed to a pattern of harm over a long period
- coordination and collaboration between services
- access to services
- responses from services other than Child Protection
- responses to Aboriginal children and young people.

Assessment of risk

In November 2021, DFFH introduced a new child protection risk assessment and management framework called the *SAFER Children Framework*. SAFER aims to improve risk assessment practice by providing more detailed guidance to practitioners and integrating the Multi-Agency Risk Assessment and Management framework to strengthen family violence risk assessment.

In 2024, DFFH rolled out practical and reflective training across Victoria for all child protection practitioners on SAFER, to increase confidence in the workforce in applying the framework. Staff in the Commission's inquiries team were also provided with training on using the framework, which has been very helpful in informing our service reviews.

The Commission welcomes the efforts to improve child protection risk assessments. The Commission notes that seven of the completed child death inquiries this year related to children who died prior to DFFH introducing SAFER.

⁷ The numbers of instances of particular practice in our thematic analysis do not add up to the total number of reports because multiple issues and themes were identified across all our reports.

Positive practice in risk assessment

The Commission noted positive practice in 10 cases in relation to the conduct of risk assessment. In six of these cases there was a clear correlation between good service collaboration and comprehensive, well-informed risk assessments.

Case study:

Kylie

Kylie was aged under 12 months old when she died. Child Protection became involved after concerns were raised about her physical safety in the family home.

This case demonstrates positive practice by Child Protection in relation to risk assessment. Child Protection consulted appropriately with services including maternal and child health and other relevant services throughout its involvement with the family. The Commission found that Child Protection conducted a safe sleeping assessment, and an assessment of Kylie's health and wellbeing and home environment. Child Protection engaged with the parents and considered their perspective of the concerns and offered appropriate cultural support.

Child Protection's SAFER assessment and decision making was well informed by its comprehensive and thorough investigation and service collaboration.

In 28 cases, however, the Commission continued to see some components of risk assessment applied inadequately despite the introduction of SAFER.

Response to family violence

Of the 28 cases where components of the risk assessment were inadequate, 15 cases (54 per cent) involved inadequate assessment of family violence risk. All but one of these related to children who died after SAFER was introduced. In all 15 cases, the inquiry found there was a lack of consideration of the seriousness of previous family violence. In 12 cases, the children and young people received no service supports following the report to Child Protection. In four cases, the subject of the child death inquiry or their siblings' disclosures of family violence were not considered or taken seriously. In another case, the risk assessment incorrectly recorded that there was no family violence history or incorporated contradictory information and appeared to reach conclusions based on assumptions rather than evidence.

Response to cumulative harm in assessment of risk

Eleven of the inquiries completed found evidence of cumulative harm not being considered as part of the risk assessment despite multiple reports to Child Protection in relation to the child, ranging from four to 24 reports.

The Commission identified examples where the cumulative impact of previously reported protective concerns was not adequately considered and, in some cases, new reports were assessed in isolation of previous reports. In one case, where a child had nine previous Child Protection reports, Child Protection substantiated cumulative harm. However, Child Protection did not adequately consider the impact of the harm or the need to engage the young person with therapeutic support, despite the young person's health and welfare being seriously affected.

Case study:

Layla

Layla died of malnutrition in the setting of complex disability. Layla had complex health needs, she could not communicate verbally, and needed assistance to be fed. At the time of her death, she lived at home with her family.

Layla was the subject of a number of reports to Child Protection. The protective concerns included family violence, significant weight loss, considerable and unexplained bruising, and the capacity of Layla's parents to meet her needs as a child with a disability.

The Commission found that Child Protection's risk assessment was inadequate. Child Protection closed one report without undertaking an adequate review of risk. As a result, Layla was left in an environment where her health and wellbeing needs were unmet. This was despite evidence of weight loss and physical harm. Child Protection also closed another report at intake without adequately considering key information – for example, concerns raised by expert professionals about Layla's significant weight loss and the documented pattern and history of poor growth, weight loss, repeat hospitalisations and susceptibility to serious illness or death. The significant risk to Layla's ongoing health and wellbeing was misunderstood and minimised by Child Protection at the closure of the final report, leaving her at risk of further harm.

Although Child Protection received four reports raising concerns about Layla's wellbeing, her need for adequate and consistent care was in some instances under-assessed and the concerns remained unaddressed.

Coordination and collaboration between services

Effective coordination and collaboration between services can be critical in protecting children and improving outcomes for them and their families. Where this does not occur, children can miss out on being connected to relevant services that may assist to mitigate significant risks.

This year, the Commission observed inadequate consultation or collaboration in 27 cases. These cases often related to Child Protection and other services not proactively gathering (22) or sharing (10) information, including about a child's mental health, risks of sexual exploitation, or about risks associated with family violence. In one of these cases, a lack of information exchange between Child Protection and Youth Justice to support the mental health and wellbeing of a young person meant that both services worked in isolation in their response, with neither service providing a complete or effective intervention that may have mitigated the risks for the young person.

Case study:

Steven

Steven's death was believed to be by suicide. Steven experienced physical abuse from his father, and also witnessed family violence in his family. There were two reports and two section 38 consultations in relation to Steven. However, the Commission found that one of these reports was closed without gathering enough information to understand the pattern and history of violence he had experienced. The Commission found that more comprehensive information gathering and collaboration with services would have supported alternative referral pathways for Steven and his family. Instead, following multiple referrals, both Child Protection and The Orange Door were aware of the harm Steven was experiencing but did not proactively confirm whether he was engaged with support services or liaise with his school to build a shared understanding of his situation, and how best to support his mental health needs or education.

Examples of positive interagency coordination and collaboration

This year, the Commission found positive examples of collaboration and coordination in 13 of its inquiries. Examples of positive practice included appropriate information gathering from a range of sources in response to an unborn child report to assess the environment a child would be born into, followed by collaborative work with services to support the mother during her pregnancy, and regular liaison with services to properly assess risk. In another case, a disability service collaborated effectively with family support services to assist with access to National Disability Insurance Scheme (NDIS) supports, supports for the other family members, and to coordinate case conferences and handover meetings when new services were involved.

Access to and engagement with services

Access to appropriate and timely services is critical to the safety and wellbeing of children and young people. This is particularly important when Child Protection determines that reports do not meet the threshold for statutory intervention, yet comprehensive and timely service involvement is needed to minimise future harm to the child in question.

As reported in our previous annual report, the Commission continued to make findings in child death inquiries throughout 2023–24 relating to poor access to services and Child Protection closing reports with referrals to services without ensuring the adequate provision of support to the child or family.

Access to services

In 15 child death inquiries, the Commission identified instances of children and families not being referred to appropriate services for additional support. This included Child Protection noting the need for service involvement but there being no evidence on file of Child Protection either making the appropriate referral or confirming the provision of support. It also included Child Protection deciding against making a referral based on the family being unlikely to engage, and child protection practitioners having a limited understanding of the cumulative effect of harmful experiences on children and young people's emotional wellbeing. In nine of these cases, no support was provided to children and young people whose lives had been impacted by family violence and significant trauma.

In one case, a young person with extensive Child Protection involvement and who was exposed to significant trauma throughout their life was increasingly engaging in high-risk behaviours and criminal activities. Rather than provide the young person with the necessary therapeutic intervention, referrals to services focused on providing support to their parent despite the young person refusing contact with them at the time. In another case, a young person and their sibling were not provided with a service response to address family violence or safety in the home. The case was endorsed for closure because the

young person was reported as having sufficient supports in place, although these were not confirmed.

Case closures with referrals to services

In cases where the risk to a child does not meet the threshold for statutory intervention, Child Protection may refer the family to another service to provide support and address risks to the child.

Each year, including in 2023–24, the Commission sees cases where Child Protection closes a report without checking there is service engagement, meaning – in the Commission’s view – Child Protection could not be satisfied the child is not at likely risk of significant harm. The Commission has seen too many cases where this leads to further reports and cumulative harm to children and has discussed the long-term impact of this in our inquiry into issues of cumulative harm and suicide in child deaths and *Lost, not forgotten*. This year, there were seven child death inquiries where this occurred.

In some cases, services were unable to engage families. In others, there were lengthy delays in services providing supports to families. The Commission found that, consequently, children continued to live with significant risk without contact from services. A lack of service provision was found to result in additional reports to Child Protection about children’s safety, with evidence in four cases of Child Protection re-referring and closing again.

For one young person, Child Protection closed the first three reports at intake with referrals to community-based services despite being aware that the family had not engaged with services after prior referrals. Consequently, the family did not receive the necessary supports to address risks within the family. Child Protection closed report four at intake without any follow-up, despite concerns being raised that were similar in nature to previous reports.

Findings specific to services other than Child Protection

While Child Protection practice is often the focus for the Commission’s analysis in child death inquiries, other services – schools, early childhood education and care, family and parenting supports, Youth Justice, The Orange Door and health and mental health services – are also in scope. These services have a critical role to play in identifying and responding to a child’s needs and helping to support their safety and wellbeing. The work of protecting children cannot be done by Child Protection alone.

In 2023–24, the Commission made 20 findings that reflect issues with services other than Child Protection. These included:

- 11 findings across 10 cases that described inadequate responses from the education sector – usually individual schools – towards children experiencing significant vulnerability who ultimately disengaged from education
- three cases where findings were made about negative practice in youth justice settings, including one that found concerning levels of force and the frequent use of isolation due to staff shortages
- four cases where negative findings were made about family and parenting support services, all of which related to failures to accurately identify parenting concerns or failure to report concerns to Child Protection.

Case study:

Tom

Tom died when he was a young child as a result of an accident. He lived with his mother, who had a complex history of trauma and was socially isolated. This impacted on her ability to effectively parent, and Tom experienced significant and chronic environmental neglect.

Positively, Tom's mother sought support from a parenting support service and remained engaged with that service for one year. Tom's mother reported that she was struggling with specific aspects of parenting and demonstrated through conversations with the service that she had limited knowledge and understanding of parenting. However, this did not lead the service to further explore the issues, nor to provide specific and targeted parenting advice and support.

The Commission identified that this service missed opportunities to identify parenting concerns early and the need for a more intensive family support service for Tom and his mother. Early identification of such issues and appropriate early responses to help resolve them are essential in reducing the risk of further harm to children. In Tom's case, parenting issues were not addressed, and his neglect continued.

Positive practice

The Commission also made positive findings about the practice of services other than Child Protection. In six cases, schools were noted to have supported the child well and worked hard to address their needs. In three inquiries positive youth justice practices were identified, including examples of good case management and support being provided. Five inquiries noted positive responses from health or mental health services.

Case study:

Serena

Serena died from an illness when she was a teenager. Serena's mother, who was the primary caregiver for Serena, had limited family support and finances. She also experienced family violence in her relationships.

Serena's life was characterised by instability, and she was the subject of many Child Protection reports relating to family violence, her mother's mental ill-health, inadequate supervision and Serena's high absenteeism from school.

Despite Serena's exposure to harm in the home environment, her schools provided her with ongoing support and encouragement. Her primary school supported Serena to regularly attend school, gave her a home program for when she couldn't attend, and shared important information with her secondary school to support a successful transition.

Serena's secondary school connected Serena and her mother with an education support officer and developed an individual learning plan for Serena, with her input, that focused on her engagement with education. The school also encouraged Serena and her mother to engage with other family supports.

While school attendance remained an issue for Serena, the supportive efforts made by her schools meant that school was a safe and positive experience for her, and she remained connected.

Culturally responsive approaches to Aboriginal children and young people

Meaningful and culturally appropriate practice for Aboriginal children and young people includes an understanding of culture, identity, family connection and community to promote their safety and wellbeing. Engagement with Aboriginal family members in relation to decision making about children is critical, as is the need for Child Protection to work closely with Aboriginal community-controlled organisations (ACCOs) in managing cases involving Aboriginal children and young people. The Commission completed six inquiries involving Aboriginal children and young people, observing insufficient consultation with ACCOs in two cases and inadequate record keeping by services in two cases. In two cases, the Commission found that no Aboriginal family-led decision making⁸ was held and identified delays or a failure to confirm the child's Aboriginal identity.

Case study:

Mick

Mick died by suicide as a teenager. Mick witnessed family violence between his parents and after their separation lived with his father, who was non-Aboriginal. Several Child Protection reports identified concerns about Mick's risk-taking behaviours. Mick's mother was reported to be Aboriginal.

Child Protection's file does not show active efforts were carried out to identify whether Mick was Aboriginal. In particular, Child Protection did not conduct an interview with Mick's mother, which would have provided an opportunity for Mick's Aboriginality to be identified. This was a missed opportunity to connect Mick to cultural supports.

Connection to culture is a protective factor in the lives of Aboriginal children and young people and fundamental to their social and emotional wellbeing. Establishing the cultural background of Aboriginal children in the child protection system is critical to upholding their right to cultural connection. Unfortunately, this did not occur for Mick.

⁸ The Aboriginal family-led decision making process supports the right to self-determination of Aboriginal and Torres Strait Islander families to make decisions about how to keep their child or young person safe and connected to their family, culture, Country and community.

Child death inquiry recommendations

Where the Commission identifies shortcomings or issues of concern in child death inquiries, we often recommend improvements or interventions that may avoid the same issue arising for other children.

Since 1 July 2019, the Commission has made 110 child death inquiry recommendations (Table 8). Most of these recommendations (68 recommendations, 62 per cent) relate to improvements to the child protection system. Of the 110 recommendations, responsible agencies accepted 73 per cent in full, seven per cent in principle, five per cent in part, and did not accept seven per cent (Table 9). The number of recommendations not accepted has decreased over the past five years, likely as a result of the Commission and responsible agencies – primarily DFFH – working closely together to ensure recommendations are meaningful and implementable.

In 2023–24, the Commission made 17 recommendations and closed 29 recommendations (Table 10). While the number of recommendations made in 2023–24 is lower than in recent years, the Commission is increasingly reiterating past recommendations if relevant recommendations have been previously made. Reiterated recommendations are discussed further below.

The vast majority of recommendations that are closed are fully implemented, and the number of fully implemented recommendations has been increasing over the past five years (Table 10). This increase is indicative of concerted efforts by the Commission to monitor recommendations and regularly seek updates and, in many cases, the commitment of departments and agencies to improving their practices for the benefit of vulnerable children.

Table 8. Total number of recommendations by responsible agency 2019–20 to 2023–24

Responsible agency	2019–20	2020–21	2021–22	2022–23	2023–24	Total
Aboriginal community-controlled organisations	0	1	0	0	0	1
Community organisations ⁹	1	1	0	0	1	3
Department of Education	2	0	3	2	1	8
Department of Families, Fairness and Housing	8	14	16	19	11	68
Department of Health	2	4	2	1	1	10
Department of Justice and Community Safety	0	0	0	0	1	1
Health services	1	0	2	2	0	5
Multiple agencies ¹⁰	1	3	5	2	2	13
Non-government education	0	0	0	1	0	1
Total	15	23	28	27	17	110

⁹ Community organisations do not include ACCOs because these have been categorised separately. The category includes a range of non-government organisations that provide services to children and families.

¹⁰ Some recommendations have more than one responsible agency, particularly where collaboration is required to effect change. In these instances, DFFH is one of the responsible agencies, alongside another government department or community organisation.

Table 9. Responses to recommendations 2019–20 to 2023–24

Response	2019–20	2020–21	2021–22	2022–23	2023–24	Total
Accept	11	17	21	24	7	80
Accept in part	3	1	1	1	0	6
Accept in principle	1	3	2	1	1	8
Not accepted	0	2	4	1	1	8
Pending response ¹¹	0	0	0	0	8	8
Total	15	23	28	27	17	110

Table 10. Recommendations by closure type 2019–20 to 2023–24¹²

Closure type	2019–20	2020–21	2021–22	2022–23	2023–24	Total
Fully implemented	9	20	23	30	26	108
Retired ¹³	2	3	5	7	3	20
Total	11	23	28	37	29	128

The Commission has analysed themes in the recommendations it has made over the past five years. Not all of the Commission's 110 recommendations focus on a particular cohort, but it is of note that over the past five years the Commission has made 15 recommendations focused on infants and 17 recommendations focused on children (or, in two cases, parents) with disability and/or complex health needs. Of recommendations that target service responses to particular protective concerns, the most frequent focus areas were family violence and mental health. These themes are discussed in more detail below.

Reiterated recommendations 2023–24

Where similar recommendations have already been made, particularly in other child death, individual or systemic inquiries, the Commission will repeat those recommendations in the inquiry report.

This year the Commission explicitly reiterated recommendations 56 times across 16 child death inquiries. Of instances where recommendations were

reiterated, 10 involved recommendations from other child death inquiries, 41 from systemic inquiries, three from individual inquiries and two from inquiries completed by external bodies such as the Yoorook Justice Commission.

Reiterated recommendations covered a range of areas requiring practice and system improvements, including the need to improve the prevention of and responses to cumulative harm (8); the need to improve family violence practice (4); and the need to better identify and respond to suicide risk (4). Four cases reiterated recommendations about the need to better monitor and manage the wait times for and engagement with services to which Child Protection frequently refers cases, including The Orange Door. Recommendations about the need for improvement in schools' responses to vulnerable children were reiterated 21 times across eight cases. These primarily related to the need to improve teachers' understanding of trauma, for a whole-school approach to trauma, and to reduce the use of suspensions for vulnerable children.

¹¹ When an inquiry report is finalised, the Commission requests a response to any recommendation be provided within six weeks of receiving the report. This reflects data as at 30 June 2024.

¹² This table counts the financial year of closure. Other tables count the financial year the recommendation was made.

¹³ Recommendations that have been retired are no longer monitored by the Commission. This could be due to a number of reasons such as the recommendation not being accepted, or the recommendation being monitored through a related systemic inquiry recommendation.

Five-year analysis of recommendations

The Commission analysed our recommendations in child death inquiries over the past five years, and the progress of implementation, and observed positive outcomes arising from our recommendations in a number of key areas, including information sharing. The Commission has also identified areas in which progress has been slow and further change is needed, including recognition of and responses to cumulative harm, responses to high-risk youth, practice in relation to children and young people with disability, and access to education for children and young people in out-of-home care.

Improvements in information sharing

Of the 26 recommendations fully implemented this year, five have contributed to strengthened information-sharing practice between services. For example, following a Commission recommendation, the Department of Education supported two schools to strengthen the ways in which high-risk students were transferred from one school to another. Other recommendations were directed to a health service that needed to bring its policies and procedures in line with the Child Information Sharing Scheme. In response, the health service conducted an extensive internal review and amended its policies and procedures accordingly.

Responses to cumulative harm

Over the past five years, the Commission has made eight recommendations to strengthen responses to cumulative harm. These recommendations all followed the 2018 and 2019 inquiries into issues of cumulative harm and suicide in child deaths. Of the reiterated recommendations made this year relating to cumulative harm responses, the majority reiterate recommendations from these inquiries.

Despite our efforts to bring to attention the need for improved policy and practice in identifying and responding to cumulative harm across these inquiries, the Commission has seen limited progress in this area.

Three of the oldest child death inquiry recommendations that remain open relate to improving responses to cumulative harm. While initially these recommendations

were put on hold due to the COVID-19 pandemic, DFFH has yet to advise the Commission about implementation.

The Commission has, however, welcomed the department's efforts to improve training practitioners in drafting court reports where cumulative harm has been identified as an issue, and to recognise and respond to cumulative harm through a staff webinar.

Responses to high-risk youth

The Commission has made four recommendations to improve responses to high-risk adolescents in the past five years.

Two of these recommendations highlighted the need for training and case reflection to strengthen accurate information sharing between schools and Child Protection where young people are at risk of disengaging from school and/or have escalating behaviours. The Commission commends the localised discussions between services in these areas to strengthen practice.

Another recommendation sought for Child Protection and a community service provider to develop a process to better identify high-risk cases and escalate responses where required. This recommendation resulted in quarterly liaison meetings between the service provider and Child Protection to ensure timely communication about high-risk children and young people.

Another of the Commission's recommendations on high-risk adolescents calls for DFFH to implement a more effective escalated response for all children who are at high risk of harm and where existing efforts to mitigate harm are not effective. The Commission first made this recommendation in an individual inquiry in 2019. We made a similar recommendation in a 2023 child death inquiry. The department did not accept these recommendations, but in June 2024 advised that it will undertake a separate piece of work to strengthen its practice and responses to high-risk youth. This advice is welcome. As recent child death and individual inquiries have highlighted, in particular the individual inquiry in relation to WD, urgent action is needed.

Practice in relation to disability or complex health needs

In the past five years, the Commission has made 17 recommendations in 12 child death inquiry reports relating to children and young people or parents with disability and/or complex health needs. Most of these related to children and young people with disability and/or complex needs, but in two cases the recommendations related to parents with disability.

Positively, 10 of the 17 recommendations have been fully implemented. For example, one recommendation, made in 2020, called for DFFH to develop an ongoing training module for the Child Protection workforce about working with children with disability and/or complex medical needs. DFFH developed a National Disability Insurance Scheme (NDIS) eLearning package, which includes guidance on NDIS system navigation and advice on gathering information, and seeking the views of children with a disability, including those with significant communication needs.

However, the Commission has continued to identify the need for improved practice, with six recommendations awaiting implementation, and one that was not accepted by the department. These recommendations primarily relate to the need for strengthened guidance and greater access to on-call advice for Child Protection practitioners when they are assessing risk to children with disability or complex health needs.

Access to education

The majority of recommendations relating to education were reiterated from the systemic inquiry, *Let us learn*. Eight child death inquiries this year highlighted the need for:

- educational responses to disengagement to be more proactive and responsive to children's learning needs
- improvements in enrolment processes, particularly for children and young people in out-of-home care who frequently transition schools due to placement changes
- greater collaboration between DFFH, the Department of Education and schools to more holistically support children and young people in out-of-home care with their learning
- teachers and schools to deepen their understanding of trauma and to embed a whole-school approach to creating safe, trauma-informed learning environments
- different responses to challenging behaviour in schools, particularly using suspensions as both a last resort and a trigger for increased health, wellbeing and learning supports for students who are struggling.

Please see page 54 for more information about the government's response to recommendations from *Let us learn*.

Coronial cluster inquest into historic child deaths

In 2023, the Principal Commissioner gave evidence in a coronial inquest into the death of four children who died between 2015 and 2017, all of whom were known to Child Protection. This was the first time the Principal Commissioner has been invited to provide an expert report and appear as a witness in coronial proceedings.

The Principal Commissioner's report and oral evidence addressed opportunities for service improvement evident in the four children's cases, and whether existing reforms were sufficient to address any identified issues or further improvements remained necessary. While the findings of the inquest have not yet been handed down, the State Coroner has ruled the Principal Commissioner's expert report will be released concurrently with publication of his findings.

Progress against previous inquiries

As in past years, the Commission requested an update from DFFH in relation to *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection* at 30 June 2024.

Lost, not forgotten



The Commission's *Lost, not forgotten* inquiry report, tabled in the Victorian Parliament on 30 October 2019, reviewed 35 child death inquiries where the children had died by suicide between 1 April 2007 and 1 April 2019. Despite the children and young people being exposed to often serious and multiple risks, the inquiry revealed a pattern of early and repeated case closure by Child Protection and failure to follow up with disengaged families who were not connected with the help they needed. The inquiry also found that responses to the children's mental health and self-harm risks were ad hoc and ineffective.

Lost, not forgotten contained six recommendations. Four remain outstanding:

- the development and implementation of a whole-of-system investment model and strategy for the child and family service system
- a set of standard analytical data sets for Child FIRST/ The Orange Door and Integrated Family Services to monitor and report on the timeliness and effectiveness of Child Protection's referrals to these services, and the services' engagement with children and families

- the development of practice advice in relation to children involved with Child Protection who are identified as at risk of suicide
- a suicide prevention strategy for children known to Child Protection.

Of these remaining four recommendations, the Commission has assessed three as being in progress (including one requiring ongoing systemic effort), and one as planned for implementation. A full table showing the original recommendations and the department's progress against each one is available on the Commission's website.¹⁴ The Commission is pleased that work has progressed this year to strengthen practice advice in the *Child Protection Manual* in relation to children identified as being at risk of suicide. The Commission remains concerned that, almost five years after the Commission recommended a suicide prevention strategy for children known to Child Protection, no such strategy has been finalised. This is urgent work; since this inquiry was tabled, a further 21 children and young people involved with Child Protection have died by suicide.

Still in train is action to enable DFFH to monitor Child Protection's referrals to other services and the timeliness and effectiveness of those referrals. As indicated above, we continue to see the need for this action in our child death inquiries. The Commission looks forward to seeing further progress in this critical area.

Requests to de-identify children and young people identified as Aboriginal and/or Torres Strait Islander in CRIS

The Commission's 2016 inquiry into compliance with the intent of the Aboriginal Child Placement Principle, *In the child's best interests*,¹⁵ highlighted concerns that Aboriginal children and young people were being too easily de-identified in DFFH's Client Relationship Information System (CRIS). As recommended in that inquiry, DFFH must consult with the Commissioner for Aboriginal Children and Young People about any de-identification requests. These requests come from the Statewide Principal Practitioner, Office of Professional Practice, Community Operations and Practice Leadership.¹⁶

Late or inaccurate identification of an Aboriginal child in CRIS can mean important aspects of the Aboriginal Child Placement Principle will not be considered or put in practice to support connection to culture. In 2022 and 2023, the Yoorrook Justice Commission heard evidence about challenges with identifying Aboriginal and Torres Strait Islander children and young people in the child protection system, stating that identification of Aboriginality is a gateway for access and eligibility to specialist services, Aboriginal children in Aboriginal care programs, consultations with the Aboriginal Child Specialist Advice and Support Service, Aboriginal family-led decision making meetings and the Aboriginal Child Placement Principle.

Requests for de-identification in 2023–24

During 2023–24, the Office of Professional Practice submitted de-identification requests for 68 children from 47 sibling groups to the Commissioner for Aboriginal Children and Young People. Of these 68, 67 were endorsed for de-identification, which means their status on Child Protection records was changed to 'neither Aboriginal or Torres Strait Islander'.

¹⁴ See <https://ccyp.vic.gov.au/inquiries/systemic-inquiries/lost-not-forgotten>.

¹⁵ Tabled in the Victorian Parliament October 2016 <https://ccyp.vic.gov.au/inquiries/systemic-inquiries/in-the-childs-best-interests/>

¹⁶ In 2016 the requests were issued by the Chief Practitioner, Office of Professional Practice.

The categories of error leading to requests for de-identification are outlined in Table 11.

Table 11. Number of requests for de-identification by category of error 2023–24

Error type	No.
Administration error ¹⁷	8
Sibling group error ¹⁸	11
Assumption or not asked – other ¹⁹	1
Reporter error ²⁰	11
New information – family finding ²¹	17
New information – family incorrectly self-identified ²²	18
New information – paternity	1
Total	67

With every request for de-identification, the Commissioner for Aboriginal Children and Young People looks at a number of factors:

- the nature of the error made in identification
- subsequent information provided
- the impact of identification on the child or young person, particularly considering their age and whether the child or young person is themselves identifying as Aboriginal
- whether the child or young person and their family is currently getting services from an ACCO
- the consent of the parents of the child or young person to de-identify the child or young person as Aboriginal.

It should be noted that endorsing a request for de-identification relates to Child Protection services only.

¹⁷ ‘Administration error’ refers to an administrative error in Child Protection record keeping – such as an incorrect click – that is made without any belief that the child may be Aboriginal.

¹⁸ ‘Sibling group error’ refers to Child Protection incorrectly assuming a child is Aboriginal because they have Aboriginal siblings.

¹⁹ ‘Assumption or not asked – other’ refers to Child Protection making an assumption-based error that is not based on sibling group assumption.

²⁰ ‘Reporter error’ refers to Child Protection recording a child as Aboriginal based on information provided by a reporter or information provided by a service, usually at intake.

²¹ ‘New information – family finding’ refers to the family identifying themselves as Aboriginal with a genuine belief that there is Aboriginal heritage in the family. Subsequent family finding work – formal or informal – later finds this not to be true, and the family consent to de-identification.

²² ‘New information – family incorrectly self-identified’ refers to a family member identifying themselves as Aboriginal to Child Protection, with the knowledge that they are not Aboriginal. This is usually motivated by wanting to access Aboriginal-specific services.

Oversight and monitoring of out-of-home care

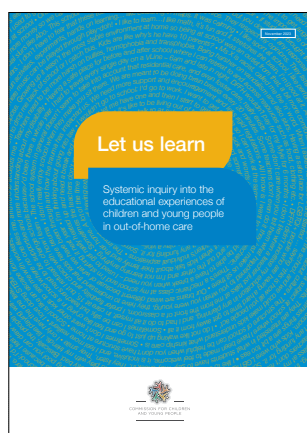
Oversight and monitoring of out-of-home care

The Commission is responsible for monitoring and oversight of the out-of-home care system.

In 2023–24, our work in this area included:

- completing a systemic inquiry into the educational experiences of children and young people living in out-of-home care
- conducting an individual inquiry into service responses to a child in out-of-home care
- monitoring serious incidents and identifying systemic issues in out-of-home care
- conducting onsite inspections of residential care services
- responding to direct approaches for assistance from the public
- monitoring the progress of recommendations from previous systemic inquiries.

Let us learn: Systemic inquiry into the educational experiences of children and young people in out-of-home care



On 16 November 2023, the Commission tabled our report *Let us learn: Systemic inquiry into the educational experiences of children and young people in out-of-home*

care in the Victorian Parliament. The inquiry examined how living in care impacts children and young people's experiences of education. The inquiry also explored children's participation in early education services and the effectiveness of Victorian Government initiatives in supporting children and young people in care to stay engaged in education.

The inquiry's 40 findings and 47 recommendations drew on consultations and surveys with more than 180 children and young people, all with a care experience. We also consulted with more than 350 other stakeholders and analysed data and information from the Department of Education (DE) and the Department of Families, Fairness and Housing (DFFH).

The inquiry revealed substantial disparities in educational outcomes for children and young people in out-of-home care compared with their peers. Our analysis showed:

- twenty-five per cent of students in care progressed from year 10 in 2020 to year 12 in 2022, compared with 82 per cent of other students²³
- in 2022, secondary school students in care had on average eight per cent lower attendance rates than other students and 64 per cent were identified as chronically absent from school – 17 per cent higher than the chronic absence rate for other students
- students in care had a 25 percentage point lower participation rate in NAPLAN in 2022, and those who participated received substantially lower results across all year levels and in each NAPLAN domain
- students in care were five times more likely to be suspended from school than the general student population, five times more likely to be expelled and seven times more likely to be subject to incidents of restraint or seclusion
- during COVID-19, the absence rate for students in care was, on average, four per cent higher than for other students throughout the period from 2019 to 2022

²³ This data does not reflect the movement of students in out-of-home care from government schools to non-government schools or TAFE to complete years 11 and 12, nor students who have continued in years 11 and 12 in government schools but are no longer living in care.

and continued to rise after the return to face-to-face learning.

Building on the Commission's *In our own words* inquiry, this inquiry demonstrated once again that a stretched out-of-home care system, chronic placement instability, poorly supported carers and ill-equipped residential care homes have a negative impact on children and young people in out-of-home care. The children and young people we spoke to as part of the inquiry told us about their willingness to learn and the positive experiences they have at school, and some told us that school was their 'safe place', before and during their time in care. But many children and young people spoke about the barriers they face getting to school or staying in school. They also spoke about challenges they experience at school, including a lack of understanding of the care system and the way trauma and instability might affect students' behaviour and ability to learn.

The inquiry revealed that although there are pockets of good practice, most schools do not apply a trauma-informed or therapeutic approach to ensure students in care are understood and supported at school. Children and young people described feeling stigmatised by negative attitudes towards them and low expectations of their abilities. Marginalised children and young people too often reported experiencing bullying and discrimination at school, from both teachers and peers. Taken together, this often discouraged their attendance or affected their participation.

The inquiry revealed that exclusionary practices (such as modified timetables, suspensions and expulsions) were more likely to be used to manage the behaviour of students in care and often contributed to disengagement and poorer outcomes.

The inquiry highlighted that Aboriginal children and young people's connection to culture and community continues to be threatened by Victoria's high rates of removal and the over-representation of Aboriginal children in out-of-home care. Consequently, failures for children in out-of-home care, including those affecting their education, disproportionately affect Aboriginal children and young

people. We also heard in consultations that racism persists in the education system from early childhood settings onwards. Aboriginal children and young people spoke about experiencing racism in school and how it affected them emotionally and threatened their engagement with education.

Overall, the inquiry identified 47 recommendations to clarify roles and responsibilities, strengthen responses by Child Protection and schools, increase resourcing and support different agencies to work together effectively to meet the needs of students in care. To address barriers in the child protection and out-of-home care systems, we made several recommendations, including:

- a stronger focus on prioritising education in the work of Child Protection, including in placement decisions and case planning
- more support for carers, including financial support, reducing their education-related expenses and increasing access to flexible funding
- free travel passes for children and young people in care
- more training to strengthen residential care providers' support for educational engagement
- improved funding for and quality of cultural plans for Aboriginal children and young people in care.

Key recommendations to enhance the educational experiences of children and young people in care included:

- a whole-school approach to trauma in all government schools
- improved understanding of out-of-home care among school leadership teams
- development of clear guidance and monitoring the use of modified timetables
- a review and update of DE's suspensions policy, including ensuring suspensions in primary schools only occur in exceptional circumstances and as a last resort
- improved understanding of and responses to imposing informal suspensions
- improved tracking of educational and wellbeing outcomes of students in care

Oversight and monitoring of out-of-home care *continued*

- review and strengthening of the *Out-of-Home Care Education Commitment* and the *Early Childhood Agreement for Children in Out-of-Home Care*, and increased resources for LOOKOUT centres.

To enhance the educational experiences of Aboriginal children and young people in care, we recommended:

- a clear and distinct policy addressing racism in education settings
- that DE develop youth relevant cultural safety resources
- requiring schools to report on actions taken to address racism
- strengthening educational supports to Aboriginal students in care.

The Victorian Government has accepted most of the recommendations, accepting 25 recommendations in full, 19 recommendations in principle and two recommendations in part. One recommendation is to be considered further. The government's response is available from [our website](#).

The Commission welcomes the government's response and the early investment in support of several of the report's recommendations. In September 2023, \$18.7 million was announced to provide 500 students in care with tailored education support and to increase access to educational needs assessments. The government advises that a further \$27.6 million announced in the 2024–25 State Budget will fund education-related initiatives for children and young people in out-of-home care, including progressing the integration of data systems and increasing resources for LOOKOUT learning advisors and early childhood learning advisors in high-demand areas of the state.

The Commission is now seeking the government's implementation plan to understand the timeframes and the specific actions to be undertaken to implement the recommendations.

While welcoming the Victorian Government's positive initial response to our recommendations, the Commission reiterates that significant action is urgently needed to prevent discrimination, mistreatment and educational neglect of students in care. Priority recommendations include action to ensure all government schools implement a whole-school approach to trauma. This recommendation will also benefit the broader student population, given the findings of a recent landmark study that found that over 62 per cent of the Australian population experienced at least one form of childhood maltreatment.²⁴

The Commission calls for related urgent action on setting guidance for the use of modified timetables; limiting the use of suspensions, especially among primary school age students; and building an understanding of the out-of-home care system among school leadership teams.

The Commission also reiterates the need to increase care allowance payments for kinship and foster carers. Adequate financial support has a significant effect on the quality and stability of care provided to our most vulnerable children and young people, including their access to educational resources and opportunities.

Inquiry into service responses to a vulnerable child – WD

Last year, young child WD was found with the body of a deceased person in a suburb of Melbourne. WD was charged with murder the next day. After being advised about this incident and the fact that WD had been in out-of-home care for many years, the Commission established an inquiry to review the services provided to WD throughout her life.

The *Commission for Children and Young People Act 2012* (CCYP Act) prevents inquiries into responses to individual children from being published. In any event, out of respect for this child's privacy, we will include limited detail about her experiences here, while also trying to serve the public

²⁴ Haslam D, Mathews B, Pacella R, et al. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief report*. Australian Child Maltreatment Study, Queensland University of Technology, 14.

interest by raising community awareness of system failings for this child.

It has been publicly reported that WD has a history of significant childhood trauma and an intellectual disability that contributed to a complex mix of behaviours and needs. It has also been reported that, before the critical incident, WD was being sexually exploited while missing from care.

The inquiry found that while many people and services were attempting to do their best to support WD, efforts to meet her needs and reduce the risks WD faced fell short. At every stage of WD's childhood, opportunities were missed to disrupt the ever-increasing risk to which WD was exposed, and that she posed to herself and others. Simply put, systems – including the out-of-home care, mental health, disability support, policing and justice systems – did not meet her needs.

Indeed, these systems are too often not working to meet the needs of Victoria's most vulnerable children. Sadly, the inquiry reflects many issues that have been highlighted in the Commission's past inquiries and that have not yet been sufficiently addressed.

Reliance on contingency placements for our most at-risk children

The inquiry found serious deficiencies in the system designed to care for the most at-risk children and young people in the care system. Children like WD, who cannot be matched with foster carers or be placed in existing residential care homes, are placed in temporary homes under 'contingency care' arrangements. In practice, what is intended as an emergency and temporary solution can become a longer-term arrangement, making them vulnerable to breakdown. This in turn leads to the need for multiple contingency placements, each in different locations and with different care providers.

This was the case for WD, who spent three years being moved through ten different contingency care placements that, despite the efforts of some of the people trying to care for her, were inappropriate and unsafe. These arrangements cost the state over \$3 million. They required

more effective monitoring and oversight by DFFH. WD's experiences in these placements and the instability she faced led to a disruption in her schooling and access to supports. This also resulted in WD increasingly leaving her placement.

Inadequate responses to children going missing from care

Unstable and poor quality of care contributes to further harm for children and can lead to their exposure to serious harms in the community. This was true for WD, who was reported missing hundreds of times, sometimes for days at a time. Between Child Protection, Victoria Police and care providers, efforts to respond to WD's absences and to ensure her safety were ineffective. In many instances, these attempts were inconsistent with relevant guidance.

This case again exposed – as previously identified in *Out of sight* – the urgent need to strengthen responses by Child Protection, Victoria Police and others to children who go missing from care to ensure they are protected from harm, including sexual exploitation, sexual assault and criminalisation. Responses to the increasing and extreme harms WD was experiencing when absent from care were ineffective and at times appeared to be impacted by service fatigue, desensitisation and a lack of clear, coordinated action between Victoria Police, Child Protection and care providers. The inquiry also identified concerns about insufficient access to forensic examinations when WD repeatedly attended hospital outside business hours.

Other issues highlighted

Other issues previously raised by the Commission and highlighted again in this inquiry are:

- the need to strengthen Child Protection's capacity to identify and respond to indicators of sexual abuse in the home
- the importance of supporting placement stability, including providing adequate support for kinship carers to help maintain kinship care arrangements
- that Child Protection's arrangements for coordinating enhanced, multi-agency responses to children and

Oversight and monitoring of out-of-home care *continued*

young people experiencing high levels of risk and harm are not consistently effective

- the need to provide adequate access to the National Disability Insurance Scheme for children and young people in out-of-home care, and for the National Disability Insurance Agency and Child Protection to work together to improve the process for funding and review applications involving this group of children
- the importance of education as a protective factor for children and young people in out-of-home care and the need to support ongoing school engagement, including by helping carers and care providers to support children to maintain this engagement
- that our health and mental health systems are not equipped to support young children with significant mental health concerns, particularly when these children lack a stable home and attachment figure.

Recommendations

Reviewing this child's treatment was a sobering task. WD's case is a tragic example of how Victoria's most vulnerable children can be failed by the systems designed to protect and support them. It demands systemic change, and the Commission's inquiry made 19 recommendations to drive improvements, directed at various departments and agencies. Some of the most critical recommendations relate to the need to:

- improve DFFH's oversight of and reliance on contingency placements
- improve responses to child sexual exploitation, including through a coordinated cross-agency approach, strengthened police responses that rely less on children to make formal statements, and greater support for children with complex trauma and disability to access forensic medical examinations, including outside of normal business hours
- strengthen Child Protection's multi-agency response to children and young people in out-of-home care who are experiencing high levels of risk, and have clearly defined

procedures for seeking senior advice and support when risk continues to escalate

- increase the mental health system's capacity to provide service outreach and case coordination for primary school-aged children who are in out-of-home care and those impacted by complex trauma.

The Commission will closely monitor the implementation of its recommendations.

Ongoing monitoring of WD's treatment and care²⁵

On 16 May 2024, criminal charges against WD were withdrawn, but the Secretary of DFFH sought orders allowing for ongoing restrictions to her movement. Following discussion with DFFH and given the unusual and complex nature of the case,²⁶ the Commission sought leave to intervene in the court proceedings as *amicus curiae* (friend of the court). Ultimately, the court authorised WD's ongoing placement in a secure facility and the use of certain other restrictive practices until December 2024, or a further order. The court also authorised the Commission to monitor WD's care and report to the court on her treatment.

The court order provides that DFFH give the Commission access to WD, the premises she lives in, and documents and information to enable the Commission to perform this monitoring role. This is the first time the Commission has intervened in court proceedings in this way. Having reviewed WD's treatment before the November incident, and the extent to which she has been repeatedly failed throughout her childhood, the Commission is committed to supporting her rights and wellbeing going forward.

²⁵ The Supreme Court Matter S ECI 2023 06014

²⁶ DFFH sought these orders once the charge of murder was withdrawn in the *parens patriae* jurisdiction of the Supreme Court, which allows a court to make orders for the protection of children and people who are otherwise not able to look after themselves.

Monitoring of out-of-home care incidents

Incidents reported in out-of-home care

There was a 17 per cent increase in the number of out-of-home care incidents reported in 2023–24 compared with the previous year (Table 12). Despite this increase, the Commission remains concerned that DFFH's Client Incident Management System (CIMS) does not capture all serious incidents impacting children and young people in out-of-home care, as raised in *Out of sight*.

This year also saw a decrease in the number of 'self-harm/attempted suicide' incidents and 'sexual exploitation' incidents reported, but the numbers remain worryingly high (947 and 190 respectively). Of concern in this year's reporting was the 71 per cent increase in reports of 'medication error' incidents.

Table 12. Incidents in out-of-home care (all care types) by incident type 2021–22 to 2023–24²⁷

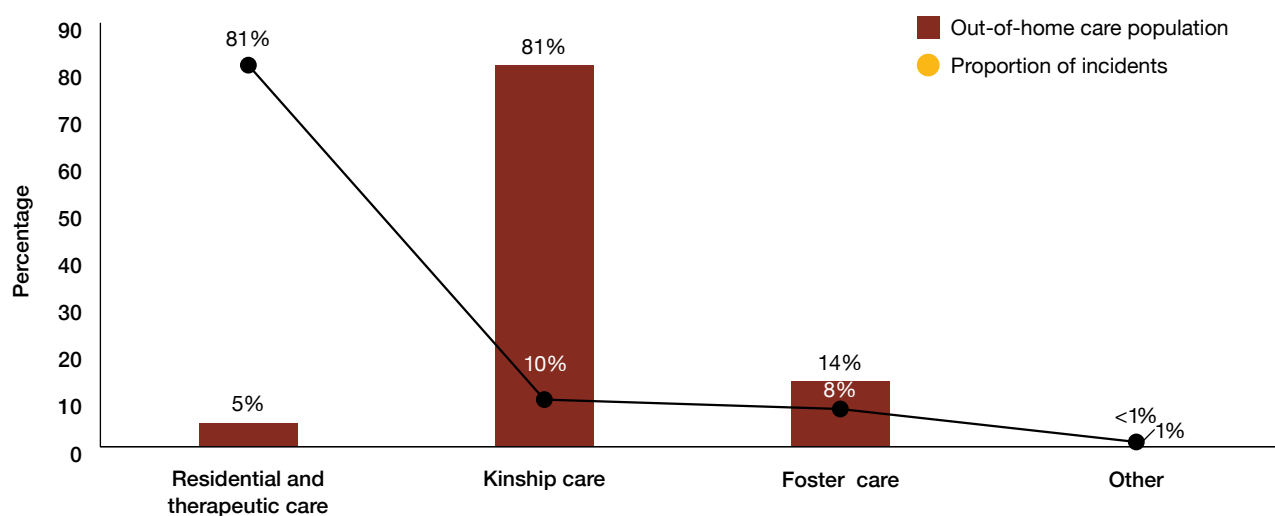
Incident type	2021–22	2022–23	2023–24	Percentage change 2022–23 to 2023–24
Absent client	3,559	3,603	4,517	25
Medication error	1,188	991	1,697	71
Dangerous actions – client	1,312	1,238	1,267	2
Self-harm/attempted suicide	1,387	1,068	947	-11
Inappropriate physical treatment	620	701	683	-3
Physical abuse	697	665	624	-6
Injury	512	482	620	29
Emotional/psychological abuse	311	302	360	19
Poor quality of care	212	320	343	7
Sexual abuse	334	343	342	0
Emotional/psychological trauma	260	190	232	22
Inappropriate sexual behaviour	175	154	190	23
Sexual exploitation	305	239	190	-21
Financial abuse	5	5	7	40
Death ²⁸	5	2	4	100
Escape from a secure facility	2	3	1	-67
Total	10,884	10,306	12,024	17

²⁷ These figures are extracted from DFFH's live database, and small data variations may occur against last year's annual report figures.

²⁸ These numbers vary from last year's annual report following DFFH advice that, while reported as deaths in out-of-home care, subsequent examination by the department determined that a number of the deaths were related to clients of Child Protection who were not in out-of-home care.

The greatest proportion of incidents reported in out-of-home care continue to come from residential care (81 per cent), despite this group of children and young people making up only five per cent of the out-of-home care population (Figure 1).

Figure 1. Out-of-home care population and proportion of incidents by care type 2023–24



Reviews of incident reports

Section 60A of the *Commission for Children and Young People Act 2012* (CCYP Act) requires the Secretary of the department to provide the Commission with information about all adverse events involving children and young people in out-of-home care. The Commission reviews each incident report to identify significant incidents and particularly vulnerable and at-risk children and young people in out-of-home care, and to identify systemic issues that require the department’s attention.

This year the Commission reviewed 12,394 incident reports compared with 10,315 in the previous year, a 20 per cent increase.²⁹ Of these incident reviews, the Commission initiated 102 incident queries, compared with 88 in the previous year. Aboriginal children and young people were involved in almost half of our incident queries. Most of our incident queries (83 per cent) related to children and young people in residential care.

Many of our incident queries sought to understand the strategies in place for children and young people who were away from placement for significant periods or reported to be involved in dangerous situations. As shown in Table 13, almost one-third of our queries related to children and young people absent from placement, over one-fifth involved dangerous actions, one-fifth involved self-harm and eight per cent were about children and young people reporting that sexual abuse had occurred in a range of settings.

²⁹ The number of incidents reviewed by the Commission is more than the number of incidents reported because some incidents reviewed in the current financial year were reported in the previous financial year (that is, more than 300 incidents reviewed in the 2023–24 year were received in the previous financial year).

Table 13. Out-of-home care incident queries by the Commission 2023–24

Incident type	No.	%
Absent/missing person	31	30
Dangerous actions – client	22	22
Self-harm/attempted suicide	20	20
Sexual assault/sexual abuse	8	8
Emotional/psychological abuse	5	5
Medication error ³⁰	4	4
Poor quality of care	3	3
Behaviour/sexual exploitation	2	2
Injury	2	2
Physical assault – other > client	2	2
Inappropriate sexual behaviour	1	1
Physical assault – client > client	1	1
Physical assault – staff > client	1	1
Total	102	100

Issues identified through incident monitoring

Through our review of out-of-home care incident reports, the Commission at times identifies trends or themes and raises these with DFFH with the aim of improving service responses to children and young people in out-of-home care.

Supporting children and young people in residential care to make complaints to Victoria Police

Between October 2018 and October 2023, we identified 63 reported incidents involving children and young people who alleged that Victoria Police had assaulted or mistreated them. The majority were reported by children and young people in residential care (88 per cent), and a quarter of the children and young people were Aboriginal.

³⁰ Medication error incident queries included errors involving incorrect medications or doses administered, refusal by children and young people to take medications, missed medications and other errors.

In January 2024, the Commission wrote to DFFH raising concerns about gaps in policy and practice supporting children and young people in residential care to make complaints about or raise concerns with Victoria Police. Through our monitoring of out-of-home care incidents, we found inconsistent responses to children and young people's allegations of mistreatment by Victoria Police, leading to few of these allegations being reported to police so they could be investigated.

The Commission welcomes the department's work with Victoria Legal Aid to produce and provide resource packs for children and young people to inform them of their rights to complain about mistreatment by Victoria Police. However, we urge DFFH to ensure staff are aware of, trained in and supported to assist young people with making a complaint. We encourage DFFH to provide resources for staff to build their competence and confidence to support children and young people in residential care to make a complaint about Victoria Police, including options to report to the Independent Broad-based Anti-corruption Commission and Professional Standards Command within Victoria Police.

Staff screening in Secure Care Services

In February 2024, we wrote to DFFH following the substantiation of a reportable conduct allegation that highlighted risks to the safety and wellbeing of children and young people in Secure Care Services.

As part of the Commission's monitoring role, we sought advice about pre-employment checks, supervision of staff, processes for monitoring staff interactions with children and young people, systems for staff to raise concerns about colleagues' behaviour, and processes for children and young people to make complaints about staff in Secure Care Services.

We appreciate the department providing advice about the processes in place for staff screening and monitoring in secure care and the mechanisms for children and young people and staff to raise complaints or concerns about staff practice. We are pleased that complaints processes

are in place for both children and young people and staff at Secure Care Services, and we encourage DFFH to regularly monitor these processes, including seeking feedback and input from children and young people.

Children and young people as victims of sexual exploitation

The Commission remains seriously concerned about the sexual exploitation of children and young people in residential care and the under-reporting of these incidents. In 2023–24, there were 190 recorded incidents of sexual exploitation in out-of-home care. Based on previous analysis of under-reporting, this is likely to represent only a small proportion of the exploitation that providers know or suspect is occurring.³¹

Through our incident monitoring, we continue to see sexual exploitation referenced in other incident categories like ‘absent client’ and ‘dangerous actions-client’, diminishing the visibility of sexual exploitation for specific intervention. The Commission wrote to DFFH about these concerns in August 2023, noting inaccurate reporting can lead to an inaccurate assessment of children and young people’s experiences of harm and, consequently, inadequate responses to this harm. The Commission hopes to see these issues addressed in the department’s implementation of findings from its CIMS review.

Case study:

Hanna

Hanna is a 17-year-old girl who came to the attention of the Commission through our incident monitoring when she was 15 years old. For the past two years, the Commission has continued to monitor Hanna’s incidents, which have involved long absences from placement including multiple days and at times weeks, poly-substance use and criminal and sexual exploitation. Hanna has been involved in serious incidents that often put her at risk of significant harm or death that include 57 absences from placement, 23 reported incidents of sexual exploitation and 21 ‘dangerous actions’. The Commission has met with DFFH on several occasions about the services and strategies in place to keep Hanna safe. The Commission acknowledged the various strategies implemented by the department to try to protect Hanna and reduce her risk but requested a case review given these strategies appeared to have little impact.

The case review included collaboration with Victoria Police, which led the organisation to reform its approach to the disruption of sexual exploitation involving children and young people in residential care.

More broadly, the Commission remains concerned about the often lengthy absences, exploitation and high-risk behaviours involving children and young people in residential care. Hanna’s case is another example of the need to continue strengthening responses from Child Protection, Victoria Police and others to children who go missing from care and become victims of sexual and criminal exploitation, and to revisit systems to ensure they promote the most effective responses to suspected or known exploitation.

³¹ Commission for Children and Young People, *Out of sight: Systemic inquiry into children and young people who are absent or missing from residential care*, 2021, pp 125–7 and Finding 18. That inquiry found that for every reported incident of sexual exploitation, there were four incidents reported as ‘absent client’ incidents that referenced risks of or actual sexual exploitation for the child. This suggests only 20 per cent of known or suspected sexual exploitation was reported as such under DFFH’s reporting guidelines. This issue has not improved in the three years since the *Out of sight* report was published.

Progress on systemic issues identified in previous years

Gender identifiers in CRIS

In response to an issue first identified by the Commission in 2019, DFFH introduced guidance for Child Protection staff engaging with children and young people about their gender identity and recording non-binary genders. We are pleased that as part of this work, this year, the department has finalised data system amendments to support the accurate recording of a child or young person's affirmed gender in Client Relationship Information System (CRIS).

Placement of children under the age of 12 in residential care

Through a series of letters in 2022, the Commission raised concerns with DFFH about the number of children under the age of 12 in residential care settings and the risks younger children face in these settings. In 2023–24, nine per cent of the children and young people in residential care were under 12 years of age (41) compared with 54 children and young people or 11 per cent in 2022–23, reflecting a small decrease from last year.

The Commission urges the department to finalise the client matching and placement planning framework that was recommended in the 2019 *In our own words* inquiry, particularly as it relates to the placement of children under 12, to continue to support this important work to minimise the presence of young children in residential care.

Medication errors by staff and abuse of over-the-counter medications

In 2021 and 2022 the Commission wrote to DFFH referencing a significant number of medication errors in residential care that involved staff error. The Commission called for the department to take urgent action to improve systems for administering medication in residential care.

In March 2023, the Commission wrote to the department after identifying a series of incidents involving the dangerous consumption of non-prescription ('over-the-

counter') medication by children and young people in residential care. The Commission recommended that the department review its current advice, policies and procedures for care providers.

The Commission acknowledges the department's work in 2023–24 to develop new policy and practice documents to support children and young people to meet their medication needs, including requirements and guidelines for medication administration and management in residential care. The Commission is also pleased to see that many of the commitments the department made in response to our earlier engagement concerning medication errors have been incorporated in the new policies and guidelines. This includes minimum expectations for community service organisations and Aboriginal community-controlled organisations (ACCOs) regarding medication prescription, administration, storage, disposal, management and planning. The 71 per cent increase in reported medication errors this year suggests this guidance must be accompanied by practice and process improvements by care providers.

Rights-based monitoring of residential care

The Commission conducts onsite monitoring of a selection of residential care homes twice a year. We are grateful to the children and young people who welcomed Commission staff into their homes and shared their thoughts and experiences with us.

Extracurricular activities and contact with family and friends

In late 2023 the Commission conducted a statewide residential care monitoring activity to understand children and young people's experiences of extracurricular activities and contact with family, friends and significant people while living in residential care. Drawing on the *Charter for children in out-of-home care*,³² Commission staff met with

³² Section 16(1)(f) of the *Children, Youth and Families Act 2005* identifies that the Secretary, DFFH, has a responsibility to publish and promote a charter for children in out-of-home care to provide a framework of principles to promote the wellbeing of those children. See *Charter for children in out-of-home care*, <https://services.dffh.vic.gov.au/charter-children-out-home-care>.

Oversight and monitoring of out-of-home care *continued*

20 children and young people living in eight randomly selected residential care homes across Victoria.

The Commission found that:

- few children and young people took part in activities in the community
- children and young people from culturally and linguistically diverse backgrounds did not have the same opportunities to take part in cultural activities
- nearly half of the children and young people said religion was important to them and almost a quarter said they wanted to attend religious activities.

These experiences demonstrated the need for staff to have deliberate, proactive and ongoing conversations with children and young people about activities they might be interested in, including community, cultural and religious activities, and to take action to support them to happen.

Observations from children and young people

I would like to play netball for a club.

I would like to do cultural dancing again.

My family are Muslim. I would like to go to a mosque when I am older.

I used to attend church. I would like to attend church.

The Commission found that for Aboriginal children and young people, keeping in contact with family living in different parts of Australia, including regional, rural and remote areas, can be challenging. Aboriginal children and young people's experiences highlighted the critical importance of supporting them to maintain connection to culture, including visiting family who live outside of Victoria.

Observations from Aboriginal children and young people

It is hard keeping in contact with family who are far away.

I want to go to the Tiwi Islands to see Dad and family.

I spend time with both my nana, aunties and mum.

Mum's family are in Alice Springs. I wouldn't mind going there.

Recommendations

The Commission's report on residential care monitoring, provided to the Minister for Children in December 2023, made the following recommendations:

- that residential care workers and care teams are supported to embed proactive conversations with children and young people about their interest in participating in activities in the community into their case practice
- that opportunities are improved for children and young people from culturally and linguistically diverse backgrounds to connect to their community and culture
- that all Aboriginal children and young people are provided regular opportunities to connect with their community and culture, including return to Country visits.

In response, the department advised:

- it funds \$850,000 per annum ongoing to ACCOs as brokerage to help implement cultural support plans, which includes return to Country
- a brokerage policy framework extending the use of funding provided to support the implementation of cultural support plans, including visiting family who

reside outside of Victoria, is now effective. Organisations have received guidance on how to use cultural plan brokerage funding to enable return to Country and other goals within a cultural plan

- it will continue to incorporate questions into the residential care audit process regarding extracurricular activities, cultural engagement and how young people from culturally and linguistically diverse backgrounds are supported
- it will continue to work with the Cultural Engagement Program to understand more about what constitutes best practice for providers in the enrichment of children and young people in residential care.

The department also advised that it shared the report findings with operational staff in the department and with all residential care providers.

Food in residential care

In 2024 the Commission began its sixth residential care monitoring activity focused on the provision of food to children and young people in residential care. The Commission will prepare a report for the Minister for Children and the department in late 2024.

Progress against previous inquiries

As in past years, the Commission requested an update from the department on the following inquiries relating to the out-of-home care system as at 30 June 2024:

- *In our own words: Systemic inquiry into the lived experience of children and young people in the Victorian out-of-home care system* (2019)
- *Keep caring: Systemic inquiry into services for young people transitioning from out-of-home care* (2020)
- *Out of sight: Systemic inquiry into children and young people who are absent or missing from residential care* (2021).

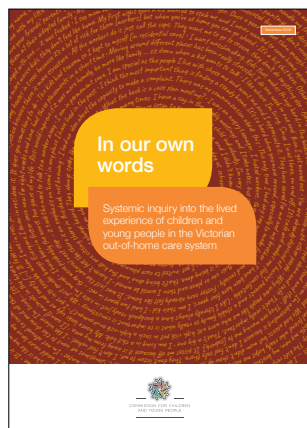
Whole-of-system investment model and strategy

A number of the Commission's systemic inquiry recommendations³³ refer back to recommendation 1 in *Lost, not forgotten* (see discussion on page 48) and recommendation 1 in *In our own words*. These recommended that the Victorian Government analyse drivers of demand for child and family services, including child protection, early intervention services and the out-of-home care system, and use the analysis to develop an evidence-based investment model and strategy to ensure funding allocated for these critical social services is enough to meet demand, provide safe, quality care and, importantly, provide earlier interventions to address harms to children in the family.

This year the department reported that it has conducted an analysis of drivers of demand and the implications for resourcing levels. This will inform the investment strategy and advice to government and external stakeholders about where to focus investment to deliver reform priorities and support the best possible outcomes for children and families experiencing vulnerability. The Commission welcomes some progress on this foundational step and looks forward to further progress.

³³ *Lost, not forgotten*, recommendation 1; *In our own words*, recommendation 1; *Keep caring*, recommendation 1; *Out of sight*, recommendation 2.

In our own words



The Commission's *In our own words* inquiry report, tabled in the Victorian Parliament on 27 November 2019, examined what it is like to be a child or young person in the out-of-home care system. *In our own words* found a pressured, poorly resourced system that repeatedly failed to take the views of children and young people into account when deciding where they should live, what they needed from their workers and carers, what was happening to them in care, and the contact they had with friends, family and community.

In our own words made 17 recommendations calling for whole-of-system change and sufficient resourcing to achieve important reforms including:

- new models of care tailored to each child's needs, with more flexible placement options including two- or single-bed placements with appropriately skilled staff and a form of professional foster care
- greater supports to help staff and carers respond to children and young people's trauma
- measures to support connection to culture for Aboriginal children and young people in care, and investment in Aboriginal-led services to support early intervention and stop the over-representation of Aboriginal children and young people in the care system

- reforms to ensure children and young people in care have a single, stable worker and that workers have regular face-to-face contact with them
- better monitoring and reporting on the out-of-home care system and its impact on children and young people.

The Victorian Government accepted six recommendations in full and 11 in principle. A full, updated table showing the original recommendations and the department's progress against each one is available on the Commission's website.³⁴

The 17 recommendations cover 42 proposed actions. This year the Commission identified two as complete and ten where some progress has been made, noting that ongoing systemic efforts are needed in relation to five actions. Significant progress was noted in relation to five, and there were six actions where no activity had occurred in the reporting year.

In the years since *In our own words* was tabled, the Victorian Government has increased investment in the child protection workforce, additional tailored forms of residential care, improvements in base funding for residential care, as well as a range of other improvements to the care system. Some of these investments are still being rolled out. Importantly, the government has also continued to fund vital early intervention supports and has invested in new programs to provide more intensive supports for families at risk of child removal and to support reunification. These programs secured a further \$198 million in the 2024–25 State Budget, enabling them to continue their vital work.

The Victorian Government has also continued to invest in reforms to support Aboriginal self-determination in the out-of-home care and child protection systems, including the transfer of state functions to ACCOs. The 2023–24 State Budget included a further \$63.9 million over four years to grow the number of children in the Aboriginal Children in Aboriginal Care program.

Despite these measures, however, most of the issues that impacted children and young people when we conducted

³⁴ See <https://ccyp.vic.gov.au/inquiries/systemic-inquiries/in-our-own-words/>.

our *In our own words* inquiry remain. Data obtained for our most recent inquiry, *Let us learn*, indicates that placement instability, high caseloads and worker turnover have not improved and in some instances have worsened. Almost one in five children in care who are case managed by Child Protection have no allocated worker.³⁵ In 2023–24 the department completed its planned review of the Child Protection Operating Model, and work to support staff recruitment and retention is ongoing. Further efforts are clearly needed to realise a stable workforce and manageable caseloads for practitioners so children and young people receive the contact and attention they need.

New models of residential care, including the KEYS model³⁶ and the tailored two- and three-bedroom homes, offer a major improvement in the quality of care provided. Unfortunately, these are still only available for a fraction of the residential care population, and many children and young people in residential care are not yet receiving the care, stability and supports they need.

While new family preservation and reunification programs are welcome and vital and must continue, there are still significant gaps in early intervention and supports for families with complex needs, and the number of children and young people in care is not reducing.

The Commission recognises that the scale of change needed to deliver a safer, more stable and supportive care system is significant and will take time. We encourage the department to continue this work, noting a number of recommendations were not progressed this year. For example, *In our own words* recommended clear guidance to case workers from Child Protection, CSOs and ACCOs about the need to ask children and young people in care about their safety while not in the presence of their carers. This has yet to be actioned. *In our own words* found that this was critical to ensuring children and young people can raise safety or other concerns about their placement.

The Commission also encourages the Victorian Government to continue to address funding and quality of care shortfalls in a system that continues to fail too many children.

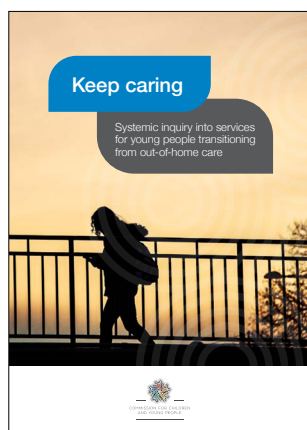
Finally, when reliant on a stretched and imperfect system and without access to a stable, known worker, it is vital that children and young people in care can access assistance and advocacy when they have problems with their care experience. This year the Commission welcomed amendments to the CCYP Act to enable the Commission to advocate for and provide advice, information and support to children and young people in care. While the new powers are welcome and much needed, the function remains unfunded and so cannot yet deliver supports for the children and young people who need it. The Commission will continue to advocate for funding so the legislative changes can result in meaningful assistance and advocacy for children and young people in care.

³⁵ Commission for Children and Young People (2023), *Let us learn: Systemic inquiry into the educational experiences of children and young people living in out-of-home care*, page 110.

³⁶ Keep Embracing Your Success – Residential Care Model

Oversight and monitoring of out-of-home care *continued*

Keep caring



The Commission's *Keep caring* inquiry report, tabled in the Victorian Parliament on 9 December 2020, considered what happens to young people when they leave care and whether young people in out-of-home care get enough help to transition to adult life.

Keep caring highlighted poorer outcomes for young people leaving care compared with other young people, including higher levels of homelessness, involvement with youth justice and admission to hospitals and mental health services. We found that the out-of-home care system is not doing enough to help young people in care to plan and prepare for their lives after care.

Keep caring made 15 recommendations and proposed 21 actions that built on the recommendations made in the *In our own words* inquiry report. This included implementing a new model of care that embeds a young person's life aspirations, talents and goals into everyday case management, planning and their day-to-day care. It also recommended a significant increase in the availability of post-care supports, an enforceable right for all young people who have left care to post-care supports and the universal extension of the Home Stretch program.

Based on the 2023–24 update, the Commission assessed five actions to be complete, seven where progress has been made and two where significant progress was made but further systemic effort is required. There were two

actions that had not been progressed in the current reporting year. A full table showing the original recommendations and DFFH's progress on each one is available on the Commission's website.³⁷

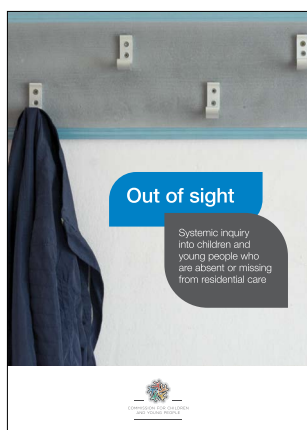
The Commission welcomes the significant investment into supports for young people leaving care through successive State Budgets, including the \$32.5 million announced in the 2023–24 State Budget for the Housing First for Young People Leaving Residential Care initiative. This initiative will provide guaranteed housing for at least two years as well as casework support and outreach for 225 young people leaving residential care and other settings.

The Commission has also been pleased to see the supports put in place for young people transitioning from care who need ongoing access to services for mental health and substance use – and considers work in relation to this recommendation complete.

The Commission's recommendation to amend the *Children, Youth and Families Act 2005* to include an enforceable right for young people who leave care between the age of 16 and 18 to receive services and supports to transition to independence until at least the age of 21 has not progressed. The 2021 Bill, which would have enshrined this right in legislation, lapsed in Parliament. The Commission urges the government to reintroduce these important amendments for the protection of young care leavers.

³⁷ See <https://ccyp.vic.gov.au/inquiries/systemic-inquiries/keep-caring/>

Out of sight



The Commission's *Out of sight* inquiry report, tabled in the Victorian Parliament on 24 June 2021, examined how often and why children and young people are absent or missing from residential care, what happens when they are, and what can be done to better respond to the issue.

Out of sight found reporting of children and young people going missing from care is inconsistent and as a result no-one knows the full extent of the problem. Despite this under-reporting, the Commission noted there were 7,431 warrant applications over an 18-month period. During those 18 months, 955 children and young people spent time in residential care.

When away from care, children and young people experience a range of serious harms. The Commission found that sexual exploitation of children is a serious concern and that many efforts previously in place to protect children from this abuse had ceased. Overall, the inquiry found that the current model of residential care is not meeting children and young people's need for human connection or, in many cases, safety. Consequently, many children and young people leave care to find connection elsewhere, with family, friends or through sexually or criminally exploitative relationships.

Out of sight made 18 recommendations to support children and young people to remain in residential care, to

safeguard them when they are absent or missing and to support them when they return. The recommendations built on our previous inquiries and included:

- driving cultural change to tackle stigma and criminalisation
- implementing a relationships-based, trauma-informed residential care model
- developing training, tools and guidance to support frontline workers across all relevant agencies, including Victoria Police, to deliver a trauma-informed approach.

We also recommended urgent reforms to better protect children and young people including:

- the rollout of statewide, cross-agency responses to child sexual and criminal exploitation
- reduced reliance on police and other measures that are experienced as punitive or stigmatising by children and young people
- improvements in information collection, monitoring and oversight.

The 18 recommendations captured 33 proposed actions. This year the Commission reviewed the department's update and assessed one to be complete, 22 where progress has been made and one where progress has been made and ongoing systemic effort is required. There were seven actions that had not been progressed in the current reporting year. A full table showing the original recommendations and the department's progress on each one is available on our website.³⁸

The Commission welcomed last year's investment to improve Child Protection's response to children and young people who go missing from care and are sexually exploited. This funding has seen the recruitment of additional sexual exploitation practice leaders and work towards an enhanced intelligence approach, to be developed jointly with Victoria Police. Victoria Police has also advised the Commission of work underway to enhance police capabilities to detect and respond to

³⁸ See <https://ccyp.vic.gov.au/inquiries/systemic-inquiries/out-of-sight-systemic-inquiry-into-children-and-young-people-who-are-absent-or-missing-from-residential-care/>.

Oversight and monitoring of out-of-home care *continued*

sexual exploitation. The Commission also notes and looks forward to DFFH's proposed child exploitation strategy, noting the need for urgent progress given what we continue to see in our inquiries and incident monitoring.

The Commission hopes to see DFFH's implementation of findings from its CIMS review address the issue of serious underreporting of children and young people missing from care and those victimised by child sexual exploitation.

Approaches from the public

The Commission responds to a wide variety of approaches and complaints from the community, mostly about the safety and wellbeing of children and young people known to Child Protection or in out-of-home care.

This year the Commission responded to 499 approaches, an increase of 24 per cent on the previous year (404).

Most approaches came from family members (293), and the primary reason for contacting the Commission was to report suspected child abuse (55) or raise safety concerns about a placement decision made by Child Protection (46). Over a quarter of approaches or complaints were about Aboriginal children and young people.

As discussed above, legislation came into effect on 1 July 2024 giving the Commission stronger powers to assist and advocate for children and young people known to Child Protection. Unfortunately, additional resources have not been provided to support these new powers, so the Commission's capacity to raise children and young people's awareness of this avenue for support is limited. The Commission will respond to children and young people who come to us for assistance and advocacy within our existing resources and continue to call on government to resource this much needed new function.

Oversight and monitoring of youth justice

Oversight and monitoring of youth justice

When children and young people are detained in closed environments, like youth justice custodial centres, independent oversight of their treatment is critical.

In 2023–24 our work in this area included:

- advocating for systemic improvements in youth justice centres
- an individual inquiry into the experiences of a young person exiting youth justice
- operating a monthly Independent Visitor Program (IVP) at each youth justice centre, including the new Cherry Creek Youth Justice Precinct
- monitoring incidents in custodial settings, as well as incident trends and the use of force, isolation and lockdowns
- providing a standby function in case children are detained by Victoria Police in preventative detention under the *Terrorism (Community Protection) Act 2003*
- assessing progress against past inquiries.

Advocating for system improvements in youth justice centres

This year the Commission continued to identify and raise concerns about a range of issues affecting children and young people's safety and wellbeing in youth justice custody including:

- high rates of behavioural isolations and lockdowns
- management of children and young people's complaints.

High rates of behavioural isolations and lockdowns

Youth Justice practices that contain children and young people in their rooms for extended periods have a serious and detrimental impact on access to education, exercise, fresh air, recreational activities, cultural and social support and overall wellbeing.

Isolations

Episodes of 'behavioural' isolations typically occur in response to an incident. The *Children, Youth and Families Act 2005* (CYFA) allows a child or young person to be held in a locked room, separate from others and away from the normal routine of the centre when:

- all other reasonable steps have been taken to prevent the person from harming himself or herself or any other person, or from damaging property
- the young person's behaviour presents an immediate threat to themselves or others or property (section 488(2)).

This year, despite a seven per cent reduction in the average monthly number of children and young people in youth justice custody (Figure 2), isolations under section 488(2) of the CYFA were over five times higher than in 2022–23 (503 per cent increase) – a dramatic increase across Victoria's youth justice custodial centres. The rate of isolation episodes per individual child or young person also increased from four to 20 episodes for the year (Figure 3).³⁹

³⁹ These figures are extracted from the Department of Justice and Community Safety's live database. Small variations in data have been reported by the department compared with other published data.

Figure 2. Average monthly number of children and young people in youth justice custody July 2020 to June 2024

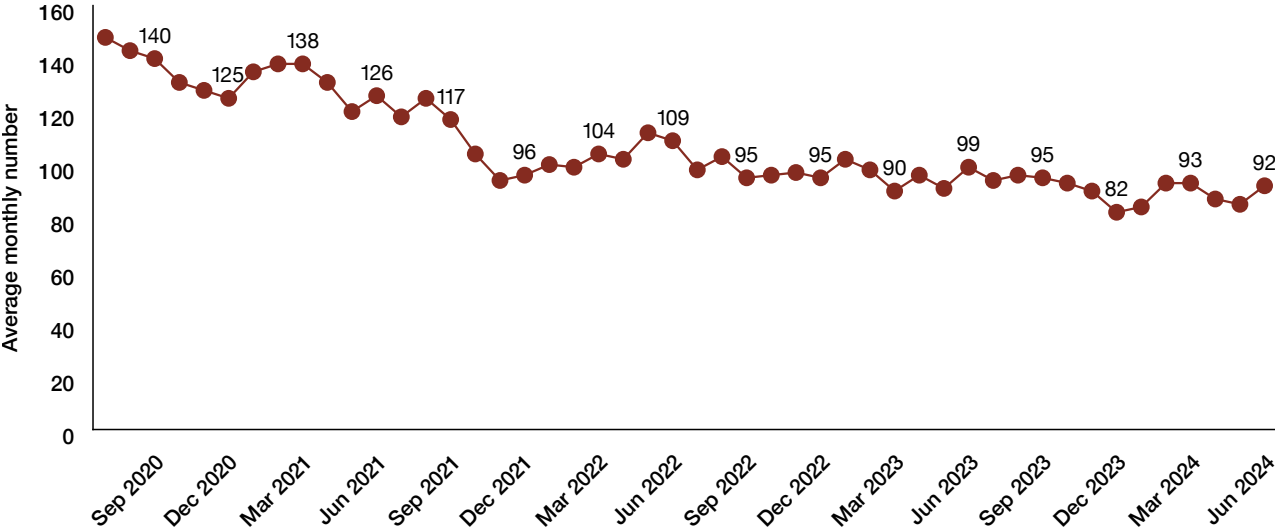
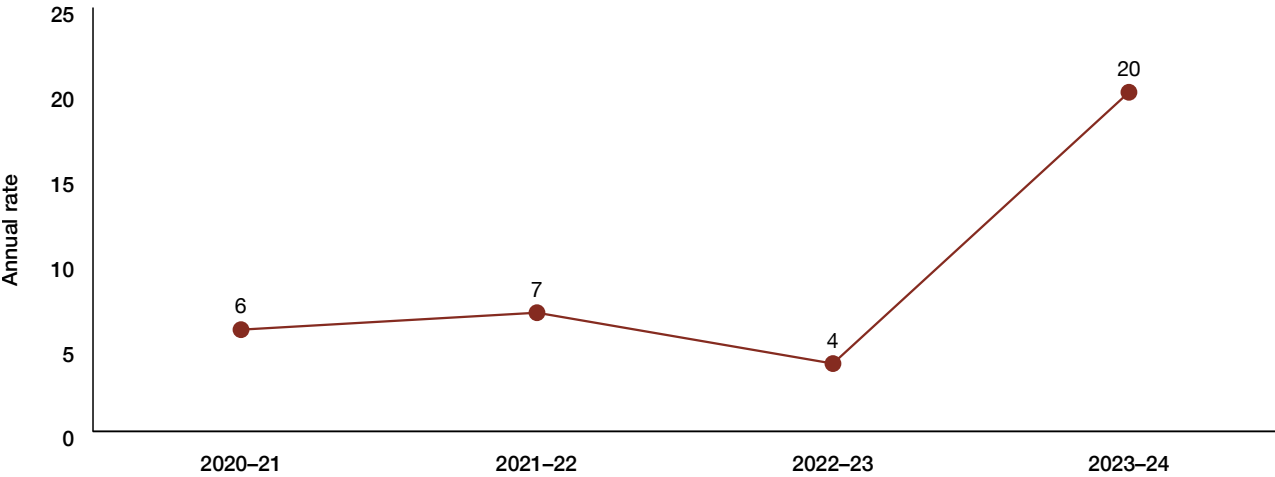


Figure 3. Annual rate of isolations for behavioural reasons per unique child or young person per year under section 488(2) of the Children, Youth and Families Act 2020–21 to 2023–24⁴⁰



This significant increase in behavioural isolations is concerning. The CYFA is clear that isolation is only to be used in certain circumstances (section 488(2)) and not as a punishment (section 487(a)).

⁴⁰ A number of children and young people move between precincts, therefore the total number of unique children and young people locked down will not be the sum of the two locations.

The Commission has previously raised concerns about the excessive use of isolation on young people following an incident.⁴¹ In 2022–23, the Commission was pleased to observe significant reductions in the use of isolations from the previous year. However, it is concerning to see that these decreases have not continued and there are instead substantial increases in the use of ‘behavioural’ isolations over the past year (2023–24), despite a reduction in the average monthly number of children and young people in youth justice custody.

The Commission urges Youth Justice to take all steps necessary to reduce the use of isolation.

Lockdowns

The CYFA also allows a child or young person to be held in their room or in isolation rooms when it is in the interests of the security of the centre (section 488(7)). These are referred to as lockdowns. Most isolations, including lockdowns, occur within the young person’s bedroom.

This year, there was a 33 per cent decrease in the number of isolations under section 488(7) of the CYFA from 46,004 episodes in 2022–23 to 30,788 episodes in 2023–24 (Table 14).⁴² These lockdowns involved 319 unique children/young people. The rate of lockdown episodes also decreased from 117 to 97 per unique child/young person (Figure 4). While this decrease in lockdowns is welcome, lockdown rates remain unacceptably high.

A large number of these lockdowns are due to staff shortages, and Youth Justice undertook a range of strategies during 2023–24 to attempt to address this issue. Measures included recruiting new staff and a new process for the daily review of lockdowns. The Commission hopes to see further reductions in lockdowns in future years.

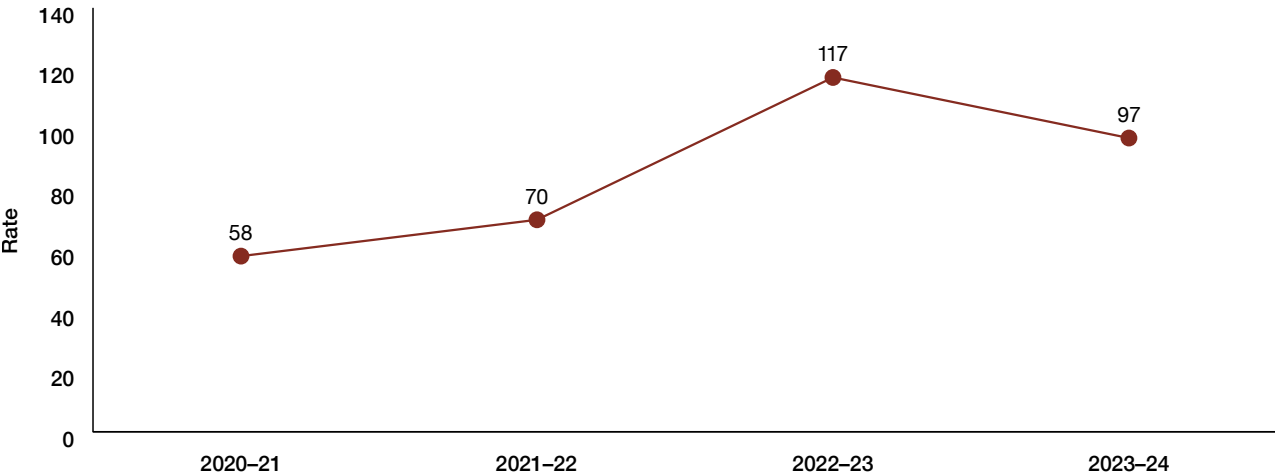
⁴¹ Commission for Children and Young People 2022, *The same four walls*, 2017; Letter from the Commission to DJCS regarding the use of ‘behavioural’ isolations, 6 April 2022.

⁴² These figures are extracted from DJCS’ live database. Small variations in data have been reported by DJCS compared with other published data.

Table 14. Number and rate of isolations for security reasons (lockdowns) under section 488(7) of the *Children, Youth and Families Act 2005* by precinct 2020–21 to 2023–24

Year	Episode data	Youth Justice Precinct			Total
		Cherry Creek ⁴³	Malmsbury	Parkville	
2020–21	Number of lockdown episodes	n/a	8,485	18,388	26,873
	Number of unique children and young people locked down	n/a	181	371	466
	Rate of lockdown episodes per unique child/young person isolated	n/a	47	50	58
2021–22	Number of lockdown episodes	n/a	8,513	15,335	23,848
	Number of unique children and young people locked down	n/a	167	263	340
	Rate of lockdown episodes per unique child/young person isolated	n/a	51	58	70
2022–23	Number of lockdown episodes	n/a	14,342	31,662	46,004
	Number of unique children and young people locked down	n/a	140	329	394
	Rate of lockdown episodes per unique child/young person isolated	n/a	102	96	117
2023–24	Number of lockdown episodes	3,650	4,207	22,931	30,788
	Number of unique children and young people locked down	73	59	289	319
	Rate of lockdown episodes per unique child/young person isolated	50	71	79	97

Figure 4. Rate of lockdowns per unique child or young person 2019–20 to 2023–24



⁴³ Note that Cherry Creek Youth Justice Precinct opened in August 2023.

Complaint handling

Youth Justice has been working for an extended period to improve complaint-handling processes for children and young people. While some work, including developing a guide for staff, has been undertaken by Youth Justice to address these issues over the past year, the Commission continues to have concerns about:

- the lack of a clear and shared understanding among staff and young people about the process for managing and investigating complaints received from children and young people
- inconsistent involvement of children and young people in investigating complaints
- the lack of consistent and timely processes for providing feedback to children and young people while a complaint is being considered, and when the matter is finalised.

The Commission has continued to observe instances in which serious complaints by young people (often relating to allegations of physical assault by staff) are not managed in a way that is consistent with standards expected of a government agency involved with vulnerable children and young people, and particularly those who are held in a closed environment such as a custodial setting.

In some cases, young people have had to raise their complaint with multiple staff members before it is documented and investigated. Young people often report lengthy delays in receiving outcomes of their complaint and frequently receive no resolution for their complaint if they leave custody. The Commission will continue to encourage further improvements to Youth Justice's complaint-handling processes, in particular the finalisation of a complaint management policy and procedure.

Independent Visitor Program

The IVP conducts monthly visits to Victoria's youth justice centres. Our volunteer independent visitors observe conditions at the centres, talk to children and young people about services and their experiences in custody, and report on their observations to the Commission after each visit. The Commission seeks to resolve issues with Youth Justice staff and management, with more serious issues escalated when required.

Issues raised

Children and young people raised 559 issues with the IVP during visits in 2023–24, a decrease of 22 per cent on 717 issues raised in the previous year.

Children and young people raised the greatest number of issues about access to programs and education, sentence management, food and meals. Young people also often raised concerns around health-related issues such as mental health, dental care and access to exercise equipment. All issues raised by children and young people are raised with leadership at the Youth Justice Precinct at the end of an IVP visit.

Education and programs

The number of issues raised about education and programs increased this year. Most of these issues related to the ability to access adequate programs of interest. The introduction of dual track sentenced young people⁴⁴ to Parkville after the closing of Malmsbury saw an increase in young people raising a concern that equivalent education and programs were not available at Parkville.

Many of the issues raised related to the delivery of programs for the older population, with young people seeking more vocational programs. Young adults strongly advocated for more Vocational Education and Training⁴⁵ courses such as building and construction, civil construction and electrical engineering. Young people

⁴⁴ Section 32 of the *Sentencing Act 1991* allows for the sentencing of a young offender to a youth justice centre until the young person's 21st birthday after having considered a pre-sentence report and it believes there are good prospects for rehabilitation, or it believes they are impressionable, immature or likely to be subjected to undesirable influences.

⁴⁵ Accredited Vocational Education and Training courses.

aged 14 to 18 had similar concerns about the ability to access meaningful programs and the lack of variety in education.

Young people consistently told visitors they would like to have jobs while in custody and learn skills that will assist their chances of gaining meaningful employment once they exit custody.

It will be important for Youth Justice to consider the specific needs of dual track sentenced young people in the youth justice system and to ensure they can access programs and education that will assist them to gain meaningful employment once they exit custody.

Sentence management – placement concerns

Concerns about placement grew from eight in 2022–23 to 25 in 2023–24. Many of the concerns raised related to the closure of Malmsbury and the relocation of young people from Malmsbury to Parkville. The concerns related to differences in rules, programs, and living and accommodation arrangements. Young people across all precincts raised concerns about placement decisions based on safety and concerns about mixing with other young people.

Food and food quality

Food presents as an important issue to young people during IVP visits. Young people raised over double the number of issues from the previous year about the food in youth justice centres, including issues with the general quality of food and concerns that they may become unwell from the meals provided. These issues were predominantly from Parkville Youth Justice Precinct. While some issues raised related to the quality of the food, some of the older population who were transferred from Malmsbury found their access to supplementary food items and capacity to cook for themselves allowed for less autonomy than at Malmsbury.

The Commission acknowledges Youth Justice responded to these concerns with a thorough review of the menu and cooking conditions. Young people have reported some improvement in the quality of food since the IVP escalated

their concerns. A range of programs and strategies are also being considered for the older population now at Parkville to be involved in planning and preparing meals.

October Malmsbury incident

In the lead up to the closure of Malmsbury, a significant incident took place that saw several young people sustain serious injuries. The independent visitors ensured they spoke to all young people involved in this incident and listened to their experiences in detail. The visitors provided a safe space for young people to express their feelings around the way the incident was managed and the seriousness of the event.

Importantly, the visitors were able to obtain information and accounts of events that were not previously known to Youth Justice. The young people involved felt the precinct had failed to keep them safe. A range of issues raised by young people victimised in the October incident were provided to Youth Justice for their consideration and resolution.

Establishment of IVP at Cherry Creek Youth Justice Precinct

IVP began monthly visits at Cherry Creek Youth Justice Precinct in October 2023. Since then, IVP has attended Cherry Creek Youth Justice Precinct on a monthly basis, monitoring the operation of the new precinct including the conditions, treatment, safety and wellbeing of children and young people.

Since starting monthly IVP visits, children and young people have raised 116 issues during visits. The number continues to grow as the youth justice facility accommodates more children and young people.

IVP phonenumber

The IVP phonenumber provides children and young people in youth justice centres with greater access to the IVP outside of the monthly IVP visits.

This year the Commission received 33 phone calls from children and young people in custody. The most common issues raised related to staff behaviour and concerns

Oversight and monitoring of youth justice *continued*

about young people's safety. All issues were promptly raised with Youth Justice for resolution.

Celebrating the Commission's volunteer independent visitors

The IVP has been operating in Victoria's youth justice centres since 2012. Since this time, the Commission has observed the benefits of giving children and young people the opportunity to voice their needs and concerns. Volunteer visitors help the Commission to uphold the rights of children and young people in youth justice centres.

In 2023–24, the Commission recruited new volunteers, including Aboriginal volunteers, to support Aboriginal children and young people in custody. The Commission continues to seek volunteers to increase the number of independent visitors from Aboriginal, South Sudanese and Pacifica communities.

This program would not be possible without the hard work and dedication of our wonderful volunteers. We would also like to acknowledge the children and young people who trust us with their experiences and concerns and to facilitate resolution on their behalf.



Independent visitors John, Belinda, Joanie and Sue receiving awards for 10 years of volunteer service to the IVP at the 2024 Volunteer Week event

Volunteer week saw Principal Commissioner, Liana Buchanan, and Commissioner for Aboriginal Children and Young People, Meena Singh, present awards to four volunteers for ten years of service and dedication to the program.



Independent visitors with Principal Commissioner Liana Buchanan and Commissioner for Aboriginal Children and Young People Meena Singh and Commission Staff at the 2024 Volunteer Week event

Monitoring incidents in youth justice custodial settings

The Commission's oversight of incidents in youth justice provides us with a valuable understanding of the system and informs our broader advocacy.

Youth Justice recorded 78 category one incidents this year, 32 per cent less than the previous year (Table 15). The three most common incident types were:

- client on staff physical assaults (15 incidents)
- staff on client physical assaults (nine incidents)
- behaviour – dangerous incidents (nine incidents).

Table 15. Category one incidents in youth justice precincts by type 2021–22 to 2023–24

Category one incident	2021–22	2022–23	2023–24	Percentage change 2022–23 to 2023–24
Assault⁴⁶	40	32	45	41
Physical assault – client > client	13	13	7	-46
Physical assault – client > staff	17	9	15	67
Physical assault – other > client	1	1	3	200
Physical assault – staff > client	1	2	9	350
Sexual assault – indecent – client > client	2	0	0	0
Sexual assault – indecent – other > client	1	6	6	0
Sexual assault – indecent – staff > client	0	0	1	-
Sexual assault – rape – client > client	1	0	0	0
Sexual assault – rape – other > client	4	1	3	200
Sexual assault – rape – staff > client	0	0	1	-
Behaviour	13	8	11	38
Behaviour – dangerous	10	6	9	50
Behaviour – sexual	1	1	2	100
Behaviour – sexual exploitation	2	1	0	-100
Other	70	74	22	-70
Breach of privacy/confidentiality matters	1	1	1	0
Community concern	1	1	0	-100
Drug/alcohol	0	2	1	-50
Escape – from centre	0	2	0	-100
Illness	46	43	2	-95
Injury	7	10	7	-30
Medical condition (known) – deterioration	2	1	3	200
Poor quality of care	9	11	4	-64
Property damage/disruption	3	3	3	0
Suicide attempted	1	0	1	-
Total	123	114	78	-32

⁴⁶ These incident categories relate to allegations and do not indicate whether the allegation was substantiated (Youth Justice has advised that category types may be changed once investigations have concluded).

Oversight and monitoring of youth justice

continued

Category one incidents of ‘physical assault – staff to client’ increased from two to nine incidents from the previous year. The Commission notes that this increase may be partly due to the change in Youth Justice categorising allegations of assaults by staff from ‘poor quality of care’ to ‘physical assaults – staff to client’. There has been a corresponding reduction in the number of ‘poor quality of care’ incidents (64 per cent). The Commission welcomes the establishment of a more accurate reporting mechanism to record alleged and proven assaults or other misconduct by staff on children and young people in youth justice centres.

The Commission noted that children and young people reported 11 sexual assault incidents this year, including two allegations of staff to young people assault. Most of these incidents occurred in the community prior to a young person entering custody but were reported to Youth Justice. This data highlights the importance of ensuring access to appropriate sexual assault and other therapeutic responses for children and young people in custody.

The Commission also notes the increase in category one ‘physical assaults – client to staff’ this year. Last year there were nine reported incidents of client to staff assaults. In this reporting year, there were 15 incidents.

The Commission is encouraged to see that, in 2023–24, Youth Justice recorded fewer category one incidents involving client-to-client assaults (decrease of 46 per cent), and there was an overall decrease in category one incidents for the year (32 per cent decrease).

Use of force

There are nearly two instances of unplanned force against children and young people in youth justice custody recorded each day.⁴⁷ This year, there were 18 oleoresin capsicum (OC) spray incidents compared with 13 in the previous year. In our incident reviews this year, we have provided feedback to Youth Justice on a range of issues, including the importance of providing adequate warning before OC spray is used, the need to use de-escalation strategies where possible before applying force, the need

to ensure young people have access to medical checks if they have sustained injury and the importance of consistently complying with requirements to activate body-worn cameras.

In August 2023, the Commission welcomed the introduction of stronger mechanisms to internally monitor use of force by Youth Justice.

The Commission continues to encourage Youth Justice to ensure staff have the skills to use non-contact options and a trauma-informed approach to prevent and de-escalate incidents. It also encourages Youth Justice to strengthen processes for use-of-force record-keeping and improving observation and welfare check procedures after force is used on children and young people.

Incident queries

This year the Commission asked for additional information under section 60A of the *Commission for Children and Young People Act 2012* for 26 incidents in youth justice custody involving 52 children and young people. Nine of the children and young people involved in these incidents were Aboriginal (17 per cent).

Almost three-quarters of our incident queries related to incidents categorised as ‘behaviour – dangerous’ (23 per cent) and physical assaults (42 per cent).

Nearly one in five (19 per cent) of all incident queries related to staff-to-young person physical assaults, which includes alleged physical assaults by staff.

⁴⁷ Department of Justice and Community Safety use of force data, 2023–24.

Individual inquiry into a young person in youth justice

Jamal

In 2023 the Commission established an individual inquiry relating to Jamal, a young person who died shortly after leaving youth justice custody. The inquiry was established due to concerns raised with the Principal Commissioner about supports provided to Jamal prior to his death.

Jamal was a young person who had experienced a significant history of trauma in his formative years, with concerns related to family violence, physical harm, neglect and cumulative harm. As an adolescent, he experienced mental health issues including suicidal ideation and self-harm and was engaged in substance misuse and criminal behaviour. Jamal spent time in youth justice custody and, while the inquiry focused on Jamal's case management prior to and following his release from custody, it also looked at other services provided to Jamal, including by Child Protection.

In relation to Child Protection, the inquiry found that cumulative harm was not considered despite multiple Child Protection reports. Child Protection repeatedly referred the family to community services and closed the case, despite the family not receiving services to reduce the harms that Jamal and his sibling were experiencing.

Jamal's experience in youth justice custody was characterised by multiple periods of isolation, which impacted his access to mental health supports. The Commission found that during one of Jamal's admissions to Parkville Youth Justice Precinct, he was subject to 81 periods of isolation. Five of these were due to COVID-19 requirements. However, many of the periods of isolation for Jamal were recorded as 'GM/Ops Manager approved lockdown' with no further rationale. Some isolations included low staff numbers as a reason recorded for lockdowns.

The Commission has long raised concerns about the use of isolation and lockdowns in youth justice; Jamal's case illustrates the damaging impact of these practices on a

young person experiencing mental ill-health. The Commission found that when Jamal was released from Parkville, he was not connected to stable accommodation, mental health services or financial support. Although Jamal was given a list of critical services and contact numbers on his release, he was not provided with the means and support to engage with these services. The care team meetings lacked leadership and service collaboration to support and prioritise Jamal's immediate and fundamental post-release needs. Jamal was referred to a large number of services that he was expected to engage with in the community. However, his lack of accommodation and his escalating mental health concerns made engaging with services overwhelming and unrealistic. Jamal was consumed with the challenges of figuring out how to get his next meal and where he would sleep, which understandably affected his ability to reintegrate and function in the community and to meet his bail conditions.

The inquiry also found that Youth Justice did not make sufficient attempts to connect and engage Jamal in cultural supports. Jamal was referred to the Youth Justice Community Support Service, which included allocating a worker from the same cultural background as Jamal to help link him to services and connect him to culture. The attempts to engage Jamal were minimal and a more concerted effort was required to engage Jamal and increase his chances for positive outcomes.

The Commission made a number of recommendations, including that the Department of Justice and Community Safety (DJCS):

- reflect on barriers that resulted in the disconnect between Youth Justice practice guidelines and practice behaviours and outcomes for Jamal to inform and strengthen future practice – the focus should include mental health, cultural connection and proper oversight for approved plans for young people exiting youth justice
- consult with the Department of Families, Fairness and Housing on options for Multi-Agency Panels (MAP) to include senior representation from Homes Victoria

and/or the housing and homelessness sector for young people referred to MAPs with complex housing needs

- revisit training and development opportunities for the youth justice workforce, including the development needed to support transitional planning for a young person's release, cultural competency and trauma-informed practice.

Monitoring children aged under 18 years in adult prison

The Commission monitors the treatment of any child aged under 18 years serving a sentence in adult custody. Children in Victoria are placed in adult custody either because of a transfer from youth justice to adult corrections by the Youth Parole Board or after being sentenced to a term of adult imprisonment.

The Commission considers that children should not be held in the adult prison system and has made repeated recommendations for legislative change to prevent this from occurring, including in our individual inquiry conducted last year on a child held in adult prison. This year the Commission continued to monitor Corrections Victoria's management of that child. Monitoring included regular visits with the child, reviews of daily reports provided by prison management and weekly meetings with Corrections Victoria. Monitoring of the child concluded after they turned 18 years of age. The Commission was pleased that no other children entered adult prison in 2023–24.

Monitoring of other confined environments

Preventative detention

In 2018 the Commission gained powers to monitor the safety and wellbeing of children held in preventative detention in Victoria pursuant to a police detention decision or preventative detention order under the *Terrorism (Community Protection) Act 2003*. The Commission's powers include monitoring the treatment of a child detained in the above circumstances, promoting the interests of the child, accessing any document or information relating to the child's treatment while in detention and providing advice to the Attorney General, other relevant ministers or the Chief Commissioner of Victoria Police about the child's treatment while in detention.

Legislation requires that we report the number of times the Commission has performed its monitoring function as per the *Terrorism (Community Protection) Act 2003* in the relevant financial year and any general observations or conclusions the Commission may want to include in the report in relation to performance of its function. In 2023–24 the Commission did not exercise its preventative detention function.

Progress against previous inquiries

Inquiry about a child in adult corrections

In 2023 a child under the age of 18 years of age in adult custody contacted the Commission and reported that prison officers had put a spit hood on him earlier that day.

The Commission established an individual inquiry to examine the application of the spit hood, the child's management and care in the lead-up to the application of the spit hood and, based on this case, the need for any improvements to the management, care and custody of children in the adult prison system.

The Commission made ten recommendations in this inquiry. These recommendations included improvements to health-related information exchange protocols and escort procedures during medical appointments, and for procedures and processes for authorising water being turned off in a prisoner's cell. In response to some of our inquiry recommendations, Corrections Victoria has established a joint taskforce to work on a health information sharing policy for health and custodial staff. The Commission welcomes Correction Victoria's draft policy enhancements to escalate reporting and accountability when amenities are switched off and we await the final endorsement of these policies.

We also recommended that the Corrections Regulations (2019) be amended to prohibit the use of a spit hood on prisoners under the age of 18 years. Noting that Corrections Victoria's statewide policies have been updated to ban spit hoods for people aged under 18 years, we urge DJCS to progress amendments to the Corrections Regulations to ensure the practice is prohibited in law.

The same four walls

In 2017 the Commission undertook a systemic inquiry into the use of isolation and lockdowns in youth justice centres, *The same four walls: Inquiry into the use of isolation, separation and lockdowns in the Victorian youth*

justice system. As at June 2024, four recommendations remained outstanding:

- recommendation 1: that the Victorian Government amends the CYFA to clarify the purpose of isolation and the circumstances under which a young person can be isolated
- recommendation 10: that the Victorian Government amends the CYFA to ensure that all young people in youth justice centres have at least one hour of fresh air each day
- recommendation 11: that the Department of Justice and Regulation⁴⁸ ensures that designated accommodation options for vulnerable children and young people are established in youth justice custodial settings, both in the proposed new facility and in existing centres
- recommendation 19: that the Department of Justice and Regulation publishes the Youth Justice Custodial Practice Manual to make its operations and policies (excluding security-related matters) visible to the community.

Recommendations 1 and 10 have now been acquitted through the Youth Justice Bill 2024, which was passed by the Victorian Parliament and was given Royal Assent in September 2024.

The department has now developed a draft isolation policy and procedure in consultation with the Commission and other stakeholders, covering both isolations and lockdowns. The Commission has welcomed improvements in reporting of each episode of isolation as part of the daily operational briefing process.

In relation to recommendation 11, the Commission encourages DJCS to consider how to implement this recommendation given the opening of Cherry Creek Youth Justice Precinct provides for increased placement flexibility and specific options for the placement of vulnerable children and young people.

⁴⁸ In November 2018, the Department of Justice and Regulation became the Department of Justice and Community Safety.

Improving outcomes for Aboriginal children

Improving outcomes for Aboriginal children

The Commission advocates for the rights and wellbeing of Aboriginal children and young people. This year the Commission focused on addressing systemic issues and promoting positive outcomes in child protection, youth justice and education.

In 2023–24 our work in this area included:

- developing resources to support cultural safety within organisations
- participating in statewide forums and advocating for improved outcomes for Aboriginal children and young people
- speaking to Aboriginal children and young people and their communities about their experiences of racism
- contributing to the Yoorrook Justice Commission
- monitoring outstanding recommendations of past systemic inquiries.

Child Safe Standard 1

Child Safe Standard 1 requires organisations to establish culturally safe environments in which the diverse and unique identities and experiences of Aboriginal children and young people are respected and valued. The implementation of this Standard is of high importance for the Aboriginal community because experiences of racism and lack of cultural safety prevent their full participation in education, hobbies and sports, as well as access to important services.

The Commission has played a lead role in raising awareness of this Standard and resources for implementation. More information can be found in the *Supporting and regulating child safe organisations* chapter of this report.

Strategic advocacy

Partnership forums

Partnership forums provide an opportunity for strategic advocacy and accountability against agreements between the Victorian Government, Aboriginal community-controlled organisations (ACCOs) and the community to improve social justice outcomes for Aboriginal children and young people, their families and community. The Commissioner for Aboriginal Children and Young People is a member of many forums as part of the Commission's role as an independent statutory body promoting the wellbeing and safety of children and young people, and as a strategic advocate for the interests of Aboriginal children and young people. The Commission also participates in committees and working groups to progress the broader aims of these forums.

Dhelk Dja Partnership Forum

The *Dhelk Dja* Partnership Forum is dedicated to addressing issues of Aboriginal family violence. This year the Commission advocated for the rights of children and young people, focusing on the causes and impacts of family violence and ensuring services are responsive to the specific needs of Aboriginal children.

Aboriginal Children's Forum

The Aboriginal Children's Forum is the accountability mechanism that oversees the *Wungurilwil Gapgapduir* tripartite agreement between the Department of Families, Fairness and Housing, ACCOs and community service organisations to improve outcomes for Aboriginal children and families in the child protection system.

In this forum, the Commission advocated for increased child and youth engagement in service design and a whole-of-government approach to reduce the over-representation of Aboriginal children in child protection. We also highlighted the need for increased investment in culturally safe prevention and early intervention services to support and strengthen Aboriginal families to prevent Aboriginal children and young people from entering the child protection system.

Improving outcomes for Aboriginal children *continued*

As more ACCOs take on the powers of the Secretary of the Department of Families, Fairness and Housing under section 18 of the *Children, Youth and Families Act 2005*, they also come into the Commission's scope of oversight for providing child protection and out-of-home care services for Aboriginal children and young people. The Commissioner for Aboriginal Children and Young People has worked to ensure their understanding of the Commission's functions and to foster a collaborative oversight relationship that ensures the continued safety and wellbeing of Aboriginal children and young people.

Marrung

Marrung: Aboriginal Education Plan 2016–2026 is a ten-year plan that aims to improve learning, developmental and educational outcomes for Aboriginal students in Victoria. Marrung was developed in partnership with the Aboriginal community, including the government's principal partner in Aboriginal education, the Victorian Aboriginal Education Association Incorporated. The Commissioner for Aboriginal Children and Young People is a member of the Marrung Central Governance Committee.

This year, Commissioner Singh presented to the Marrung Central Governance Committee on Child Safe Standard 1 and the status of the recommendations relating to education made in *Our youth, our way: Inquiry into the over-representation of Aboriginal children and young people in the Victorian youth justice system*. The commissioner continues to advocate for action to reduce Aboriginal children and young people's experiences of racism in schools.

Aboriginal Justice Forum

The *Victorian Aboriginal Justice Agreement* and the Aboriginal Justice Forum (AJF) work to address over-representation of Aboriginal children, young people and adults in the criminal justice system.

In the past 12 months, the AJF has worked towards developing a performance framework for *Wirkara Kulpa: Aboriginal Youth Justice Strategy 2022–23*, and advocated for much needed bail reforms to address disproportionate

impacts on Aboriginal communities, particularly Aboriginal women with children.

In our work with the AJF and the Department of Justice and Community Safety, the Commission continued to advocate for the Victorian Government to raise the age of criminal responsibility to 14 without exceptions, as recommended in *Our youth, our way*.

The Commission raised matters including the need for prevention, early intervention and diversion programs for young people, including Aboriginal young people, at risk of entering the youth justice system and the impact of successive lockdowns on young people in youth justice settings due to staff shortages.

Senate inquiry into missing and murdered First Nations women and children

In June 2024 Commissioner Singh appeared before the *Senate inquiry into missing and murdered First Nations women and children*. This followed the Commission's December 2022 submission to the inquiry expressing serious concern about the unacceptable rates of violence endured by Aboriginal women and children, rooted in systemic oppression stemming from Australia's colonial history. Commissioner Singh's evidence focused on the impact of family violence on child removal, supports needed for children in out-of-home care, and the underfunding of crucial services for Aboriginal communities.

Engaging with Aboriginal children and young people and their communities

Engaging and connecting with Aboriginal children, young people and their communities is crucial to the Commission's work. Commissioner Singh and Commission staff regularly travel to metropolitan and regional areas to speak with Aboriginal children and young people, as well as those who work to support them in living lives connected to their culture, family and community.

Experiences of racism project

In 2023–24 the Commission initiated a series of consultations with Aboriginal children and young people and their communities about their experiences of racism. This project was sparked by what the Commission heard in consultations during our last systemic inquiry, *Let us learn*, as well as concerns raised by community in the wake of the 2023 referendum.

In *Let us learn*, many Aboriginal children and young people in out-of-home care told us that experiences of racism persist in Victoria's education system. This included racism from peers and teachers. We also heard from stakeholders that Aboriginal students do not feel supported to speak out when they experience racism in schools. The Commission repeatedly heard that a lack of cultural safety in schools is an ongoing issue that has a negative impact on Aboriginal children and young people in care.

In May 2024, Commissioner Singh and Commission staff visited Mildura to hear from Aboriginal children and young people about their experiences of racism. The team visited schools, Sunraysia TAFE, the STARS program and other key community stakeholders. With the support of Mallee District Aboriginal Services (MDAS), the team hosted a drop-in centre at the MDAS youth hub. Over three days we spoke to 50 Aboriginal children and young people about their experiences. The team is planning further engagement across the state in 2024–25.

Contributing to the Yoorrook Justice Commission

In September 2023 the Yoorrook Justice Commission published its *Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems*. The report made 46 recommendations, many of which were directly related to the work of the Commission, including legislating the role of the Commissioner for Aboriginal Children and Young People.

In 2024 the Yoorrook Justice Commission held public hearings into the experiences of First Nations Victorians in areas of education, health and housing. Read more about Youth Council member Elias' experience giving evidence to Yoorrook alongside the commissioners in the *Strengthening the engagement and participation of children and young people* chapter of this report.

The Yoorrook Justice Commission will deliver its final report to the First People's Assembly of Victoria and the Victorian Government in 2025.

Monitoring outstanding recommendations

The Commission continued to advocate for the full implementation of the recommendations in *Our youth, our way*, tabled in June 2021, which presented 75 recommendations for a reimagined service system for Aboriginal children. The Commission will publish an update on the status of these recommendations for the first time in 2024. The government's *Wirkara Kulpa* was informed by *Our youth, our way* and incorporates 56 recommendations, as well as other measures to address the over-representation of Aboriginal children and young people in the youth justice system.

As the Commission monitors the implementation of recommendations, we urge the Victorian Government to dedicate adequate and ongoing funding for programs and support services that reduce reoffending and promote rehabilitation through community-led initiatives. Victoria's

Improving outcomes for Aboriginal children *continued*

positive progress to support Closing the Gap Target 11 demonstrates that Aboriginal-led initiatives create positive change for Aboriginal children and young people.

However, recent amendments to the Youth Justice Bill in August 2024 and the Victorian Government's decision to abandon its commitment to raise the minimum age of criminal responsibility to 14 by 2027 will have harmful impacts on all children. These changes will lead to higher rates of Aboriginal children and young people in the youth justice system and undermine efforts to create a more rehabilitative and supportive approach to youth justice.

The Commission continued to monitor two inquiries undertaken by the inaugural Commissioner for Aboriginal Children and Young People, Andrew Jackomos. These landmark inquiries, *Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria* and *In the child's best interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* were both tabled in October 2016. The Commission will continue to monitor implementation of the outstanding recommendations while acknowledging the broad reforms that are underway within Child Protection and the ACCO sector, including delegation of authority to ACCOs for Aboriginal children in out-of-home care.

Influencing policy, services and the law

Influencing policy, services and the law

The Commission's functions include providing advice to government on improvements to policies, practices and services that affect children and young people, and promoting the interests of children and young people experiencing vulnerability.⁴⁹ We do this by engaging with government departments and ministers, writing letters and submissions to government, and responding to consultation opportunities in reviews and inquiries. The commissioners also speak in the media and give speeches to advocate for action to improve the lives of children and young people. Our advocacy covers a range of issues impacting on the rights, safety and wellbeing of children and young people.

In 2023–24 our work in this area included:

- partnering with the Commission's Youth Council on education reform
- contributing to youth justice and criminal justice reforms
- informing a United Nations Special Rapporteur about sexual exploitation of children and young people in out-of-home care
- advocating for better responses to the impact of family violence on children and young people
- contributing to reforms to improve the mental health and wellbeing of children and young people
- participating further in the review of Victoria's Reportable Conduct Scheme.

We also made confidential contributions on permanency laws and laws relating to firearms protection orders and criminal organisations.

All Commission submissions that are permitted to be published are available on our website.

Partnering with the Commission's Youth Council on education reform

The Commission's policy work in 2023–24 was strengthened by our growing inclusion of young people's views and experiences.

As highlighted in *Strengthening the engagement and participation of children and young people* (see page 22), members of the Commission's Youth Council made a submission highlighting our *Let us learn* inquiry to the parliamentary inquiry into the state education system in Victoria. Their submission accompanied the Commission's submission to the inquiry and shared the Youth Council members' perspectives on key issues from *Let us learn*, as well as their own experiences at school:

'I would not be where I am today if it wasn't for the people who held onto hope for me when I felt hopeless. I'm so grateful for the teachers who would ask if I had eaten, how things were at home, if I needed extra time or help with homework or just to let me know they believed in me.'

– Kita, Commission Youth Council member

'We know, like for me, school is one of the only safe and or happy places that children and young people have. We need to protect that, not strip it away from them. Disengagement from education is not caused by only one thing, there are so many multi-layered barriers that we face as students in care. Many of these barriers are invisible and others don't know they exist. In most cases, if not all, children and young people in these situations don't choose to disengage but rather it's something that happens to them as a result of systemic issues in the education and child protection systems.'

– Amelia, youth project officer at the Commission

⁴⁹ Sections 8(1)(a) and 8(1)(b) of the *Commission for Children and Young People Act 2012*.

‘[The data on suspensions for students in care] is indicative of an education system not equipped to support students with complex needs or difficult behaviours.’
– **Ravin, Commission Youth Council member**

Following the submission, Youth Council members gave powerful evidence at an inquiry hearing, appearing alongside the commissioners. The Parliament of Victoria highlighted the Youth Council’s input in their news wrap up of the hearing.⁵⁰

Youth justice and criminal justice reforms

The Commission made a number of submissions relating to youth justice and criminal justice policy issues during 2023–24.

Youth justice legislation and minimum age of criminal responsibility

The Commission continued to advocate for the rights of children and young people during the final stages of developing Victoria’s new youth justice legislation. This included advising the government on changes to implement the first stage of reform to the minimum age of criminal responsibility while continuing to advocate for the age to be raised to 14 years.

In June 2024 the Youth Justice Bill 2024 was introduced. The Commission contributed to the Bill’s development over several years, and the Bill incorporated many of the recommendations we made. While the Commission welcomed the Bill as a positive step towards youth justice reform in Victoria, we identified areas where the Bill could be improved and were disappointed in the Victorian Government’s August 2024 decision to abandon its commitment to raise the age of criminal responsibility to 14 by 2027.

⁵⁰ Parliament of Victoria, 13 June 2024, *State education inquiry’s powerful impact*, <https://www.parliament.vic.gov.au/news/society/eduhearingsend>

⁵¹ For example, see the Commission’s April 2023 media statement, <https://ccyp.vic.gov.au/news/statewide-action-overdue-amid-new-data-showing-continuing-sexual-exploitation-of-children-in-residential-care/#>

Bail reform

The Commission continued to advocate for changes to the *Bail Act 1977* to create an age-appropriate, specialised bail system for children and young people. We welcomed expansion of the Act’s considerations relating to children and Aboriginal people, which aligned with the Commission’s recommendations, including from *Our youth, our way*.

The Commission was disappointed that the Victorian Government did not proceed with its proposed reform of the ‘reverse onus’ bail tests for children and young people. Removing these tests for children and young people was a key recommendation of *Our youth, our way*, and the Commission will continue to advocate for this change.

Sexual exploitation of children and young people

In October and November 2023, the Commission brought critical issues to the attention of the United Nations Special Rapporteur on the sale and sexual exploitation of children, for her visit to Australia. The Special Rapporteur visits countries (by invitation) to examine the state of protection of children’s human rights.

The Commission’s submission to assist the Special Rapporteur highlighted findings from our 2021 *Out of sight* inquiry and our significant ongoing concerns about:

- the continued high numbers of incidents involving sexual exploitation of children and young people who are absent or missing from state residential out-of-home care⁵¹
- the active targeting of children and young people by perpetrators, offering drugs or money to leave care
- the compounding harms for Aboriginal children and young people who are over-represented in the residential care and the broader child protection system.

The commissioners discussed the issues with the Special Rapporteur, along with children's commissioners, guardians and advocates from other Australian states and territories.

In a statement about the visit, the Special Rapporteur referred to key issues the Commission raised.⁵²

The impact of family violence on children and young people

The Commission continued to advocate for improved responses to children and young people as victims of family violence in their own right.

In January 2024, the Commission made recommendations for the Victorian Government's third and final family violence reform rolling action plan 2024–2026 (to be released later in 2024). We are pleased the action plan will have a clear focus on children and young people. Our recommendations to the government included to:

- embed specific mechanisms to involve children and young people with lived experience in policy advice to government, service design and evaluation and practice development, including guidance and training for practitioners
- increase the availability of specialised, accessible therapeutic services for children and young people affected by family violence⁵³
- continue to improve Child Protection responses, including responses to cumulative harm and concerns of sexual abuse in the context of family violence
- take further action to address sexual violence against children and young people.

The commissioners' public engagements also included a focus on the needs of children and young people who experience family violence. In late 2023, both

commissioners delivered keynote addresses at a conference on child-centred approaches to ending family violence, and the Principal Commissioner spoke about supporting and empowering children impacted by family violence at the National Family Safety summit in Perth. In May 2024, the Principal Commissioner presented at the Bayside Peninsula Integrated Family Violence Partnership's forum on ensuring children and young people's voices are heard. In the same month, the commissioner spoke alongside young advocates from the Commission at a Campaspe Family Violence Action Group forum. She spoke about the work that remains to be done to achieve meaningful change for children and young people.

Also during 2023–24, the Commission contributed further to developing the Department of Justice and Community Safety's Victim-Centred Restorative Justice Program for Adolescent Violence in the Home, providing insights from the Commission's child death inquiries.

Children and young people's mental health and wellbeing

One of the Commission's 2022–25 strategic priorities is to contribute to the mental health and wellbeing reforms following the Royal Commission into Victoria's Mental Health System to ensure the reforms deliver for children and young people.

This year we made a submission to inform the Victorian Government's strategy towards eliminating seclusion and restraint in mental health and wellbeing service delivery. Our submission highlighted children and young people's rights and the relevance of the Child Safe Standards and Reportable Conduct Scheme in these settings.

Mental health and wellbeing continues to be a major concern for the Commission's Youth Council and many other children and young people we connect with. The Commission continued to engage with the Department of

⁵² *Preliminary Observations and End of mission statement of the UN Special Rapporteur on the sale and sexual exploitation of children*, 10 November 2023, <https://www.ohchr.org/sites/default/files/documents/issues/children/sr/statements/2023-11-10-sr-sale-children-eom-std-australia.pdf>.

⁵³ In May 2024, the Victorian Government announced a package of reforms including 'increased therapeutic support for children and young people to help with healing and recovery': <https://www.premier.vic.gov.au/changing-laws-and-culture-save-womens-lives>.

Health during the year on key reforms affecting children and young people, and opportunities for the Commission to contribute. We look forward to ongoing engagement as the Commission continues to monitor progress of reforms and promote the need to prioritise children and young people's voices, experiences and rights.

The review of Victoria's Reportable Conduct Scheme

Following the Commission's 2022 submission to the Department of Families, Fairness and Housing's review of the Reportable Conduct Scheme, we engaged further with the department to inform the final report.

The final report was tabled in the Victorian Parliament on 2 May 2024 and identified key issues raised in the Commission's submission as opportunities for reform.

Joint advocacy

Both commissioners are members of the Australian and New Zealand Children's Commissioners, Guardians and Advocates (ANZCCGA). During 2023–24, joint advocacy by the ANZCCGA included:

- a statement on isolation in youth detention, calling for nationally consistent minimum standards (noting isolation must only be used as a last resort and for the shortest possible time), improved data collection and transparency, and National Preventive Mechanisms in all states and territories⁵⁴
- calling for a nationally consistent Working with Children Check, mandatory reporting and reportable conduct schemes
- advocating to the Australian Government to make the Leaving Violence Payment available to children and young people aged under 18 years who are experiencing family violence.⁵⁵

⁵⁴ <https://ccyp.vic.gov.au/assets/Uploads/ANZCCG/ANZCCGA-Statement-Isolation-in-Youth-Detention-Feb2024.pdf> – 21 February 2024

⁵⁵ <https://ccyp.vic.gov.au/assets/Uploads/ANZCCG/ANZCCG-letter-to-Minister-Rishworth-Leaving-violence-payment-24-May-2024.pdf> – 23 May 2024

⁵⁶ <https://ccyp.vic.gov.au/assets/Uploads/ANZCCG/ACCGA-Media-Release-Appointment-of-National-Commissioner.pdf> – 14 February 2024

In February 2024 the ANZCCGA welcomed the announcement of a new National Commissioner for Aboriginal children and young people.⁵⁶ This appointment has been championed by the Commissioners, Guardians and Advocates.

Public engagements

This year our commissioners continued their broad engagement with the media, with around 60 media reports across print, online, radio and television, and made many public appearances.

Media coverage

This year the Commission's media coverage spanned a wide range of issues, with youth justice again a focus, including the closure of Malmsbury Youth Justice Detention Centre, raising the age of criminal responsibility, calls to prohibit spit hoods in youth justice detention, crime statistics, and youth offending.

Broad coverage of child protection issues included malnutrition deaths of young children, a cluster inquest of children known to Child Protection, child victims of domestic violence, and child death inquiries.

Two television reports saw child sexual exploitation in residential care covered by the ABC's *7.30* program and Channel 9's *60 Minutes* in the context of the Commission's findings and recommendations from the *Out of sight* inquiry.

Coverage also featured the Child Safe Standards, the Reportable Conduct Scheme, the Commission's annual report and the *Let us learn* inquiry on the education experiences of children and young people in state care.

More than 20 per cent of our media coverage this year concerned issues relevant to Aboriginal children and young people. This included reports on Closing the Gap,

evidence and outcomes of the Yoorrook Justice Commission, the announcement that a national commissioner for children and young people would be appointed, racism, the Senate inquiry into missing and murdered First Nations women and children, and advocacy following the failed Voice referendum.

Public appearances

This year saw our commissioners engage in 90 public appearances to promote the Commission's work, engage with our diverse stakeholders and advocate for reform across child protection, out-of-home care, youth justice, Child Safe Standards, the Reportable Conduct Scheme and stronger recognition of children's rights. Some of these engagements have been discussed earlier in this chapter.

The commissioners presented individually and jointly throughout the year. This included:

- the Principal Commissioner giving the Vernon Collins Oration 2023 at the Royal Children's Hospital, where she spoke of the progress made and the challenges that remain in realising children's rights in Victoria⁵⁷
- the Commissioner for Aboriginal Children and Young People speaking about how, as a community, we need to rehumanise children and young people in the youth justice system, in her keynote address at the Australasian Youth Justice Conference in April 2024
- the commissioners presenting with Youth Council members on the *Let us learn* inquiry in multiple forums such as the Statewide LOOKOUT Forum and (as mentioned earlier) the parliamentary inquiry and Yoorrook Justice Commission hearings.

In addition to their public engagements, the commissioners attended numerous meetings with government ministers, agencies, child-related organisations and other commissioners throughout the year.

⁵⁷ A recording of the address is available at <https://blogs.rch.org.au/grandrounds/2023/10/04/vernon-collins-oration-2023-liana-buchanan-childrens-rights-progress-and-challenges/>.

Supporting and regulating child-safe organisations

Supporting and regulating child-safe organisations

The Commission as child safety regulator

Victoria was the first jurisdiction to introduce both the Reportable Conduct Scheme (the Scheme) and the Child Safe Standards (the Standards) to tackle child abuse in organisations. These two important schemes were later recommended for all states and territories in the 2017 report of the Royal Commission into Institutional Responses to Child Sexual Abuse, and other jurisdictions have gradually followed Victoria's lead. The Commission has been the regulator for the Scheme and a regulator for the Standards since 2017. In this work, we engage with hundreds of organisations each year to help them prevent child abuse and to make sure they do the right thing when a complaint or allegation is raised.

As will be discussed in the following chapters, 2023–24 was another significant year for these schemes, with the Commission:

- receiving a record 1,892 notifications of reportable allegations under the Scheme, which was a 30 per cent increase on the number received in 2022–23
- referring 383 people found to have committed substantiated reportable conduct for reassessment of their Working with Children Check in relation to 1,135 substantiated allegations of reportable conduct
- preparing for the start of legislation on 1 July 2024 to increase the types of employees covered by the Scheme, with labour hire workers to be covered for the first time
- implementing changes to reduce our oversight of individual cases under the Scheme given the 136 per cent increase in notifications since 2017 without additional government funding
- increasing its use of enforcement powers to tackle issues of non-compliance with the Standards, with eight notices to comply and seven notices to produce issued, three inspections undertaken and an official warning issued for suspected non-compliance with a Commission-issued notice

- building capacity in our authorised officers to use their full range of powers to promote compliance with the Standards
- hosting two in-person community of practice forums for organisations subject to the Standards
- collaborating with the other five Standards regulators, including hosting the Standards Regulator Senior Executive Group, Steering Group, and supporting a community of practice for compliance officers to support the regulators to discuss issues of mutual importance to regulating the Standards.

Supporting compliance

An important part of the Commission's role is to help organisations and sectors to understand and meet the requirements of the Standards and the Scheme, and to keep children safe. We take a holistic approach, focusing attention on the culture and systems of organisations through the Standards, as well as providing oversight to ensure individual allegations of inappropriate or abusive conduct towards children are properly reported and investigated through the Scheme.

In many instances, we can bring about compliance through education and support, with more significant enforcement powers and sanctions being used for organisations that are uncooperative, have repeated or serious failings in compliance, or where significant risk of harm to children has been identified.

This year we saw a high level of engagement with our website and resources, with more than one million webpage views in 2023–24.

Our full range of child safety videos were viewed 59,575 times this year (a 17 per cent increase on 2022–23), and our publications on the Standards and the Scheme were downloaded approximately 100,000 times. Our most popular resources continued to be plain language information about the Standards, including the *Short guide to the Child Safe Standards* and the Standards plain language poster.

Two introductory videos for the Standards and the Scheme continued to be popular resources with this content being viewed just under 20,000 times in 2023–24.

Three videos supporting organisations to interview children and young people in Scheme investigations, developed in collaboration with Griffith University, continue to be accessed frequently, with a 20 per cent increase in views on the prior year (103,329 views since they were published in 2019).

We continued to engage with our audience through our digital and social media channels to connect people with relevant child safety information and resources. This included:

- sharing information and resources to our email subscriber base of more than 18,000 people
- growing our LinkedIn followers by approximately 100 per cent over the course of the year.

Capacity-building information sessions and webinars

The Commission delivers introductory information about the Standards through a comprehensive video available on demand on our website. This video was viewed over 23,000 times in 2023–24.⁵⁸ More than 40 different types of organisations subject to the Standards accessed the video, with early childhood education making up the highest proportion of viewers.

Table 16. Viewers of Child Safe Standards on-demand video by sector

Sector ⁵⁹	Proportion of attendees %
Early childhood education	35
Not-for-profit	10
Education – school	8
Education – other	6
Disability services	3

⁵⁸ This forms part of the total 59,575 child safety video views.

⁵⁹ Sector type as nominated by attendee.

In 2023–24, we delivered a range of presentations on the Standards and the Scheme at meetings and forums run by external bodies including education providers, government and statutory agencies, religious organisations and disability transport providers.

This year the Commission hosted two in-person Child Safe Standards community of practice forums for organisations subject to the Standards. The first brought together more than 80 people, with speakers from the eSafety Commissioner for a half-day forum about online safety for children and young people. The second forum focused on cultural safety for Aboriginal children and young people and Child Safe Standard 1. The full-day forum was delivered to 92 people in person, with up to 170 people viewing online. The Child Safe Standards Community of Practice Working Group, with representatives from organisations covered by the Standards, helped plan these forums and provided valuable guidance to target issues of interest to those working to implement the Standards.



Commission Youth Council member Elias and Commissioner for Aboriginal Children and Young People, Meena Singh, presenting at the Child Safe Standard 1 community of practice

Resources and guidance

The Commission provides a range of resources to educate and guide organisations about meeting the requirements of the Standards and the Scheme.

Our focus included guidance for organisations on Child Safe Standard 1. The Commission consulted with the Victorian Aboriginal community and worked with the Commission's Aboriginal Advisory Committee to develop guidance to help organisations understand cultural safety for Aboriginal children and young people. The guidance and supporting tools and resources were published on the Commission's website in July 2024.

The Commission also focused on supporting organisations to understand their obligations following legislative changes to the definition of employee for the Scheme coming into effect on 1 July 2024. We published information and guidance on our website to raise awareness and assist organisations to prepare for the changes.

The Commission received at least 3,271⁶⁰ enquiries in 2023–24 for information and advice across all the Commission's functions (a four per cent increase on 2022–23).

The Commission has a target of 80 per cent of phone and email queries regarding the Scheme or the Standards being resolved within three business days. This year the target was exceeded, with 90 per cent being resolved within three business days.

⁶⁰ This figure includes 2,119 phone calls and 1,139 emails.

Reportable Conduct Scheme

Reportable Conduct Scheme

Overview⁶¹

- In 2023–24 the Commission received 1,892 notifications⁶² of reportable allegations, a 30 per cent increase on the number of notifications received in 2022–23 and a 136 per cent increase since the first year of the Reportable Conduct Scheme (the Scheme). This was a record number of annual notifications, and notifications are expected to further increase next year.
- These notifications relate to 3,831 allegations received in 2023–24, with 20,137 allegations received since the start of the Scheme.
- There has also been a steady increase in the number of public notifications received since the start of the Scheme (38 per cent increase on 2022–23).
- In 2023–24, as in each of the seven years since the Scheme started, the highest number of allegations received (35 per cent) related to physical violence.
- Since the Scheme started, 70 per cent of all sexual misconduct allegations across all sectors subject to the Scheme were in the education sector. Sexual misconduct is the most common allegation type for the whole education sector (37 per cent of allegations since the start of the Scheme).
- In 2023–24, eight per cent of unique alleged victims were identified as Aboriginal and/or Torres Strait Islander. This represents a significant over-representation of Aboriginal and Torres Strait Islander children and young people, who only make up two per cent of the Victorian population under 18 years of age.⁶³
- Consistent with previous years, 30 per cent of reportable allegations were substantiated in 2023–24.
- The substantiation rate for sexual offence allegations has substantially increased, rising from 15 per cent in 2018–19 to 38 per cent in 2023–24. The reportable conduct investigations for this conduct type may take

longer to complete, noting that they often involve criminal investigations undertaken by Victoria Police.⁶⁴

- The substantiation rate for sexual misconduct allegations has also increased in each of the past five years, rising from 21 per cent in 2018–19 to 38 per cent in 2023–24.

Increase in workers and volunteers covered by the Scheme

The Commission welcomed the passing by Parliament of the *Children and Health Legislation Amendment (Statement of Recognition, Aboriginal Self-determination and Other Matters) Act*, which expanded the definition of an employee for the Scheme.

Labour hire workers are used extensively in some sectors where children and young people are highly vulnerable, including in residential care, hospitals and schools. With changes starting on 1 July 2024, child abuse and child-related misconduct by labour hire workers will be included in the Scheme for the first time.

The new types of employees covered by the Scheme include workers or volunteers provided by labour hire agencies, companies or other providers; secondees; individual business owners who employ or engage staff; and directors of companies where the director performs work for the organisation.

⁶¹ Data presented in this chapter was extracted on 1 July 2024 from a live database and is subject to change.

⁶² Each mandatory notification can contain multiple reportable allegations and multiple alleged victims.

⁶³ Data sourced from Australian Bureau of Statistics (2011 to 2031), <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/latest-release>, ABS website, accessed 29 July 2024.

⁶⁴ The substantiation rate is the percentage of allegations that were substantiated after investigation under the Scheme. This does not reflect the outcomes of criminal investigations and charges.

Notifications of reportable allegations

The Scheme requires heads of organisations to notify the Commission of allegations of reportable conduct. Since the start of the Scheme on 1 July 2017, the Commission has received 8,122 mandatory notifications. For the period from 1 July 2023 to 30 June 2024, the Commission received 1,892 notifications of reportable allegations from heads of organisations. This was a 30 per cent increase on the number of notifications received in 2022–23, and a 136 per cent increase on the number received in 2017–18.

The *Child Wellbeing and Safety Act 2005* (CWSA) also allows any person – for example, young people, parents or other members of the public – to disclose allegations to the Commission. Since the Scheme started seven years ago, the Commission has noted a steady increase in the number of public notifications received, with a 38 per cent increase on the number of notifications received in 2022–23 and a 584 per cent increase on the number received in 2017–18.

The monthly average of notifications has substantially increased from 67 in the first year of the Scheme to 158 in 2023–24. Notifications are expected to further increase next year, with changes starting on 1 July 2024 increasing the types of employees covered by the Scheme.

The Commission has received no additional funding for the Scheme since it began in 2017. Given the 136 per cent increase in notifications over that time, the Commission continued efforts in 2023–24 to implement changes to reduce our oversight of individual cases. Previous operational changes have not been enough to keep up with increasing notifications of alleged child abuse and child-related misconduct. This year the Commission therefore started implementing changes to significantly reduce our oversight of a high number of investigations under the Scheme. This means, in turn, we will be unable to give guidance and support to most organisations as we have in the past. We will focus our limited resources on the cases of most obvious and serious risk to children but are

concerned that resource limitations are now impacting our ability to run the Scheme in a way that maximises child safety.

The Commission is also updating its communications to alleged victims, parents, carers, subjects of allegation, organisations and the community to support their understanding of the more limited role the Commission can play under the Scheme within current funding levels.

Reportable Conduct Scheme

continued

Mandatory notifications

The following sections contain information about notifications of reportable allegations received by the Commission from heads of organisations or where the Commission is conducting an own motion investigation.⁶⁵ This data details allegations only; for many of these, findings have not yet been made about whether the alleged conduct occurred.

For the period from 1 July 2023 to 30 June 2024, the Commission received 1,892 notifications of reportable allegations (Table 17 and Figure 5).

Table 17. Reportable conduct matters received by notification type 2021–22 to 2023–24 and Scheme total⁶⁶

Type	2021–22	2022–23	2023–24	Since the start of the Scheme ⁶⁷
Mandatory notification	1,237	1,457	1,892	8,122
Public notification ⁶⁸	233	377	520	1,672

Notifications received

The monthly average of notifications has substantially increased from 67 in the first year of the Scheme to 158 in 2023–24. The Commission expects the number of notifications will continue to increase in future years as organisations strengthen their processes to ensure all reportable allegations are appropriately notified to the Commission, awareness of the Scheme's requirements grows and organisations strengthen their reporting processes. Also, legislative changes that took effect on 1 July 2024 have increased the types of employees covered by the Scheme to include labour hire workers, secondees, directors of companies and individual business owners.

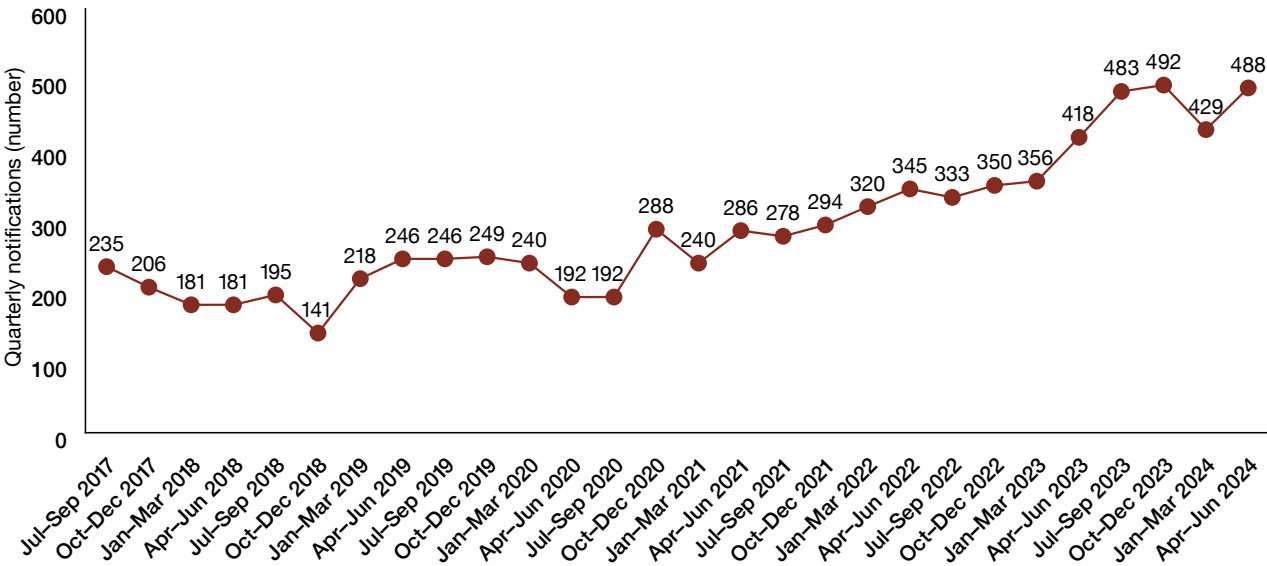
⁶⁵ In some matters where the Commission is conducting an own motion investigation, no mandatory notification was received from an organisation. If this is the case, the allegations in the own motion investigation will be counted in data where analysis is based on allegations but not included where analysis is based on mandatory notifications. Where allegations are attached both to a mandatory notification and to a Commission own motion investigation, they will be counted only once.

⁶⁶ In some cases, data from previous financial years expressed in this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified accordingly.

⁶⁷ This refers to the period from 1 July 2017 to 30 June 2024.

⁶⁸ Public notifications will often result in the head of an organisation submitting a mandatory notification to the Commission. Others will be assessed as being outside the jurisdiction of the Scheme due to not meeting the relevant legislative requirements.

Figure 5. Number of mandatory notifications received by the Commission 2017–18 to 2023–24



Mandatory notifications by sector

In 2023–24, the education, early childhood education and out-of-home care sectors contributed the highest proportion of notifications (40 per cent, 28 per cent and 21 per cent respectively). Compared with the previous year, there was a 75 per cent increase in notifications in the education sector and a 39 per cent increase in the early childhood education sector (Table 18).

Reportable Conduct Scheme

continued

Table 18. Notifications of reportable allegations received by sector 2021–22 to 2023–24 and Scheme total^{69,70}

Sector	2021–22		2022–23		2023–24		Percentage change 2022–23 to 2023–24	Since the start of the Scheme	
	No.	%	No.	%	No.	%		No.	%
Out-of-home care ⁷¹	485	39	409	28	396	21	-3▼	2,538	31
Residential care	158		143		105		-27▼	824	
Kinship care	148		132		164		24▲	818	
Foster care	170		118		113		-4▼	804	
Employee – other/admin	1		9		11		22▲	43	
Respite and contingency care	2		2		1		-50▼	24	
Lead tenant	4		3		2		-33▼	20	
Permanent care	2		2		0		-100▼	5	
Education ⁷²	289	23	436	30	762	40	75▲	2,415	30
Government school ⁷³	121		199		485		144▲	1,104	
Non-government school – Catholic ⁷⁴	79		92		135		47▲	634	
Non-government school – independent ⁷⁵	83		126		115		-9▼	599	
Senior secondary course/ qualification ⁷⁶	5		15		26		73▲	63	
International-student course	0		1		0		-100▼	6	
Student exchange program	1		2		0		-100▼	5	
Employee – other/admin	0		1		1		-	4	

⁶⁹ In some cases, data from previous financial years expressed in this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme. In some cases, data is also consolidated where it is identified that multiple notifications have been made for the same matter and are reclassified accordingly.

⁷⁰ This table breaks up notifications we received by sector and service type. The Commission notes that different sectors and service types have different types of engagement with children and young people. The number of organisations in sectors and service types is also different. Some sectors including out-of-home care and education have been subject to the Scheme since it began on 1 July 2017, whereas other sectors have been subject to the Scheme for less time. Religious bodies and disability services have been covered since 1 January 2018, and early childhood education has been covered since 1 January 2019. The Commission is concerned there may be under-reporting of notifications in some sectors and service types.

⁷¹ Includes services provided by the Department of Families, Fairness and Housing (DFFH), community service organisations and other organisation types providing out-of-home care.

⁷² Summary statistics on Victorian schools published by the Department of Education state that the number of full-time equivalent students attending Victorian schools in February 2024 was 1,049,889.6. Of this, 661,326.7 attended a government school, 216,039.3 attended a non-government school – Catholic and 172,523.6 attended a non-government school – independent. Information about the education sector can be found at: <https://www.vic.gov.au/statistics-victorian-schools-and-teaching>.

⁷³ Includes primary and secondary schools.

⁷⁴ Includes primary and secondary schools.

⁷⁵ Includes primary and secondary schools.

⁷⁶ These are courses and qualifications that are not delivered by registered schools.

Table 18. Notifications of reportable allegations received by sector 2021–22 to 2023–24 and Scheme total (continued)

Sector	2021–22		2022–23		2023–24		Percentage change 2022–23 to 2023–24	Since the start of the Scheme	
	No.	%	No.	%	No.	%		No.	%
Early childhood education	284	23	384	26	535	28	39▲	1,911	24
Long day care	224		286		438		53▲	1,477	
Preschool/kindergarten	31		56		39		–30▼	218	
Outside-school-hours care	21		34		46		35▲	169	
Family day care	8		8		8		0	43	
Employee – other/admin	0		0		2		–	2	
Other	0		0		2		–	2	
Religious body⁷⁷	88	7	68	5	57	3	–16▼	421	5
Disability⁷⁸	26	2	46	3	42	2	–9▼	225	3
Youth justice⁷⁹	17	1	29	2	22	1	–24▼	217	3
Child protection⁸⁰	10	<1	5	<1	6	<1	20▲	54	<1
Accommodation⁸¹	6	<1	22	2	14	<1	–36▼	53	<1
Health⁸²	4	<1	9	<1	2	<1	–78▼	50	<1
Victorian government departments⁸³	10	<1	6	<1	12	<1	100▲	46	<1
Other⁸⁴	18	1	43	3	44	2	2▲	192	2
Total	1,237	100	1,457	100	1,892	100	30▲	8,122	100

⁷⁷ Excludes notifications about services provided by religious bodies in other sectors.

⁷⁸ Includes registered and non-registered disability service providers, residential services for children with a disability and DFFH disability support services.

⁷⁹ Youth justice functions provided by the Department of Justice and Community Safety including custodial and community-based.

⁸⁰ Includes child protection services provided by DFFH, child protection services provided by organisations pursuant to a DFFH contract and DFFH secure care.

⁸¹ Includes overnight camps, homelessness service providers with overnight beds and residential facilities for boarding schools.

⁸² Includes hospitals (public and private), mental health services with inpatient beds and inpatient drug and alcohol services.

⁸³ Excludes notifications about state government workers or volunteers in other sectors.

⁸⁴ In this category, some notifications are included from organisations subsequently deemed outside the scope of the Scheme and some relate to organisations not yet identified. Of those notifications within the scope of the Scheme, these relate to employees not otherwise captured in other sectors including youth services, aquatic and leisure centre workers, council workers and overnight camps.

Reportable Conduct Scheme

continued

Reportable allegations by type of reportable conduct

Each mandatory notification can contain multiple reportable allegations and multiple alleged victims. The 8,122 notifications received since the Scheme started contained 20,137 allegations.⁸⁵

There are five types of 'reportable conduct'⁸⁶ listed in the CWSA:

- sexual offences (against, with or in the presence of a child)
- sexual misconduct (against, with or in the presence of a child)
- physical violence (against, with or in the presence of a child)⁸⁷
- behaviour that causes significant emotional or psychological harm
- significant neglect of a child.

In 2023–24, like previous years, the highest number of allegations (35 per cent) related to physical violence (Table 19).

Table 19. Category of reportable conduct allegations 2021–22 to 2023–24 and Scheme total⁸⁸

Category	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Physical violence ⁸⁹	1,426	37	1,343	32	1,356	35	7,458	37
Behaviour that causes significant emotional or psychological harm to a child	792	21	1,003	24	712	19	4,061	20
Sexual misconduct ⁹⁰	627	16	889	21	740	19	4,038	20
Significant neglect of a child	737	19	804	19	790	21	3,284	16
Sexual offences ⁹¹	253	7	194	5	233	6	1,296	6
Total	3,835	100	4,233	100	3,831	100	20,137	100

⁸⁵ Analysis of allegations in this annual report includes some allegations that are subject to an own motion investigation by the Commission where no mandatory notification was received.

⁸⁶ The Commission's website has information sheets that provide a detailed explanation about the different types of reportable conduct <https://ccyp.vic.gov.au/resources/reportable-conduct-scheme/reportable-conduct-scheme-information-sheets/#TOC-2>.

⁸⁷ This covers a range of conduct including actual and threatened physical violence. Where physical contact is made with a child, it will be considered 'physical violence' if the contact was capable of causing injury or harm to the child. It is not, however, necessary for injury or harm to have occurred.

⁸⁸ In some cases, data from previous financial years expressed throughout this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme.

⁸⁹ Includes physical violence against, with or in the presence of a child.

⁹⁰ Includes sexual misconduct against, with or in the presence of a child.

⁹¹ Includes sexual offences against, with or in the presence of a child.

Reportable allegations by sector and type of reportable conduct

Different types of allegations appear more prevalent in some sectors. For example, there is a higher proportion of sexual offence allegations in religious bodies than any other sector, and the most common allegation type in the out-of-home care and early childhood education sectors is physical violence.

Overall, and for the past five years, the highest number of allegations in the education sector relate to sexual misconduct (Table 20).

Table 20. Reportable allegations by sector and conduct type 2021–22 to 2023–24 and Scheme total

Sector ⁹² and conduct type ⁹³	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Education	1,182	100	1,687	100	1,560	100	7,661	100
Sexual misconduct	452	38	638	38	498	32	2,826	37
Physical violence	287	24	391	23	405	26	1,973	26
Behaviour that causes significant emotional or psychological harm to a child	281	24	408	24	329	21	1,768	23
Significant neglect of a child	95	8	167	10	215	14	640	8
Sexual offences	67	6	83	5	113	7	454	6
Out-of-home care	1,683	100	1,309	100	1,044	100	6,768	100
Physical violence	726	43	465	36	386	37	2,888	43
Significant neglect of a child	523	31	452	35	367	35	1,935	29
Behaviour that causes significant emotional or psychological harm to a child	331	20	334	26	219	21	1,376	20
Sexual misconduct	65	4	43	3	40	4	347	5
Sexual offences	38	2	15	1	32	3	222	3
Early childhood	491	100	660	100	799	100	3,053	100
Physical violence	289	59	362	55	486	61	1,866	61
Behaviour that causes significant emotional or psychological harm to a child	84	17	118	18	97	12	474	16
Significant neglect of a child	70	14	94	14	109	14	375	12
Sexual misconduct	31	6	70	11	77	10	260	9
Sexual offences	17	3	16	2	30	4	78	3

⁹² Some sectors including out-of-home care and education have been subject to the Scheme since it began on 1 July 2017, whereas other sectors have been subject to the Scheme for less time. Religious bodies and disability services have been covered since 1 January 2018, and early childhood education has been covered since 1 January 2019. Also, this analysis is of reportable allegations, not substantiated incidents of reportable conduct.

⁹³ Reportable conduct types have been grouped in this table. Physical violence, sexual misconduct and sexual offences includes against, with or in the presence of a child.

Table 20. Reportable allegations by sector and conduct type 2021–22 to 2023–24 and Scheme total (continued)

Sector ⁹² and conduct type ⁹³	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Religious body	292	100	243	100	111	100	1,126	100
Sexual offences	97	33	73	30	34	31	383	34
Sexual misconduct	44	15	58	24	34	31	274	24
Behaviour that causes significant emotional or psychological harm to a child	67	23	75	31	21	19	229	20
Physical violence	75	26	32	13	12	11	189	17
Significant neglect of a child	9	3	5	2	10	9	51	5
Youth justice	36	100	68	100	43	100	367	100
Physical violence	17	47	30	44	24	56	220	60
Significant neglect of a child	7	19	21	31	16	37	71	19
Sexual misconduct	4	11	11	16	1	2	42	11
Behaviour that causes significant emotional or psychological harm to a child	5	14	4	6	2	5	22	6
Sexual offences	3	8	2	3	0	–	12	3
Disability	29	100	82	100	72	100	356	100
Physical violence	13	45	30	37	20	28	168	47
Significant neglect of a child	8	28	23	28	18	25	61	17
Sexual misconduct	2	7	12	15	15	21	52	15
Behaviour that causes significant emotional or psychological harm to a child	0	–	17	21	9	13	40	11
Sexual offences	6	21	0	–	10	14	35	10
Accommodation	15	100	61	100	69	100	159	100
Sexual misconduct	8	53	21	34	29	42	62	39
Significant neglect of a child	1	7	17	28	25	36	43	27
Behaviour that causes significant emotional or psychological harm to a child	2	13	18	30	15	22	36	23
Sexual offences	0	–	4	7	0	–	10	6
Physical violence	4	27	1	2	0	–	8	5

Table 20. Reportable allegations by sector and conduct type 2021–22 to 2023–24 and Scheme total (continued)

Sector ⁹² and conduct type ⁹³	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Victorian government departments	32	100	17	100	22	100	118	100
Sexual offences	13	41	0	–	4	18	38	32
Physical violence	3	9	11	65	5	23	31	26
Behaviour that causes significant emotional or psychological harm to a child	8	25	6	35	4	18	25	21
Sexual misconduct	4	13	0	–	3	14	14	12
Significant neglect of a child	4	13	0	–	6	27	10	8
Child protection	33	100	13	100	9	100	110	100
Physical violence	9	27	4	31	3	33	41	37
Significant neglect of a child	10	30	5	38	5	56	32	29
Sexual misconduct	6	18	1	8	0	–	15	14
Behaviour that causes significant emotional or psychological harm to a child	8	24	2	15	1	11	14	13
Sexual offences	0	–	1	8	0	–	8	7
Health	8	100	13	100	3	100	101	100
Significant neglect of a child	6	75	7	54	0	–	25	25
Sexual offences	0	–	0	–	1	33	24	24
Behaviour that causes significant emotional or psychological harm to a child	1	13	2	15	1	33	20	20
Sexual misconduct	1	13	3	23	0	–	17	17
Physical violence	0	–	1	8	1	33	15	15
Other	34	100	80	100	99	100	318	100
Sexual misconduct	10	29	32	40	43	43	129	41
Physical violence	3	9	16	20	14	14	59	19
Behaviour that causes significant emotional or psychological harm to a child	5	15	19	24	14	14	57	18
Significant neglect of a child	4	12	13	16	19	19	41	13
Sexual offences	12	35	0	–	9	9	32	10
Total	3,835		4,233		3,831		20,137	

Sexual misconduct

The Commission's *Strategic Plan 2022–2025* includes a commitment to 'hold organisations to account for their obligation to rigorously investigate, and keep children and young people safe from, grooming and sexual misconduct'. While we have seen some improvement, the Commission continues to see concerning instances where organisations misunderstand the scope of 'sexual misconduct' for the purposes of the Scheme or appear reluctant to characterise behaviour as 'sexual misconduct', despite there being a proven pattern of overly personal and intimate conduct towards a child or conduct that seriously crosses professional boundaries. We also continue to see cases where organisations may substantiate that grooming has occurred but are reluctant to substantiate it as sexual misconduct under the Scheme.

The Commission will continue to support and guide organisations to conduct thorough investigations, give appropriate weight to the evidence of affected children, and make sound decisions about whether proven conduct amounts to sexual misconduct.

The education sector has contributed the majority of allegations of sexual misconduct since the Scheme began (70 per cent) (Table 21).

Table 21. Reportable allegations of sexual misconduct by sector 2021–22 to 2023–24 and Scheme total⁹⁴

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Education	452	72	638	72	498	67	2,826	70
Out-of-home care	65	10	43	5	40	5	347	9
Religious body	44	7	58	7	34	5	274	7
Early childhood	31	5	70	8	77	10	260	6
Accommodation	8	1	21	2	29	4	62	2
Disability	2	<1	12	1	15	2	52	1
Youth justice	4	<1	11	1	1	<1	42	1
Health	1	<1	3	<1	0	–	17	<1
Child protection	6	1	1	<1	0	–	15	<1
Victorian government departments	4	<1	0	–	3	<1	14	<1
Other	10	2	32	4	43	6	129	3
Total	627	100	889	100	740	100	4,038	100

⁹⁴ In some cases, data from previous financial years expressed throughout this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications or results in matters being excluded because they are subsequently determined to be out of the scope of the Scheme.

Education sector

In 2023–24 there was a 75 per cent increase in mandatory notifications received from the education sector⁹⁵ compared with 2022–23 (Table 21). This was contributed to by a 144 per cent increase in notifications from government schools and a 47 per cent increase in notifications from non-government Catholic schools. Non-government independent schools showed a nine per cent decrease in notifications from the previous financial year.

Most notifications in the education sector were made against registered teachers. However, almost a quarter of education-related notifications in 2023–24 were made against subjects of allegation who were not registered teachers (Table 22).⁹⁶

Table 22. Mandatory notifications in the education sector by subject of allegation VIT registration 2021–22 to 2023–24 and Scheme total

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Registered ⁹⁷	203	70	335	77	588	77	1,798	74
Not registered	86	30	101	23	174	23	617	26
Total	289	100	436	100	762	100	2,415	100

Sexual misconduct has been the most common allegation type for the whole education sector since the start of the Scheme (37 per cent). The education sector accounts for 70 per cent of all sexual misconduct allegations across all sectors subject to the Scheme.

Sexual misconduct has been the most common conduct type in non-government Catholic and non-government independent schools since the start of the Scheme (35 per cent and 45 per cent respectively).

In 2023–24 physical violence was the most common allegation type in government schools (33 per cent). This contrasts with the previous two years, where the majority of allegations in government schools related to sexual misconduct. There has been an increase in the number of sexual offence allegations in government schools rising from 44 in 2021–22 to 71 in 2023–24 (Table 23).

⁹⁵ Information about the education sector can be found at: <https://www.vic.gov.au/statistics-victorian-schools-and-teaching>.

⁹⁶ Many roles in schools do not require a person to be a registered teacher.

⁹⁷ Includes 14 notifications for the period 2017–24 where subjects of allegation ceased to be registered with the Victorian Institute of Teaching after the notification was submitted.

Reportable Conduct Scheme

continued

Table 23. Reportable allegations by education service type and conduct type 2021–22 to 2023–24 and Scheme total

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Non-government school – Catholic	461	100	547	100	439	100	2,783	100
Sexual misconduct	133	29	142	26	137	31	978	35
Behaviour that causes significant emotional or psychological harm to a child	128	28	157	29	106	24	709	25
Physical violence	118	26	133	24	104	24	670	24
Significant neglect of a child	70	15	96	18	60	14	317	11
Sexual offences	12	3	19	3	32	7	109	4
Government school	383	100	533	100	688	100	2,770	100
Physical violence	109	28	148	28	228	33	888	32
Sexual misconduct	154	40	214	40	188	27	885	32
Behaviour that causes significant emotional or psychological harm to a child	65	17	97	18	102	15	558	20
Sexual offences	44	11	51	10	71	10	266	10
Significant neglect of a child	11	3	23	4	99	14	173	6
Non-government school – independent	313	100	580	100	336	100	1,889	100
Sexual misconduct	155	50	266	46	117	35	853	45
Behaviour that causes significant emotional or psychological harm to a child	81	26	151	26	94	28	452	24
Physical violence	53	17	107	18	67	20	385	20
Significant neglect of a child	14	4	46	8	48	14	129	7
Sexual offences	10	3	10	2	10	3	70	4
Senior secondary course/qualification⁹⁸	23	100	20	100	95	100	191	100
Sexual misconduct	10	43	12	60	56	59	95	50
Behaviour that causes significant emotional or psychological harm to a child	6	26	1	5	26	27	44	23
Physical violence	7	30	3	15	5	5	28	15
Significant neglect of a child	0	–	2	10	8	8	20	10
Sexual offences	0	–	2	10	0	–	4	2

⁹⁸ These are courses and qualifications that are not delivered by registered schools.

Table 23. Reportable allegations by education service type and conduct type 2021–22 to 2023–24 and Scheme total (continued)

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
International student course	0	–	2	100	0	–	13	100
Sexual misconduct	0	–	1	50	0	–	11	85
Behaviour that causes significant emotional or psychological harm to a child	0	–	1	50	0	–	1	8
Sexual offences	0	–	0	–	0	–	1	8
Student exchange program	2	100	4	100	0	–	10	100
Behaviour that causes significant emotional or psychological harm to a child	1	50	1	25	0	–	3	30
Sexual misconduct	0	–	3	75	0	–	3	30
Sexual offences	1	50	0	–	0	–	2	20
Significant neglect of a child	0	–	0	–	0	–	1	10
Physical violence	0	–	0	–	0	–	1	10
Employee – other/admin	0	–	1	100	2	100	5	100
Sexual offences	0	–	1	100	0	–	2	40
Behaviour that causes significant emotional or psychological harm to a child	0	–	0	–	1	50	1	20
Physical violence	0	–	0	–	1	50	1	20
Sexual misconduct	0	–	0	–	0	–	1	20
Total	1,182		1,687		1,560		7,661	

Alleged victims

This analysis relates to notifications of reportable allegations, not substantiated incidents of reportable conduct. The term ‘alleged victim’⁹⁹ is used in this section to reflect this.

The term ‘unique alleged victim’¹⁰⁰ refers to where an alleged victim is known.¹⁰¹ Of the 8,381 unique victims of reportable allegations identified since the start of the Scheme, 54 per cent were male, 45 per cent female, and less than one per cent did not identify as either male or female or their gender was unknown.¹⁰²

In 2023–24, there were 1,982 unique alleged victims identified relating to 1,615 notifications.¹⁰³ Fifty-three per cent of these unique alleged victims were male and 46 per cent were female. The remaining one per cent of alleged victims did not identify as either male or female or their gender was unknown.

As in previous years, alleged victims of sexual misconduct were more likely to be female. This year 69 per cent of sexual misconduct allegations related to girls or young women. Sexual misconduct accounted for 28 per cent of all allegations involving a female alleged victim in 2023–24 and only 10 per cent of all allegations involving a male alleged victim.¹⁰⁴

This year there has been an increase in the proportion of sexual offence allegations that have involved girls and young women as alleged victims, rising from 45 per cent last year to 57 per cent this year.¹⁰⁵

Sixty per cent of allegations of physical violence involved a male alleged victim (Figure 6). This type of conduct accounted for almost half of all allegations involving a male alleged victim in 2023–24 (45 per cent) and over a quarter of all allegations involving a female alleged victim (26 per cent).

⁹⁹ Alleged victims must be aged under 18 years at the time of the alleged conduct to be covered under the Scheme.

¹⁰⁰ ‘Unique alleged victim’ refers to an individual child or young person who has been the victim of a reportable allegation at least once during the Scheme. Where unique alleged victims are referred to in terms of the financial year, this refers to the number of people who were the victim of a reportable allegation within the financial year referenced. Where a child or young person has been the victim of multiple allegations over multiple years, they will be counted once for each financial year. As a result of this, financial year totals will not add up to the whole-of-Scheme totals because they are based on different counting methodologies.

¹⁰¹ In some notifications the identity of the alleged victim may be unknown.

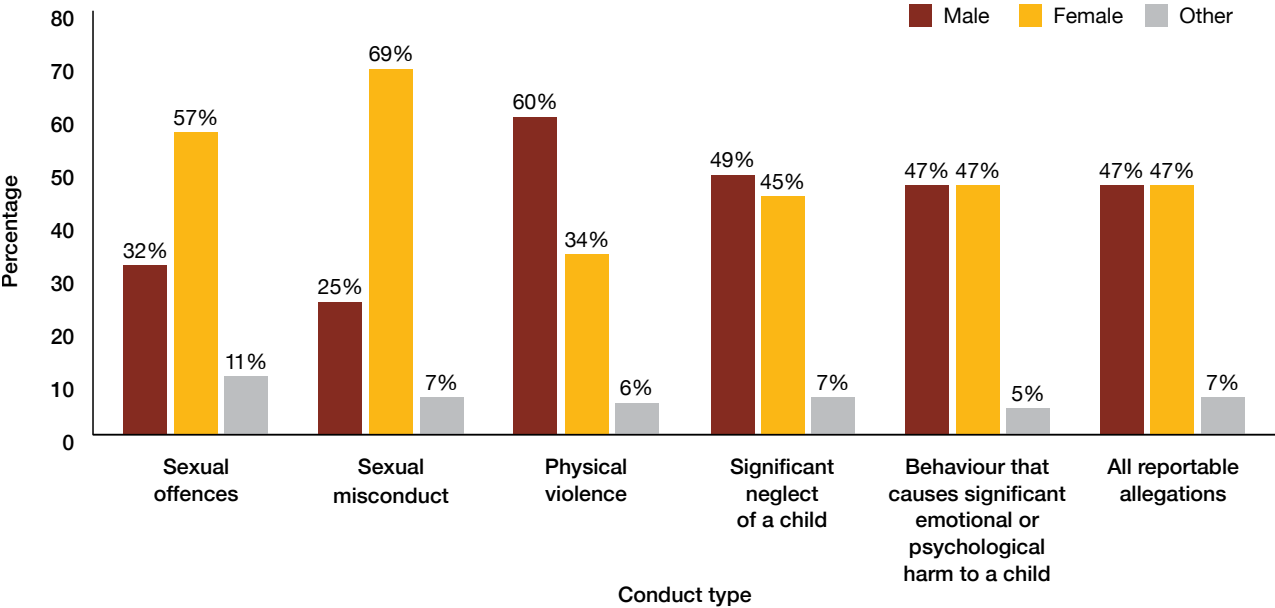
¹⁰² Alleged victims with a recorded gender of ‘other’ may identify as non-binary or gender diverse. There have been 46 unique alleged victims (less than one per cent) with a recorded gender of ‘other’ and another five whose gender is not known.

¹⁰³ This also includes unique alleged victims where no mandatory notification was received but the Commission is conducting an own motion investigation.

¹⁰⁴ This paragraph is based on an analysis of reportable allegations, not unique alleged victims.

¹⁰⁵ In some cases, data from previous financial years expressed throughout this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time.

Figure 6. Reportable allegations by type of reportable conduct and gender of alleged victims 2023–24¹⁰⁶



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

In 2023–24, organisations subject to the Scheme identified:¹⁰⁷

- eight per cent of unique alleged victims as being Aboriginal and/or Torres Strait Islander,¹⁰⁸ which is a substantial over-representation of Aboriginal and Torres Strait Islander children and young people, who only make up two per cent of the Victorian population under 18 years of age¹⁰⁹
- 15 per cent of unique alleged victims as being from a culturally and/or linguistically diverse background¹¹⁰
- 17 per cent of unique alleged victims as having a disability.¹¹¹

¹⁰⁶ Alleged victims with a recorded gender of ‘other’ may identify as non-binary or gender diverse. ‘Other’ also includes alleged victims with an unknown gender. In 2023–24 there were 18 allegations where the alleged victim had an identified gender of ‘other’ that account for less than one per cent of alleged victims and 237 allegations had an alleged victim with an unknown gender. For most of these allegations, the alleged victim was unknown.

¹⁰⁷ The Commission was not provided with details of characteristics of the alleged victim in a high number of matters. In the next financial year the Commission will continue to further increase efforts to require organisations to turn their minds to these characteristics.

¹⁰⁸ This is consistent with the nine per cent of unique alleged victims who were identified as Aboriginal and/or Torres Strait Islander since the start of the Scheme.

¹⁰⁹ Australian Bureau of Statistics (2011 to 2031), Estimates and Projections, Aboriginal and Torres Strait Islander Australians, ABS website, accessed 29 July 2024.

¹¹⁰ This is consistent with the 15 per cent of unique victims who were identified as being from a culturally and/or linguistically diverse background since the start of the Scheme.

¹¹¹ This is slightly more than the 14 per cent of unique alleged victims who were identified as having a disability since the start of the Scheme.

Age of alleged victim and alleged reportable conduct type

Across almost all age groups, physical violence was consistently the most likely type of reportable conduct about which allegations were raised.¹¹²

In 2023–24 physical violence accounted for 56 per cent of all allegations for children aged zero to four years, 46 per cent for children aged five to nine years and 31 per cent for children aged 10 to 14 years.¹¹³

In contrast, the most common allegation conduct type for young people aged 15 to 17 years was sexual misconduct (37 per cent), which is consistent with previous years. Sexual misconduct made up seven per cent of allegations for children aged zero to four years, seven per cent for children aged five to nine years and 19 per cent of allegations for children aged 10 to 14 years.¹¹⁴

The average age of unique alleged victims at the time of the first reportable allegation in 2023–24 was nine years.

Consistent with previous years, the largest proportion of unique alleged victims in 2023–24 was aged 10 to 14 years (26 per cent), followed by those aged zero to four years (26 per cent).

Table 24. Age of unique alleged victim at date of first reportable allegation 2021–22 to 2023–24 and Scheme total¹¹⁵

Age ¹¹⁶	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
0 to 4 years	324	22	404	24	510	26	1,978	24
5 to 9 years	310	21	315	19	386	19	1,581	19
10 to 14 years	475	32	546	32	519	26	2,387	28
15 to 17 years	302	20	328	19	354	18	1,628	19
18 years ¹¹⁷	4	<1	≤3	<1	≤3	<1	13	<1
Not identified	86	6	91	5	211	11	794	9
Total	1,501	100	1,686	100	1,982	100	8,381	100

¹¹² This paragraph is based on an analysis of reportable allegations, not unique alleged victims.

¹¹³ This paragraph is based on an analysis of reportable allegations, not unique alleged victims.

¹¹⁴ This paragraph is based on an analysis of reportable allegations, not unique alleged victims.

¹¹⁵ In order to maintain confidentiality, person-based counts with a value of 1 to 3 are given a value of 2 to calculate totals and are denoted by '≤3'.

¹¹⁶ Where a child or young person has been the victim of multiple reportable allegations, age is calculated based on the earliest reportable allegation.

¹¹⁷ These allegations were determined to be out of jurisdiction of the Scheme, or remain under review.

Subjects of allegation

A worker or volunteer who is alleged to have committed reportable conduct is known as the subject of allegation. A person can be the subject of allegation for more than one notification with multiple reportable allegations involving more than one alleged victim. The following analysis relates to the characteristics of the subjects of reportable allegations, not substantiated incidents of reportable conduct.

In 2023–24, there were 1,749 unique individuals who were subjects of allegation¹¹⁸ (a 27 per cent increase on 2022–23). Just over half of these individuals were subject to one allegation (55 per cent) and a small proportion (nine per cent) were the subject of five or more allegations.

Since the start of the Scheme, 6,861 unique individuals have been the subject of allegations. Ninety per cent of these individuals were involved in one notification to the Commission since the start of the Scheme and the remainder were involved in two to nine reportable notifications.

Gender and reportable conduct type

Of the 1,749 individuals who were the subject of the 3,831 reportable allegations made in 2023–24, just over half were female (55 per cent) and 44 per cent were male. The remaining individuals did not identify as either male or female (less than one per cent).

Physical violence was the largest category of reportable allegations for women (46 per cent), and sexual misconduct was the largest category for men (32 per cent) in 2023–24 (Table 25).¹¹⁹

For men, the combined categories of sexual misconduct and sexual offences accounted for 43 per cent of all reportable allegations this year. In 2023–24, 85 per cent of

all sexual offences and 84 per cent of all sexual misconduct reportable allegations were made against men.¹²⁰

Women were more likely to be the subject of a reportable allegation of physical violence (65 per cent) or significant neglect of a child (63 per cent) compared with men (35 per cent and 36 per cent respectively), (Figure 7).

¹¹⁸ 'Unique subject of allegation' refers to an individual who has been the subject of a reportable allegation at least once during the Scheme. Where the unique subject of allegations are referred to in terms of the financial year, then this refers to the number of individuals who were the subject of a reportable allegation within the financial year referenced. Where an individual has been the subject of multiple allegations over multiple years, they will be counted once for each financial year. As a result of this, financial year totals will not add up to the whole-of-Scheme totals because they are based on different counting methodologies.

¹¹⁹ This paragraph is based on an analysis of reportable allegations, not unique subjects of allegation.

¹²⁰ This paragraph is based on an analysis of reportable allegations, not unique subjects of allegation.

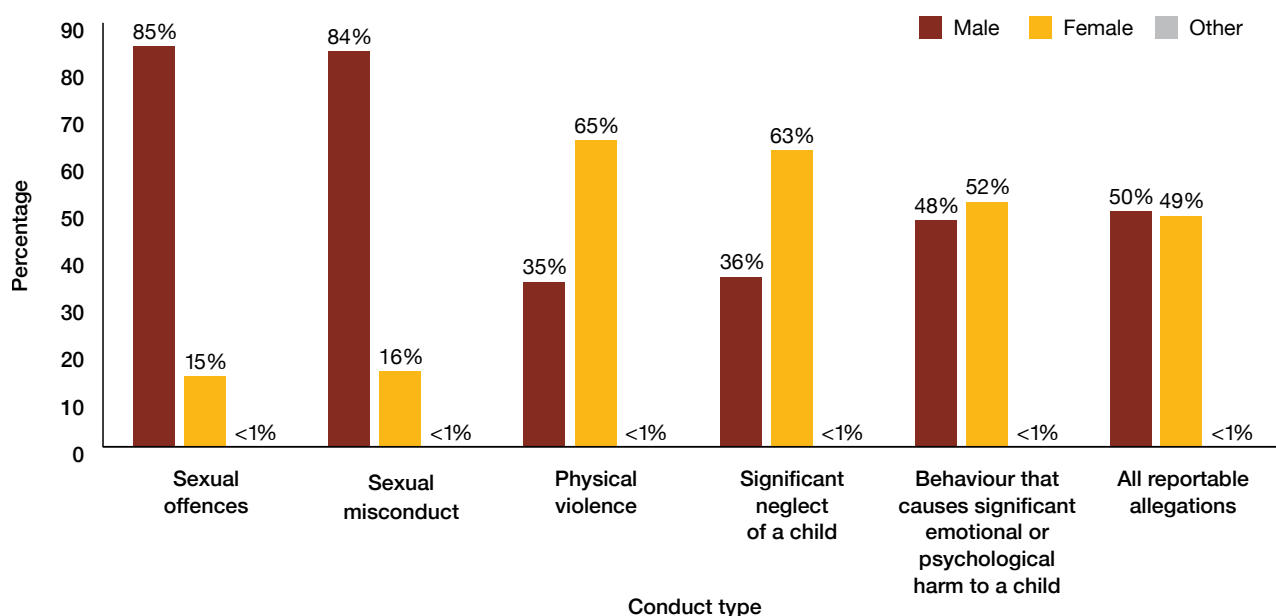
Table 25. Reportable allegations by gender of subject of allegation and conduct type 2021–22 to 2023–24 and Scheme total

Gender of subject of allegation ¹²¹ and conduct type	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Female	1,949	100	2,201	100	1,896	100	9,723	100
Physical violence	848	44	807	37	876	46	4,478	46
Significant neglect of a child	553	28	582	26	501	26	2,288	24
Behaviour that causes significant emotional or psychological harm to a child	401	21	572	26	369	19	2,099	22
Sexual misconduct	102	5	212	10	116	6	681	7
Sexual offences	45	2	28	1	34	2	177	2
Male	1,865	100	2,024	100	1,923	100	10,373	100
Sexual misconduct	524	28	675	33	619	32	3,349	32
Physical violence	577	31	535	26	477	25	2,975	29
Behaviour that causes significant emotional or psychological harm to a child	387	21	429	21	342	18	1,955	19
Sexual offences	208	11	164	8	198	10	1,116	11
Significant neglect of a child	169	9	221	11	287	15	978	9
Other¹²²	21	100	8	100	12	100	41	100
Significant neglect of a child	15	71	1	13	2	17	18	44
Sexual misconduct	1	5	2	25	5	42	8	20
Behaviour that causes significant emotional or psychological harm to a child	4	19	2	25	1	8	7	17
Physical violence	1	5	1	13	3	25	5	12
Sexual offences	0	–	2	25	1	8	3	7
Total	3,835		4,233		3,831		20,137	

¹²¹ This table is based on an analysis of reportable allegations and not unique subjects of allegation.

¹²² Subjects of allegation with a recorded gender of 'other' may identify as non-binary or gender diverse.

Figure 7. Reportable allegations by type of conduct and gender of subject of allegation 2023–24¹²³



Employment status of subjects of allegation

The Commission records the employment status of subjects of allegation. The categories are based on the relationship of the subject of allegation to the organisation that submitted the mandatory notification. In 2023–24, 85 per cent of subjects of allegation were identified as employees of an organisation and 13 per cent identified as foster or kinship carers (Table 26).

Table 26. Unique subjects of allegation by employment type 2021–22 to 2023–24 and Scheme total¹²⁴

Employment type ¹²⁵	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Employee	776	69	1,068	78	1,480	85	5,291	77
Foster or kinship carer	293	26	235	17	225	13	1,256	18
Volunteer	21	2	41	3	31	2	169	2
Minister of religion or religious leader	34	3	29	2	13	<1	138	2
Other ¹²⁶	≤3	<1	≤3	<1	0	–	7	<1
Total	1,126	100	1,375	100	1,749	100	6,861	100

¹²³ Subjects of allegation with a recorded gender of ‘other’ may identify as non-binary or gender diverse.

¹²⁴ In order to maintain confidentiality, person-based counts with a value of 1 to 3 are given a value of 2 to calculate totals and are denoted by ‘≤3’.

¹²⁵ An individual can be the subject of allegation in more than one notification and may have different roles in different organisations. Where this has occurred, the employment type referenced in the individual’s earliest reportable conduct has been used.

¹²⁶ ‘Other’ includes contractors.

Findings from investigations into reportable allegations

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

Finalised mandatory notifications

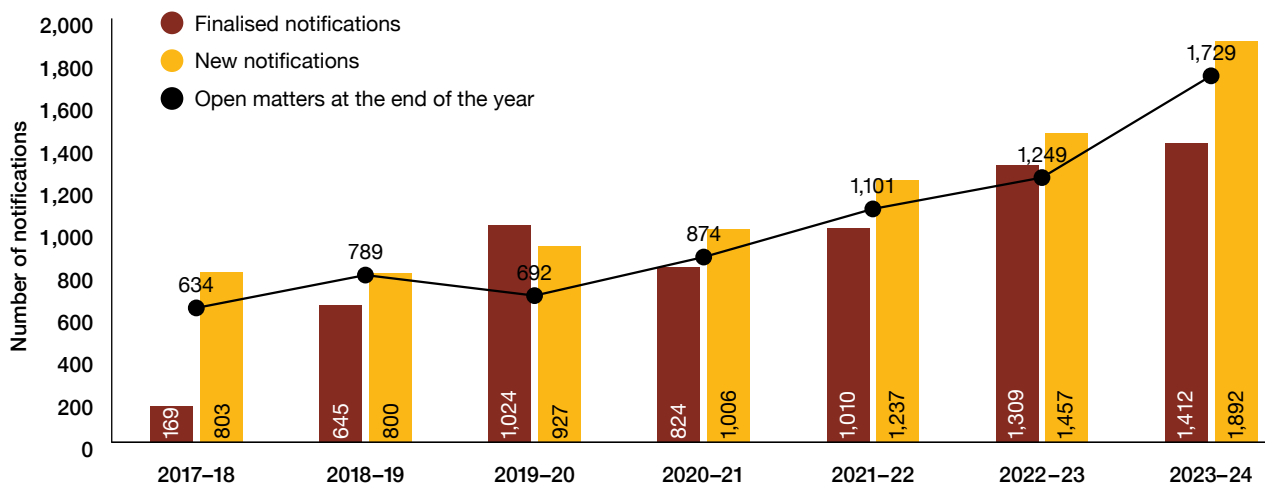
Out of the 8,122 mandatory notifications received by the Commission since the start of the Scheme, 6,393 (79 per cent) were finalised and, of these, 414 (five per cent) were assessed as being outside the scope of the Scheme as at 30 June 2024.

There were 1,729 open mandatory notifications at 30 June 2024, a 39 per cent increase on the same time last year (Figure 8).

A total of 1,412 notifications of reportable allegations were finalised by the Commission in 2023–24.¹²⁷ The finalisation rate¹²⁸ for 2023–24 was 75 per cent.

Out of the 20,137 reportable allegations¹²⁹ received by the Commission since the start of the Scheme, 16,539 (82 per cent) had been finalised by the Commission as at 30 June 2024. A total of 4,062 reportable allegations were finalised by the Commission in 2023–24.¹³⁰

Figure 8. New notifications each year, matters open and finalised at the end of each financial year 2017–18 to 2023–24



¹²⁷ Of these, 97 notifications (seven per cent) were assessed by the Commission as being outside the jurisdiction of the Scheme, and 15 were closed as the subject of allegation was deceased.

¹²⁸ This is the rate of finalisation of notifications compared with new notifications being received.

¹²⁹ Includes reportable allegations finalised through own motion investigations conducted by the Commission under section 160 of the *Child Wellbeing and Safety Act 2005*.

¹³⁰ Includes reportable allegations finalised through own motion investigations conducted by the Commission under section 160 of the *Child Wellbeing and Safety Act 2005*.

Reportable conduct findings

There have been 5,901 notifications^{131,132} and 16,418 reportable allegations finalised following an investigation since the Scheme started.¹³³

Thirty per cent of reportable allegations were substantiated in 2023–24, which is consistent with previous years (Table 27).

Table 27. Findings per allegation 2021–22 to 2023–24 and Scheme total¹³⁴

Finding type	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Substantiated	757	28	1,185	28	1,191	30	4,722	29
Unsubstantiated – insufficient evidence	851	31	1,262	30	1,209	30	4,825	29
Unsubstantiated – lack of evidence of weight	673	25	1,068	25	774	19	3,665	22
Unfounded	215	8	401	9	383	10	1,506	9
Conduct outside scheme	213	8	346	8	441	11	1,700	10
Total	2,709	100	4,262	100	3,998	100	16,418	100

In 2023–24, sexual misconduct and sexual offences had the equal highest substantiation rate of any conduct category, with 38 per cent of allegations in these categories resulting in a substantiated finding (Table 28).

The substantiation rate for sexual misconduct allegations has steadily increased in each of the past five years, rising from 21 per cent in 2018–19 to 38 per cent in 2023–24.

The substantiation rate for sexual offence allegations has substantially increased over the life of the Scheme, rising from 15 per cent in 2018–19 to 41 per cent in 2022–23.¹³⁵ In 2023–24 the substantiation rate for sexual offence allegations was 38 per cent.¹³⁶

¹³¹ Excludes mandatory notifications determined to be outside the scope of the Scheme, where the entity has ceased its operations, and where an investigation was not completed due to issues including safety concerns for alleged victims.

¹³² Includes matters finalised through own motion investigations conducted by the Commission under section 160 of the *Child Wellbeing and Safety Act 2005*.

¹³³ Includes allegations where the Commission was notified that a subject of allegation was deceased after completing of the investigation and allegations investigated or identified through Commission own motion investigations.

¹³⁴ By year of finalisation by the Commission.

¹³⁵ This does not reflect the outcomes of criminal investigations and charges.

¹³⁶ The reportable conduct investigations for this conduct type may take longer to complete because they often involve criminal investigations by Victoria Police.

Reportable Conduct Scheme

continued

Table 28. Findings per reportable conduct category 2021–22 to 2023–24 and Scheme total¹³⁷

Conduct type and finding	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Physical violence	1,033	100	1,351	100	1,247	100	6,184	100
Substantiated	246	24	367	27	379	30	1,803	29
Unsubstantiated – insufficient evidence	315	30	423	31	345	28	1,745	28
Unsubstantiated – lack of evidence of weight	308	30	376	28	305	24	1,573	25
Unfounded	67	6	92	7	108	9	480	8
Conduct outside scheme	97	9	93	7	110	9	583	9
Behaviour that causes significant emotional or psychological harm to a child	523	100	1,020	100	920	100	3,434	100
Substantiated	117	22	194	19	160	17	650	19
Unsubstantiated – insufficient evidence	184	35	351	34	350	38	1,210	35
Unsubstantiated – lack of evidence of weight	144	28	272	27	198	22	847	25
Unfounded	55	11	136	13	74	8	356	10
Conduct outside scheme	23	4	67	7	138	15	371	11
Sexual misconduct	596	100	872	100	887	100	3,387	100
Substantiated	183	31	304	35	336	38	1,109	33
Unsubstantiated – insufficient evidence	199	33	194	22	242	27	915	27
Unsubstantiated – lack of evidence of weight	112	19	200	23	108	12	590	17
Unfounded	50	8	69	8	82	9	302	9
Conduct outside scheme	52	9	105	12	119	13	471	14
Significant neglect of a child	382	100	840	100	705	100	2,523	100
Substantiated	145	38	246	29	225	32	858	34
Unsubstantiated – insufficient evidence	121	32	240	29	197	28	707	28
Unsubstantiated – lack of evidence of weight	50	13	195	23	124	18	452	18
Unfounded	28	7	82	10	97	14	264	10
Conduct outside scheme	38	10	77	9	62	9	242	10

¹³⁷ By year of finalisation by the Commission.

Table 28. Findings per reportable conduct category 2021–22 to 2023–24 and Scheme total (continued)

Conduct type and finding	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Sexual offences	175	100	179	100	239	100	890	100
Substantiated	66	38	74	41	91	38	302	34
Unsubstantiated – insufficient evidence	32	18	54	30	75	31	248	28
Unsubstantiated – lack of evidence of weight	59	34	25	14	39	16	203	23
Unfounded	15	9	22	12	22	9	104	12
Conduct outside scheme	3	2	4	2	12	5	33	4
Total	2,709		4,262		3,998		16,418	

Substantiated reportable conduct

Substantiation rates in different sectors vary. Among the three sectors contributing the highest number of notifications, in 2023–24 out-of-home care had a substantiation rate consistent with that of all sectors since the start of the Scheme (29 per cent), early childhood education had a slightly lower substantiation rate of 27 per cent, and education had a higher rate of 36 per cent (Table 29).

Table 29. Substantiation rate of reportable conduct incidents by sector 2021–22 to 2023–24 and

Scheme total ^{138,139}

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	Sub. rate	No.	Sub. rate	No.	Sub. rate	No.	Sub. rate
Education	273	28%	542	35%	536	36%	1,968	33%
Out-of-home care	277	30%	335	21%	334	29%	1,562	27%
Early childhood education	90	20%	189	28%	190	27%	661	24%
Religious body	71	33%	63	27%	53	19%	237	27%
Youth justice	9	53%	13	42%	8	16%	70	28%
Disability	10	24%	11	26%	8	15%	55	20%
Victorian government departments	1	100%	2	10%	17	49%	29	37%
Child protection	11	42%	0	–	2	11%	26	25%
Health	7	64%	6	75%	1	8%	21	22%
Accommodation	2	67%	7	29%	2	2%	13	9%
Other	6	32%	17	29%	40	32%	80	29%
Total	757	28%	1,185	28%	1,191	30%	4,722	29%

Victims of substantiated findings

During the Scheme’s seven years of operation, 4,409¹⁴⁰ allegations have been substantiated involving 2,615 individual unique victims.¹⁴¹ A small number (seven per cent) of substantiated incidents involved unknown victims.

Of the 2,615 unique victims, over half (53 per cent) were male and 46 per cent were female.¹⁴²

The majority of these 2,615 victims had one substantiated reportable conduct incident (67 per cent) since the start of the Scheme. Just under one-fifth (19 per cent) had two substantiated incidents and 10 per cent had between three and four substantiated incidents. The remaining four per cent had five or more substantiated incidents.

Of the substantiated incidents where the victim was known, the largest proportion of victims was aged between 10 and 14 years at the time of the reportable conduct (30 per cent), followed by those aged 15 to 17 years (24 per cent).¹⁴³

¹³⁸ ‘No.’ refers to total number of substantiated reportable conduct incidents. Substantiation rate is the percentage of all findings in the sector that were substantiated by the organisations conducting investigations.

¹³⁹ By year of finalisation by the Commission.

¹⁴⁰ This includes only allegations where there is a known victim.

¹⁴¹ ‘Unique victim’ refers to an individual child or young person who has been the victim of a substantiated allegation of reportable conduct at least once during the Scheme. Where a child or young person has been the victim of multiple incidents of reportable conduct over multiple years, they are counted once.

¹⁴² A small proportion (less than one per cent) of victims had a recorded gender of ‘other’ and may identify as non-binary or gender diverse.

¹⁴³ Where a child or young person has been the victim of multiple substantiated reportable allegations, their reported age is based on the earliest substantiated allegation.

Persons found to have engaged in substantiated reportable conduct

Since the start of the Scheme, there have been 1,833 individuals found to have engaged in reportable conduct.¹⁴⁴

Of the 1,833 people found to have engaged in substantiated reportable conduct, over half (53 per cent) were women and 47 per cent were men.¹⁴⁵

Just under three-quarters of all people who engaged in substantiated reportable conduct since the Scheme started were classified as employees of an organisation (72 per cent). A further 23 per cent were foster or kinship carers, and the remaining five per cent were spread across ministers of religion or religious leaders, contractors, volunteers and other types of involvement.

Just under half of people found to have engaged in substantiated reportable conduct had one substantiated allegation (48 per cent). Twenty-four per cent had two substantiated allegations, 24 per cent had between three and nine substantiated allegations and the remaining three per cent had 10 or more substantiated allegations.

Ninety-five per cent of individuals found to have engaged in substantiated reportable conduct were the subject of one notification, four per cent were the subject of two notifications and the remaining (less than one per cent) were the subject of three notifications.

Almost half (44 per cent) of those found to have engaged in reportable conduct since the start of the Scheme were aged between 40 and 59 years at the time of the

reportable conduct and over one-third (38 per cent) were aged between 20 and 39 years.¹⁴⁶

Historical allegations

A historical allegation is defined as an allegation of reportable conduct where the conduct occurred before the start of the Scheme – 1 July 2017.¹⁴⁷

The Scheme requires certain allegations of past or historical reportable conduct to be reported to the Commission and investigated by organisations. Some historical matters can proceed through an investigation without undue challenge, while others can be significantly impacted by the passage of time.

Since the start of the Scheme, 670 (eight per cent) of all mandatory notifications involved alleged conduct that is historical. These notifications involved 2,051 allegations. Over a quarter of these historical allegations relate to alleged conduct that occurred in the three years before the Scheme started (27 per cent). However, 20 per cent of these historical allegations refer to alleged conduct that occurred prior to 1980.

Allegations associated with subjects of allegation engaged by religious bodies make up 35 per cent of all historical notifications and 39 per cent of historical reportable allegations. Since the start of the Scheme, 71 per cent of allegations in relation to religious organisations were historical.

Allegations associated with subjects of allegation engaged by the education sector make up 41 per cent of all historical notifications and 41 per cent of historical reportable allegations. This is slightly higher than the

¹⁴⁴ 'Person found to have engaged in substantiated reportable conduct' refers to an individual who has been the subject of at least one substantiated reportable allegation during the Scheme. Where an individual has been found to have multiple substantiated allegations over multiple years, they are counted once.

¹⁴⁵ A small proportion (less than one per cent) of persons found to have engaged in substantiated reportable conduct had a recorded gender of 'other' and may identify as non-binary or gender diverse.

¹⁴⁶ Where an individual has been found to have multiple substantiated allegations, age is calculated based on the earliest substantiated allegation.

¹⁴⁷ For example, religious bodies were brought into the Scheme on 1 January 2018. A historical allegation in relation to a religious body concerns conduct alleged to have occurred before 1 January 2018. These allegations will be covered by the Scheme where the allegation was raised after that date and the subject of allegation was employed or engaged by an organisation covered by the Scheme after that date. For the purposes of this analysis, allegations have been classified as historical if they relate to conduct prior to the start of the Scheme (1 July 2017). This means there will be an underestimation of historical allegations.

overall proportion of reportable allegations, where those in the education sector make up 38 per cent.

Over a third (37 per cent) of reportable allegations involving conduct before 1980 involved sexual offences. For the period 1980 to 2014,¹⁴⁸ almost a third (32 per cent) of the allegations were for sexual offences and almost a third (29 per cent) were for sexual misconduct.

However, in the three years before the Scheme began, over one-third (38 per cent) of all allegations related to sexual misconduct, while sexual offences accounted for 13 per cent.

Historical substantiated reportable conduct

The Commission has received 670 notifications relating to 2,051 allegations of historical reportable conduct. To date, 411 allegations relating to 132 notifications have been substantiated. This is a substantiation rate of 26 per cent,¹⁴⁹ which is slightly lower than the overall substantiation rate.

Over one-third (40 per cent) of substantiated historical allegations were in the education sector, and a further 33 per cent were for religious bodies. Within the education sector, 70 per cent of substantiated historical allegations related to sexual misconduct and sexual offences (62 per cent and eight per cent respectively). Within religious bodies, 71 per cent of substantiated historical allegations related to sexual misconduct and sexual offences (21 per cent and 50 per cent respectively).

Sharing information

The Scheme enables the sharing of information about allegations, findings and other information to assist organisations to take action to support children's safety. The information sharing provisions in the CWSA are supplemented by the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme in Victoria.

Notifications to Victoria Police

Organisations and the Commission must notify Victoria Police of reportable allegations that may involve conduct that is criminal in nature.

Of the 1,892 notifications of reportable allegations made to the Commission in 2023–24, 53 per cent (996) were reported to Victoria Police by either the organisation or the Commission because they involved possible criminal conduct.^{150,151}

During this period, the Commission referred 420 notifications that had not previously been reported to police.¹⁵²

For the period from 1 July 2023 to 30 June 2024, the Commission referred 67^{153,154} matters that involved conduct that may be criminal in nature that were not within the jurisdiction of the Scheme.

¹⁴⁸ This period refers to January 1980 to June 2014.

¹⁴⁹ Includes four allegations where the Commission was notified that a subject of allegation was deceased after completing the investigation.

¹⁵⁰ There is a variance of less than one per cent between the figures reported by Victoria Police and the Commission due to different counting methodologies.

¹⁵¹ The Commission referred another seven notifications that were received in the previous financial year.

¹⁵² This number is based on the information provided to the Commission at the time of the notification being made. The allegation may have been reported concurrently or via an alternative pathway.

¹⁵³ This includes one subject of allegation who died during the Commission's assessment of the notification.

¹⁵⁴ There were another 35 notifications that were referred to Victoria Police because the conduct may be criminal in nature. At the end of the financial year, these 35 notifications were under review by the Commission to determine whether they are within the scope of the Scheme, and, if so, whether a mandatory notification is required to be submitted by an organisation.

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

- terms of imprisonment, including suspended sentences
- good behaviour bonds
- intervention orders, including family violence intervention orders granted
- community correction orders
- diversion
- adjournment without conviction.

Referrals to the Working with Children Check Unit

One of the important ways the Commission contributes to children's safety is by referring substantiated allegations of reportable conduct to the Secretary of the Department of Government Services (DGS). This enables DGS to assess whether the person should retain a Working with Children Check under the *Worker Screening Act 2020*.

In 2023–24, 383 people found to have committed substantiated reportable conduct were referred to DGS in relation to 1,135 substantiated allegations of reportable conduct.

Since the start of the Scheme, 1,726 people found to have committed reportable conduct have been referred to DGS in relation to 4,577¹⁵⁵ substantiated allegations of reportable conduct.

In the Commission's 2019 and 2023 reviews of the administration of the *Working with Children Act 2005* and the *Worker Screening Act*, the Commission recommended the Victorian Government amend laws to enable DGS to share information with the Commission on the outcomes of all assessments triggered by a Commission notification. DGS has implemented a process to enable this

information to be shared with the Commission, and we hope this will commence next year.

Referrals to the Victorian Institute of Teaching

On becoming aware that a registered teacher is the subject of a reportable allegation, the Commission must notify the Victorian Institute of Teaching (VIT) in line with the *Education Training and Reform Act 2006*. The Commission must also refer any findings of substantiated reportable conduct to VIT at the completion of an investigation. In practice, the Commission referred all findings from completed reportable conduct investigations to VIT in 2023–24.

In 2023–24 the Commission advised VIT of 654¹⁵⁶ notifications of reportable allegations in relation to registered teachers and shared information with VIT about the findings in 277 finalised notifications.

Since the start of the Scheme, the Commission has advised VIT of 2,070¹⁵⁷ notifications relating to 1,935 registered teachers and has shared information about 1,315¹⁵⁸ finalised notifications.

¹⁵⁵ In some cases, data from previous financial years expressed throughout this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time.

¹⁵⁶ This refers to notifications of reportable allegations, not individual teachers. Individual teachers could have more than one notification of reportable allegations made against them. Registered teachers do not work solely in schools and may work in sectors including early childhood education and out-of-home care.

¹⁵⁷ Data was extracted on 1 July 2024 from a live database and is subject to change.

¹⁵⁸ Data was extracted on 1 July 2024 from a live database and is subject to change.

Public notifications

The Commission can be notified of allegations by any person and that person can choose to remain anonymous and have protection under the CWSA if disclosures are made in good faith.

In 2023–24, public notifications came from a range of sources including workers in organisations subject to the Scheme about the conduct of workers inside their organisation and other organisations, parents or carers, Victoria Police, other regulators and members of the public.

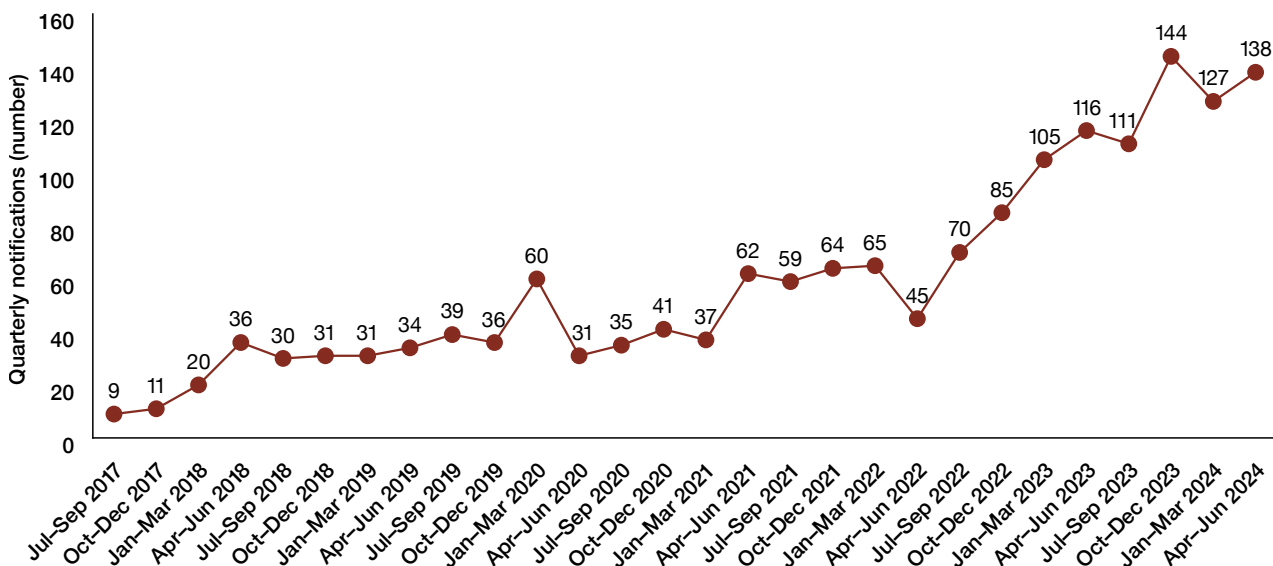
In 2023–24, the Commission received 520 disclosures of potential reportable allegations from people other than the head of an organisation. These related to 344 unique organisations.¹⁵⁹ Mandatory notifications were subsequently submitted by organisations in relation to

43 per cent of public notifications. In some cases, multiple public notifications may be made about the same conduct and will result in only one mandatory notification being made.

Some public notifications do not disclose a matter within the jurisdiction of the Scheme. The Commission assessed 19 per cent as being outside the jurisdiction of the Scheme. Another 20 per cent of public notifications were under consideration at 30 June 2024.

Due to the relatively small numbers, public notifications received by the Commission can vary from quarter to quarter. However, as can be seen in Figure 9, the number of public notifications received by the Commission each quarter has risen substantially over the life of the Scheme. In 2023–24, the Commission received an average of 130 public notifications per quarter.

Figure 9. Public notifications by quarter received 2017–18 to 2023–24



¹⁵⁹ Public notifications are recorded based on the subject of allegation and the organisation they are employed or engaged by.

The majority of public notifications in 2023–24 relate to the education sector (37 per cent) and out-of-home care (14 per cent), which is consistent with the Scheme to date, 41 per cent and 17 per cent respectively (Table 30).

Table 30. Public notifications received by sector 2021–22 to 2023–24 and Scheme total¹⁶⁰

Sector	2021–22		2022–23		2023–24		Since the start of the Scheme	
	No.	%	No.	%	No.	%	No.	%
Education	85	36	165	44	194	37	691	41
Out-of-home care	41	18	52	14	86	17	279	17
Early childhood education	31	13	56	15	89	17	211	13
Disability	21	9	21	6	46	9	118	7
Religious body	10	4	14	4	19	4	85	5
Child protection	16	7	5	1	19	4	55	3
Accommodation	7	3	12	3	5	1	31	2
Health	5	2	8	2	7	1	26	2
Victorian government departments	1	<1	2	<1	2	<1	8	<1
Youth justice	0	–	1	<1	2	<1	4	<1
Other	16	7	40	11	51	10	164	10
Total	233	100	376	100	520	100	1,672	100

¹⁶⁰ In some cases, data from previous financial years expressed in this report is different from that published in previous Commission annual reports. Variations are due to the fact that Scheme data is live and includes open matters, causing some movement of data over time. New information can come to light as a matter progresses that alters previous classifications.

Own motion investigations and other compliance actions

In limited circumstances, the Commission may, on our own motion, investigate an allegation of reportable conduct by a worker or volunteer who is or was engaged by an organisation subject to the Scheme (sections 16O(1) and 16O(2) of the CWSA). The Commission may also conduct an investigation concerning any inappropriate handling of, or response to, a reportable allegation (section 16O(3)).

In 2023–24, the Commission completed six own motion investigations under section 16O(1) and 16O(2)¹⁶¹ and has completed 12 own motion investigations since the start of the Scheme.

The Commission has completed one own motion investigation into the inappropriate handling of, or response to, an investigation into a reportable allegation by an organisation under section 16O(3). This was concluded in the previous financial year and no new investigations of this type were launched in 2023–24.

In 2023–24, 24 own motion investigations were active, with the Commission launching four new investigations and progressing 20 existing investigations started in previous years (Table 31). Sectors involved in these own motion investigations include accommodation, disability, early childhood education, education, out-of-home care and religious bodies.

Table 31. Reportable Conduct Scheme compliance actions 2023–24

Action type	No.
Section 16K – recommendation for action regarding reportable conduct systems	nil
Section 16O – own motion investigation concerning a reportable allegation	24 ¹⁶²
Section 16ZG – notice to produce	nil

Table 32. Reportable Conduct Scheme enforcement action 2023–24

Action type	No.
Section 16ZF – prosecution for providing false or misleading information	nil
Section 16ZH – application for civil penalty – failure to comply with a notice to produce	nil

Table 33. Reportable Conduct Scheme decisions reviewed 2023–24

Action type	No.
Section 16ZI – internal review	nil
Section 16ZJ – review by VCAT	nil

¹⁶¹ In addition, the Commission started two own motion investigations that were discontinued.

¹⁶² This captures own motion investigations that were active during 2023–24.

Child Safe Standards

Child Safe Standards

Overview

- In 2023–24, the Commission initiated compliance action in relation to 43 organisations for potential non-compliance with the Child Safe Standards (the Standards). In the same time frame, we also completed compliance activity with 67¹⁶³ organisations.
- The Commission increased its use of enforcement powers to tackle issues of non-compliance with the Standards where organisations were resistant or slow to act on safety risks. We issued eight notices to comply and seven notices to produce, undertook three inspections and issued an official warning for suspected non-compliance with a notice issued by the Commission.
- This year we have identified a number of concerning situations in different organisations where a worker or volunteer was facing allegations of child abuse and was under investigation by Victoria Police or had been charged. In these situations, potential risks to children had not been properly managed by the organisation and we acted to require these organisations to improve their protections for children.

Strengthening our approach to promoting compliance with the Standards

The Standards are mandatory requirements that must be implemented by certain organisations that provide services or facilities for children, or that engage children. They promote children's safety by requiring organisations to take certain steps to prevent, respond to and report allegations of child abuse and to maintain a culture and environment that supports children's safety and wellbeing. On 1 January 2023 the *Child Wellbeing and Safety (Child Safe Standards Compliance and Enforcement) Amendment Act 2021* came into effect introducing new powers for the Commission and other Standards regulators to monitor and enforce the Standards. This legislation also changed

the co-regulatory model and clarified which sectors are regulated by which Standards regulator.

This year, the Commission continued to build capacity in our authorised officers to use their full range of powers to promote compliance with the Standards. We further developed our authorised officer training course, delivered training to staff and expanded policies and procedures to guide staff in their use of powers.

The Commission collaborates with the other five Standards regulators hosting the Standards Regulator Senior Executive Group and the Standards Regulator Steering Group to support the regulators to discuss issues of mutual importance to regulating the Standards. These forums are convened to build the co-regulatory approach between Standards regulators to further the safety of children and young people, reduce the regulatory burden for organisations and make best use of mutually limited resources.

This year, the Commission chaired two senior executive group meetings and two steering group meetings. Together, the Standards regulators established a shared workplan to address three priority co-regulatory issues:

- working together to support organisations with more than one Standards regulator
- adopting a collaborative approach to safeguarding Aboriginal children and young people and working with Aboriginal organisations
- sharing information effectively to promote child safety.

The Commission's compliance officers also share knowledge and experience, taking part in a community of practice with the other Standards regulators. This year the Commission co-hosted three community of practice events for compliance officers. This included two in-person events, delivered alongside the Department of Health (DH), to re-establish and foster new connections among officers and building knowledge on promoting safety in online environments, with a presentation by the eSafety Commissioner. The Commission also co-hosted a session

¹⁶³ This includes concluding compliance cases begun in prior years.

with the Victorian Registration and Qualifications Authority (VRQA) where officers shared practice knowledge on conducting inspections with a focus on assessing how organisations embed child safety in their leadership, governance and culture and implement child-focused complaints processes. Attendees reported that they gained valuable insights into the operations and approaches of different regulators working with various cohorts.

Action by the Commission about non-compliance

The Commission is made aware of potential non-compliance with the Standards in a range of ways, including by members of the public contacting the Commission and through information gathered under the Reportable Conduct Scheme.

We assess concerns about non-compliance, taking into account the seriousness of the concern, the risk profile of the organisation and the strategic significance of engaging the organisation in compliance action.

Throughout 2023–24, the Commission continued to provide education and support for organisations to implement and comply with the 11 Standards. We have also increased our activities to enforce compliance with the Standards given organisations have now had more than two years to act since the updated Standards took effect on 1 July 2022.

The Commission initiated compliance action in respect of 43 organisations in 2023–24 (Table 34).

Table 34. Organisations by sector where the Commission started action about potential non-compliance with the Standards in 2023–24

Sector ¹⁶⁴	No.	%
Cultural, sporting or recreational services¹⁶⁵	29	67
Community sporting clubs	14	–
Other sporting organisations including businesses, associations and peak bodies	4	–
Dance, acting, fine arts, music and theatre	9	–
Other	2	–
Religious bodies ¹⁶⁶	5	12
Counselling or other support services ¹⁶⁷	4	9
Other ¹⁶⁸	5	12
Total	43	100

Since the Commission started administering the Standards on 1 January 2017, we have begun action with 347 organisations about concerns of non-compliance with the Standards.

We concluded compliance action in respect of 67 organisations in 2023–24. As at 30 June 2024, there were 62¹⁶⁹ open matters where the Commission had begun but not concluded compliance action (Table 35).

¹⁶⁴ In 2023–24, the Commission has aligned its reporting of data to the sector classifications listed in Schedule 1 of the *Child Wellbeing and Safety Act 2005*. Some organisations may come within multiple sectors due to the different types of services and facilities they provide. Organisations have been allocated to only one sector in this report, with the sector chosen that is most representative of the services and facilities they provide to children and young people. Some sectors have been grouped together to aid in de-identifying the data.

¹⁶⁵ Includes applicable entities that provide cultural, sporting or recreational services specifically for children.

¹⁶⁶ Includes religious bodies within the meaning of section 81 of the *Equal Opportunity Act 2010*.

¹⁶⁷ Includes applicable entities that provide counselling or other support services specifically for children.

¹⁶⁸ Includes post-secondary education providers, overnight camps, photography services and babysitting services.

¹⁶⁹ Counting rules for this data have been adjusted by the Commission in 2023–24 to increase consistency with other Child Safe Standards co-regulators. Cases are counted where action to address concerns about potential non-compliance with the Standards has commenced.

Table 35. Organisations by sector where the Commission has open action as at 30 June 2024 regarding concerns of non-compliance with the Standards

Sector ¹⁷⁰	No.	%
Cultural, sporting or recreational services ¹⁷¹	31	50
Community sporting clubs	10	–
Other sporting organisations including businesses, associations and peak bodies	9	–
Dance, acting, fine arts, music and theatre	4	–
Language and cultural schools and services	3	–
Other	5	–
Religious bodies ¹⁷²	10	16
Counselling or other support services ¹⁷³	7	11
Victorian government departments and entities ¹⁷⁴	6	10
Overnight camps ¹⁷⁵	3	5
Other ¹⁷⁶	5	8
Total	62	100

The Commission became aware of a number of organisations that had failed to take sufficient action to respond to serious child safety concerns in 2023–24.

These included organisations:

- not taking action to properly manage risks to children where serious allegations of child abuse have been raised about a worker, volunteer or leader in religious or sporting organisations, including where charges had been laid against the individual
- sporting organisations engaging individuals who could not obtain Working with Children Check clearance, or individuals under investigation for serious allegations of child abuse, due to poor screening practices.

The Commission took action to address these serious concerns including:

- working alongside, and in consultation with, Victoria Police to understand and address risks to children where criminal investigations or prosecutions were underway
- issuing notices to produce to require organisations to demonstrate to the Commission they have taken sufficient action to address risks to children posed by people operating in their organisation
- issuing notices to comply to require organisations to act to manage risks to children, including where people in organisations have been charged or found guilty of child sexual abuse offences
- conducting an inspection to identify compliance failures that increase the risks of harm and abuse of children in organisations
- providing education and advice to organisations to support them to strengthen their screening, recruitment and complaints procedures and to improve their understanding of managing risks to children.

¹⁷⁰ In 2023–24, the Commission has aligned its reporting of data to the sector classifications listed in Schedule 1 of the *Child Wellbeing and Safety Act*. Some organisations may come within multiple sectors due to the different types of services and facilities they provide. Organisations have been allocated to only one sector in this report, with the sector chosen that is most representative of the services and facilities they provide to children and young people. Some sectors have been grouped together to aid in de-identifying the data.

¹⁷¹ Includes applicable entities that provide cultural, sporting or recreational services specifically for children.

¹⁷² Includes religious bodies within the meaning of section 81 of the *Equal Opportunity Act 2010*.

¹⁷³ Includes applicable entities that provide counselling or other support services specifically for children.

¹⁷⁴ Includes departments within the meaning of the *Public Administration Act 2004* and applicable entities that are constituted by or under any Act and that has functions of a public nature.

¹⁷⁵ Includes an applicable entity that provides overnight camps for children.

¹⁷⁶ Includes not-for-profit organisations (that are not otherwise captured under other sectors in this table), babysitting, entertainment and party services, coaching and tuition services.

The Commission’s compliance activities have resulted in these organisations taking action that has included:

- implementing comprehensive risk management plans requiring those charged with child sexual abuse offences to be closely supervised at the organisation and restricted in their engagement with children
- improving screening procedures for volunteers, employees and leaders
- changing the organisation’s practices and providing information targeted at children and their families to increase empowerment to raise child safety concerns and complaints
- developing complaints-handling policies and procedures to improve responses to child safety issues and allegations of child abuse.

Other themes identified by the Commission in 2023–24 when addressing concerns about potential non-compliance include:¹⁷⁷

- lack of comprehensive child-focused complaints-handling policies and procedures; frequently organisations had guidance about reporting to Victoria Police and Child Protection but no policies or procedures for organisational management and response to complaints
- lack of tangible action regarding cultural safety for Aboriginal children and their families or children from culturally and linguistically diverse backgrounds
- organisations failing to prioritise taking action to implement the Standards, including downplaying the extent of involvement of children in the organisation
- weak or overly complex governance arrangements for child safety systems, leading to failures or delays in acting on inappropriate conduct
- poor or no screening of parent volunteers, creating significant gaps in safety systems that allow alleged perpetrators of abuse to move between organisations

- failures to take action on emotionally abusive behaviour occurring towards children or in the presence of children, such as aggression and verbal abuse
- poorly embedded child safety practices, policies and procedures where organisations have been required to adopt their peak body’s policies and procedures.

In 2023–24, the Commission expanded its use of compliance and enforcement powers, including those that started on 1 January 2023. Three onsite inspections were undertaken, seven notices to produce documents or information were issued and eight notices to comply with the Standards were issued (Table 36). We also issued one official warning for non-compliance with a Commission-issued notice. The use of these powers has been an effective way to drive changes to better protect children in organisations that do not respond to direct engagement and advice from the Commission.

Table 36. Statutory compliance and enforcement actions under the *Child Wellbeing and Safety Act 2005*

Actions	No.
Notice to produce	7
Notice to comply	8
Official warning	1

The Commission conducted 18 assessments of compliance with the Standards in respect of 16 organisations in 2023–24.¹⁷⁸

¹⁷⁷ These themes have been compiled from the Commission’s full range of interactions with organisations concerning non-compliance with the Standards, not just from compliance assessments.

¹⁷⁸ Some organisations were assessed for a Standard on more than one occasion.

Table 37. Standards assessed by the Commission and outcomes 2023–24¹⁷⁹

Standard	Number of times Standard assessed	Non-compliance identified	No non-compliance identified
1	0	0	0
2	15	13	2
3	2	2	0
4	0	0	0
5	0	0	0
6	1	1	0
7	13	13	0
8	1	1	0
9	6	6	0
10	0	0	0
11	12	12	0

- identifying patterns of non-compliance in specific sectors, engaging with key organisations within the sector to discuss identified issues and planning the distribution of resources and guidance to organisations to target concerns
- gathering information about non-compliance with the Standards through issuing requests for information, notices to produce, meeting with key staff and community members and testing systems and observing activities and testing systems during inspections.

The Commission continues to use a broad range of strategies to address concerns of non-compliance in organisations including:

- meeting with senior leaders or key personnel in organisations to support them to understand and address compliance failures identified by the Commission
- presenting at meetings or in webinars on compliance concerns to sectors or to key personnel in an organisation of concern
- issuing reminders to comply
- conducting focused compliance assessments that examine implementation of Standards relevant to the identified child safety issues within an organisation and providing guidance on improvements needed
- assessing an organisation’s policies and systems for reporting and responding to allegations of abuse or inappropriate conduct where information from oversight activities under the Scheme indicates potential lapses in reporting obligations or inappropriate responses

¹⁷⁹ Each Standard has more than one minimum requirement. Reference to a Standard in this table relates to where at least one minimum requirement for that Standard was assessed, noting not all minimum requirements for that Standard may have been assessed.

Child Safe Standards co-regulation

Changes to the *Child Wellbeing and Safety Act 2005* (CWSA) from 1 January 2023 changed the co-regulatory model for the Standards and introduced sector regulators and integrated sector regulators in place of relevant authorities. This group of six co-regulators includes the Commission, DH, Wage Inspectorate Victoria (WIV), the Department of Education (DE) (Quality Assessment and Regulation Division), the VRQA and the Department of Families, Fairness and Housing (DFFH). Sectors subject to the Standards have been allocated to a single regulator. Some organisations that deliver multiple types of services to children, or that have a particular structure (such as a registered charity that also provides certain services), will have more than one regulator.

Versions of the Standards are also in place in other states and territories in Australia, with some organisations operating in multiple jurisdictions. This means situations arise where the Commission may need to collaborate with an interstate Standards regulator to take action on concerns about non-compliance with the Standards.

The Commission collaborates with other Standards regulators to support strong information sharing practices, decrease regulatory burden on organisations that are regulated by more than one regulator and prioritise child safety outcomes.

The Commission has worked with Standards regulators on a number of matters where there are multiple regulators. In some matters, an agreed lead regulator takes action on concerns about non-compliance, sharing information with the other regulator as appropriate. In other cases, both regulators may take action, with appropriate coordination and information occurring throughout to support each regulator to undertake their role, reduce regulatory burden and ensure a focus on child safety.

Action by sector regulators and integrated sector regulators

This section describes the activities of sector regulators (other than the Commission) and integrated sector regulators¹⁸⁰ to provide education, information and advice on the Standards and to monitor and enforce compliance in 2023–24. Each co-regulator takes a different approach to their role as a regulator consistent with the model established under the CWSA.

Department of Families, Fairness and Housing

Throughout 2023–24, DFFH continued to focus on supporting organisations to implement the Standards. DFFH promoted the requirements of the Standards and the upcoming commencement of the Social Services Regulator¹⁸¹ through its e-news bulletin, newsletters, social media and engagement with organisations. Actions taken included:

- publishing regular e-bulletins to organisations regarding the Standards, with focused spotlight on individual Standards
- preparing and publishing updated documents, guidance, and tools on its website
- promoting the Standards with a coordinated campaign of social media and DFFH newsletters
- maintaining a dedicated enquiry line and email inbox for organisations seeking information and advice about the Standards and distributing information on the Standards to a range of organisations that provide services or facilities to children and young people
- updating online resources on DFFH's provider webpage, including resources designed to assist organisations with strategies to identify common risks of abuse and potential courses of action to help protect children from abuse
- engaging with Aboriginal community-controlled organisations to support and build understanding and compliance with the Standards in a culturally safe way.

¹⁸⁰ Sector regulators and integrated sector regulators are DH, WIV, DE (Quality Assessment and Regulation Division), VRQA and DFFH.

¹⁸¹ On 1 July 2024, the Social Services Regulator began operation, assuming responsibility for regulating certain organisations for the Standards previously regulated by DFFH.

DFFH has supported the capacity of organisations to comply with the Standards by:

- responding to requests from organisations for meetings and guidance on the implementation of, and compliance with, the Standards
- promoting training opportunities, including training sessions led by the Commission and the Centre for Excellence in Child and Family Welfare
- promoting and providing support for using assessment tools and resources to support compliance including its *Implementation Guide*, *Minimum Practice Standards*
- informing providers about specialist and community support services responding to child sexual abuse
- promoting significant changes in the regulation of the Standards including
 - informing disability services, including services registered under the National Disability Insurance Scheme, that DFFH regulates their compliance with the Standards
 - educating organisations about the commencement of the new Social Services Regulator on 1 July 2024
- promoting the importance of considering safeguarding measures that are specific to the child safety risks to children and young people with disabilities.

DFFH is made aware of potential non-compliance with the Standards in a range of ways, including through information gathered through DFFH activities and information referred from external sources such as the Commission. DFFH assesses concerns about potential non-compliance, considering the seriousness of the concern, the risk profile of the organisation and the strategic significance of engaging the organisation in regulatory action.

Activities resulting from assessing the intelligence it received in 2023–24 included:

- engaging with organisations about whether they are in scope for the Standards and their compliance obligations
- providing information about how to implement the Standards
- ongoing monitoring of organisations' compliance and providing compliance advice
- commencing assessment of compliance with the Standards, including select individual Standards and minimum requirements.

During 2023–24 there was also a significant focus on transitioning of the regulatory functions of DFFH, including the regulation of the Standards, to the Social Services Regulator.

DFFH conducted assessments of compliance with the Standards in respect of 17 organisations in 2023–24.¹⁸² In 2023–24, DFFH closed 10 cases (Table 38).¹⁸³

DFFH's regulatory responsibilities for the Standards transfer to the Social Services Regulator on 1 July 2024. The Social Services Regulator is an integrated sector regulator and will operate under the *Social Services Regulation Act 2021* to investigate, monitor and enforce compliance with the Standards. DFFH will refer any remaining open assessments to the Social Services Regulator when it commences operation.

¹⁸² Twelve assessments began in 2023–24, of which ten were completed and closed and two remain open. One assessment started in 2022–23 and was completed and closed in 2023–24. Four assessments that began in 2022–23 remain open.

¹⁸³ One additional case not previously reported on was closed in 2022–23.

Table 38. Organisations where DFFH started action about potential non-compliance with the Standards by sector 2023–24 and cases open at 30 June 2024

Sector	Number of cases started in 2023–24 ¹⁸⁴	Number of cases open at 30 June 2024 ¹⁸⁵
Disability services ¹⁸⁶	5	3
State-funded support services for parents and families ¹⁸⁷	1	3
Out-of-home care services ¹⁸⁸	5	0
State-funded housing services or assistance to people experiencing homelessness ¹⁸⁹	1	0

The department conducted detailed assessments of compliance with the Standards in respect of three organisations in 2023–24. Details of the assessments by Standard and outcome are in Table 39.

Table 39. Standards assessed by DFFH and outcomes 2023–24

Standard ¹⁹⁰	Number of times Standard assessed ¹⁹¹	Non-compliance identified	No non-compliance identified
2	3	3	0
6	1	1	0
7	1	1	0
8	2	2	0
9	1	1	0

¹⁸⁴ Each case in this column is a separate organisation. Where organisations provide multiple service types, the sector has been recorded where DFFH became aware of concerns about potential non-compliance with the Standards.

¹⁸⁵ Each case in this column is a separate organisation. Where organisations provide multiple service types, the sector has been recorded where DFFH became aware of concerns about potential non-compliance with the Standards.

¹⁸⁶ Includes disability service providers within the meaning of the *Disability Act 2006*, and applicable entities, other than a disability service provider within the meaning of the *Disability Act*, that provides disability services.

¹⁸⁷ Includes applicable entities that receive funding under a State contract to provide support services for parents and families.

¹⁸⁸ Includes out-of-home care services within the meaning of the *Children, Youth and Families Act 2005*.

¹⁸⁹ Includes applicable entities that receive funding under a State contract to provide housing services or other assistance to people experiencing homelessness.

¹⁹⁰ Each Standard has more than one minimum requirement. Reference to a Standard in this table relates to where at least one minimum requirement for that Standard was assessed, noting not all minimum requirements for that Standard may have been assessed. Where a Standard is not listed in the table, this means no assessments of this Standard were conducted.

¹⁹¹ Some organisations were assessed multiple times in 2023–24.

Child Safe Standards

continued

While all organisations DFFH engaged with indicated commitment to child safety, some common themes or issues found to contribute to non-compliance with the Standards included the following:

- some organisations were yet to implement the Standards, particularly in sectors that are not funded by DFFH
- other organisations that had previously implemented the Standards were yet to take adequate action to update to the new Standards that commenced on 1 July 2022
- poor engagement and understanding by senior leaders of child safety and how to manage child abuse risks leads to poor compliance with the Standards
- when key staff and leaders leave, organisations struggle to maintain child safety due to inadequate child safety policies and processes.

DFFH has also seen some organisations take significant steps in their implementation of the Standards in 2023–24, such as:

- clearly articulating the child safety requirements for relevant roles in the organisation and delivering training on child safety for board members, senior management and staff
- allocating dedicated resources focused on child safety
- conducting comprehensive assessments of the risks of child abuse in their organisation and creating child abuse risk management plans.

No enforcement activity was undertaken in 2023–24 for the Standards, with DFFH's activities focused on compliance assessments, followed by education and providing support to comply.

Department of Health

DH completed activities to support compliance, educate and build capacity of organisations it regulates for the Standards:

- The department sent five email bulletins highlighting each Standard and other topics specific to health organisations and the Standards. The bulletins support organisations with implementation and ongoing improvement and reach more than 1,000 recipients.
- The department developed a series of short educational videos on each of the Standards to complement written resources to support health organisations and staff in understanding their requirements for implementing and complying with the Standards. The 11 videos provide a snapshot of each Standard and what the minimum requirements are, along with some questions organisations can consider when determining if they are meeting the Standard. There have been 2,474 views across the 11 videos.
- The department responded to multiple requests from organisations for meetings and discussions on the implementation of and compliance with the Standards.
- The department delivered two community of practice (CoP) sessions for health organisations in September 2023 and March 2024. After identifying non-compliance with Standard 9, at the March CoP the eSafety Commissioner provided an educational presentation on creating safe online environments for children and young people. The September 2023 CoP had 30 participants across 25 organisations and the March 2024 CoP had 60 participants across 43 organisations.
- The department distributed two surveys to health organisations to understand the usefulness of DH's engagement activities to inform future initiatives, including the CoP.

In December 2023, the Minister for Health announced the establishment of the Health Regulator within DH to better protect Victorians and provide greater consistency to regulation across the health system. The Health Regulator was formally established in February 2024, reinvigorating the Standards team's focus on regulatory compliance and

operations. In line with these structural changes, the Standards team has been upskilling by attending Standards co-regulator CoPs and regulatory seminars, and undertaking training. The team will continue to focus on sector engagement and familiarisation.

DH commenced action with 11 organisations in 2023–24, noting that some of these organisations provide multiple services (Table 40). Eleven organisations were sent a request for information in response to potential non-compliance. Cases were closed in relation to 24 organisations.¹⁹²

Table 40. Organisations where DH started action about potential non-compliance with the Standards by sector 2023–24 and cases open at 30 June 2024¹⁹³

Sector	Number of cases started in 2023–24	Number of cases open at 30 June 2024
Maternal and child health centres ¹⁹⁴	2	2
Public hospitals ¹⁹⁵	1	1
Public health services ¹⁹⁶	2	2
Denominational hospitals ¹⁹⁷	1	1
Private hospitals ¹⁹⁸	2	2
Community health centres ¹⁹⁹	3	3
Mental health and wellbeing service providers ²⁰⁰	6	6
State-funded drug or alcohol treatment services ²⁰¹	5	5

DH conducted detailed assessments of compliance with the Standards in respect of 16 organisations in 2023–24. Details of the assessments by Standard and outcome are in Table 41.

¹⁹² Some organisations provide multiple services.

¹⁹³ Cases started and open relate to 11 organisations. Some organisations provide multiple services.

¹⁹⁴ Includes applicable entities that operate a maternal and child health centre.

¹⁹⁵ Includes hospitals listed in Schedule 1 to the *Health Services Act 1988* as a public hospital.

¹⁹⁶ Includes public health services within the meaning of the *Health Services Act 1988*.

¹⁹⁷ Includes hospitals listed in Schedule 2 to the *Health Services Act 1988* as a denominational hospital.

¹⁹⁸ Includes applicable entities that operate a private hospital within the meaning of the *Health Services Act 1988*.

¹⁹⁹ Includes registered community health centres within the meaning of the *Health Services Act 1988*.

²⁰⁰ Includes mental health and wellbeing service providers within the meaning of the *Mental Health Act 2022*.

²⁰¹ Includes applicable entities that receives funding under a State contract to provide drug or alcohol treatment services.

Table 41. Standards assessed by DH and outcomes 2023–24²⁰²

Standard	Number of times Standard assessed	Non-compliance identified	No non-compliance identified
1	15	9	6
2	16	9	7
3	15	8	7
4	15	7	8
5	15	5	10
6	15	6	9
7	16	7	9
8	15	3	12
9	15	8	7
10	15	4	11
11	16	3	13

Non-compliance was most commonly identified by DH across Standards 1, 2, 3 and 9. DH took a range of actions in response to non-compliance including ongoing monitoring of the organisation, providing compliance advice and targeted education to support organisations improve and sustain compliance.

Department of Education

Quality Assessment and Regulation Division

DE’s Quality Assessment and Regulation Division (QARD) is the integrated sector regulator for the Standards in the early childhood education sector.

Activities undertaken by QARD to support compliance with the Standards by organisations included:

- publishing articles about the Standards in its newsletters
- making material regarding the Standards available online²⁰³

- raising the Standards as part of regular meetings with the sector representatives including, for example, the Early Childhood Education and Care Regulatory Reference Group
- publishing enforcement action against a service or provider that is found to have breached the Standards and QARD has taken enforcement action against.

QARD assesses compliance with the Standards as part of its broader regulatory visits to services, as well as through its investigations and assessments. These visits include discussions about the Standards but do not necessarily assess compliance with all Standards.

In 2023–24, QARD considered the Standards as part of 4,192 broader regulatory visits to early childhood education services in Victoria. QARD identified 46 non-compliances with the Standards. Non-compliances identified via QARD’s broader regulatory visits were predominately against Standard 2 (33 non-compliances), Standard 8 (five non-compliances) and Standard 11 (three non-compliances).

²⁰² Each Standard has more than one minimum requirement. Reference to a Standard in this table relates to where at least one minimum requirement for that Standard was assessed, noting not all minimum requirements for that Standard may have been assessed.

²⁰³ This is available at <https://www.vic.gov.au/early-childhood-services-child-safe-standards>.

In March 2024, QARD also began a program of specific visits to organisations around the Standards. This Focused Child Safe Standards Visits Program saw QARD authorised officers undertake compliance visits focusing on all 11 Standards at 41 early childhood education and care services (Table 42). Services visited included those working towards, meeting and exceeding the *National Quality Framework* across both metropolitan and regional Victoria. Services were asked for evidence to verify the implementation and compliance with the Standards.

Table 42. Standards assessed by Quality Assessment and Regulation Division and outcomes between April and June 2024²⁰⁴

Standard	Number of times Standard assessed	Non-compliance identified	No non-compliance identified
1	41	36	5
2	41	34	7
3	41	19	22
4	41	7	34
5	41	23	18
6	41	13	28
7	41	25	16
8	41	22	19
9	41	36	5
10	41	19	22
11	41	29	12

All early childhood education and care services identified to have non-compliance, either through QARD’s broader regulatory visits or the Focussed Child Safe Standards Visits Program, receive letters specifying the non-compliance. Services must address identified non-compliance within a specified timeframe and demonstrate to QARD that required action to meet compliance has occurred. QARD also meets with such services as required to provide advice. In 2023–24, two services were issued a compliance notice related to non-compliance against the Standards, while another service was suspended for six months due to significant non-compliance, including non-compliance with the Standards.

²⁰⁴ These assessments were from the Focussed Child Safe Standards Visits Program. Each Standard has more than one minimum requirement. Reference to a Standard in this table relates to where at least one minimum requirement for that Standard was assessed, noting not all minimum requirements for that Standard may have been assessed.

QARD also provided training for its authorised officers in 2023–24, with activities including:

- embedding the Standards in the training for new QARD authorised officers and staff, with 22 people completing a Standards training module in 2023–24
- holding discussions about the Standards at its March 2024 Authorised Officer Forum, including a presentation by Victoria's Commissioner for Aboriginal Children and Young People
- supporting authorised officers involved in the Focused Child Safe Standards Visits Program via weekly drop-in sessions and new QARD-specific tools and templates to capture compliance evidence across all Standards.

Victorian Registration and Qualifications Authority

The VRQA is the Standards regulator for registered schools, school boarding premises, school-sector providers of courses to overseas students (that is, providers on the Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS)), Non-School Senior Secondary and Foundation Secondary Providers (NSSSFSP), student exchange organisations (SEOs) and VRQA-regulated registered training organisations (RTOs) that deliver training to children under 18 years of age.

Registered schools and school boarding premises are required to comply with Ministerial Order No. 1359: *Implementing the Child Safe Standards – Managing the risk of child abuse in schools and school boarding premises.*²⁰⁵

The VRQA has appointed two review bodies with responsibility for reviewing their schools' compliance with the Standards.²⁰⁶ These are DE in respect of government schools and the Victorian Catholic Education Authority (VCEA) in respect of non-government Catholic schools.

During 2023–24, the VRQA continued to provide guidance and stakeholder engagement focused on assisting providers to comply with the Standards.

The Child Safe Standards for education providers website, a shared DE and VRQA resource hosted on the vic.gov.au platform, continues to promote the implementation of the Standards by providing guidance for education providers about how to comply. The website maintained high user satisfaction and remains a key resource, with 116,113 session views by 81,567 users in 2023–24.

The VRQA conducts annual client and stakeholder research, including to ensure education providers are satisfied with the level of guidance provided on the Standards. Ninety-three per cent of independent schools, 94 per cent of government schools, and 97 per cent of Catholic schools agreed the website is helpful in implementing the Standards. All RTOs agreed. The research will help improve VRQA's website and guidance for education providers.

In March 2024, the VRQA held information sessions for schools and school boarding premises and CRICOS providers that included guidance about how to comply with the Standards. Both DE and VCEA also continue to support schools to comply with the Standards.

VRQA has a review body CoP together with its appointed review bodies (VCEA and DE) for registered schools. Discussion of Ministerial Order 1359 and assuring consistent approaches to compliance and assessment continued to be a topic at the review body CoP. The VRQA also hosted briefings for school reviewers and RTO auditors and presented at forums for review bodies and system owners, including VCEA, Independent Schools Victoria and DE.

VRQA, DE and VCEA conduct cyclical and out-of-cycle reviews of registered schools and school boarding premises against the minimum standards for registration including Ministerial Order 1359. The data in Table 43 consolidates Standards assessment activity undertaken by the VRQA and its review bodies. The VRQA undertakes assessments of the Standards when it registers and regulates government, Catholic and independent schools, school

²⁰⁵ This is in addition to being required to comply with the gazetted Standards as per section 19 of the CWSA.

²⁰⁶ Appointed under section 4.3.2 of the *Education and Training Reform Act 2006*. See VRQA, 'School regulation', <https://www2.vrqa.vic.gov.au/independent-schools>.

boarding premises, SEOs, CRICOS providers and RTOs. The VRQA also directly reviews independent schools. Under the review body arrangements, VCEA and DE undertake cyclical reviews of Catholic and government schools. With the exception of a small number of providers who were working towards compliance at 30 June 2024, all education providers assessed were fully compliant with Ministerial Order 1359 or the Standards following rectification. The VRQA accepted one enforceable undertaking from a school and imposed conditions on one school and seven SEOs to ensure compliance with the Standards.

Table 43. Standards assessed for registered schools, school boarding premises and CRICOS providers and outcomes 2023–24

Standard	Number of assessments				Non-compliance identified			Number assessed as not compliant following rectification ²⁰⁷		
	All schools	Government	Catholic	Independent	Government	Catholic	Independent	Government	Catholic	Independent
1	615	451	114	50	71	3	24	0	0	0
2	614	451	114	49	245	15	35	0	0	3
3	614	451	114	49	159	5	26	0	0	1
4	614	451	114	49	149	4	22	0	0	0
5	614	451	114	49	117	5	31	0	0	0
6	615	451	114	50	250	12	37	0	1	2
7	614	451	114	49	102	6	42	0	0	4
8	614	451	114	49	171	10	37	0	1	3
9	614	451	114	49	109	6	34	0	0	2
10	374	211 ²⁰⁸	114	49	51	3	25	0	0	3
11	614	451	114	49	331	14	40	0	1	3

The areas of the Standards that featured more prominently in assessments of non-compliance in all school sectors in 2023–24 were:

- Standard 11 (Policies and procedures document how the organisation is safe for children and young people)
- Standard 6 (People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice)
- Standard 2 (Child safety and wellbeing is embedded in organisational leadership, governance and culture).

²⁰⁷ Four schools and one school boarding premise were working towards compliance at 30 June 2024.

²⁰⁸ DE changed its approach to recording compliance outcomes in relation to Standard 10 during the reporting period. For approximately seven months during the reporting period, DE only recorded compliance outcomes for Standard 10 in relation to schools that had a significant child safety incident after 1 July 2022 (when the obligation to review child safety policies, processes and practices after such incidents took effect). School compliance with the other elements of Standard 10 (which relate to the broader review of child safety policies) was recorded against the Standard that related to the particular child safety policy.

DE and VRQA’s review models and assessment methodology are similar. VCEA is moving to a similar model and methodology in 2025.

In 2021, VRQA entered into a strengthened Review Body Memorandum of Understanding (MoU) with DE. DE, in its role as Review Body for government schools, subsequently developed a new assurance framework and approach to review and assessment of school compliance with the minimum standards, including the Standards.

The VRQA entered into a new Review Body MoU with the VCEA in June 2023. This requires, among other things, that the VCEA transitions to directly conducting cyclical reviews of Catholic schools and develops a new assurance framework.

The VRQA continues to drive consistency and quality across the sector through its Review Body Assurance Program and its review body MoUs. The VRQA is currently in the process of renegotiating its MoU with the DE (the term of which has been extended and will end in February 2025) and will shortly commence review of its MoU with VCEA (as required under the MoU).

Table 44. Standards assessed for non-school senior secondary and foundation secondary providers, student exchange organisations and registered training organisations and outcomes 2023–24

Standard	Number of assessments ²⁰⁹			Non-compliance identified			Number assessed as non-compliant following rectification		
	NSSSFSP ²¹⁰	SEO	RTO ²¹¹	NSSSFSP	SEO ²¹²	RTO	NSSSFSP	SEO	RTO
1	0	9	10	–	8	5	–	6	0
2	1	9	10	1	9	4	1	7	0
3	0	9	10	–	8	5	–	7	0
4	0	9	10	–	8	4	–	7	0
5	0	9	10	–	7	5	–	6	0
6	1	9	10	1	7	2	1	6	0
7	1	9	10	1	7	5	1	6	0
8	1	9	10	–	7	4	–	6	0
9	1	9	10	1	7	2	1	6	0
10	0	9	10	–	7	4	–	6	0
11	1	8	10	1	7	5	1	6	0

²⁰⁹ Registration activities, including approvals and reapprovals, for non-school senior secondary and foundation secondary providers (NSSSFSP), student exchange organisations (SEO) and registered training organisations (RTO) include an assessment of compliance against the Standards.

²¹⁰ One NSSSFSP provider was not assessed and was continuing to work towards compliance at 30 June 2024.

²¹¹ Thirty-two RTOs were approved or reapproved in the period. The 22 RTOs not assessed either do not deliver to students under 18 or are registered schools and therefore are assessed against Ministerial Order 1359 during their school review.

²¹² Non-school SEOs assessed during the period were continuing to work towards compliance at 30 June 2024 and had conditions imposed on their registration.

Wage Inspectorate Victoria

Businesses that employ children under 15 years of age need a Child Employment Licence from the Wage Inspectorate Victoria and are required to abide by child employment laws, which include the Standards and the *Child Employment Act 2003* (CE Act).

The Wage Inspectorate educated and supported compliance by organisations with the Standards in 2023–24 through:

- child employment law presentations and webinars to organisations including the Entertainment Working Group, several media organisations, casting agents, a retail food franchise, the Migrant Workers Centre and WorkSafe
- informing the public through an updated Wage Inspectorate Standards webpage
- providing education within an eLearning module
- providing a student learning module to the University of Melbourne, Swinburne and JMC Academy

- informing 883 employers who were granted a Child Employment Licence about their obligations concerning the Standards
- having authorised officers visit 66 businesses in the Surf Coast local government area during summer to make them aware of child employment laws.

In 2023–24, 143 organisations were assessed by the Wage Inspectorate for compliance with Standard 6, with 12 determined to be non-compliant. The Wage Inspectorate assessed 129 organisations for compliance with Standard 7, with seven determined to be non-compliant (Table 45). These organisations were further assessed and, after considering the Wage Inspectorate's *Compliance and Enforcement Policy*,²¹³ all non-compliance resulted in providing information and education to support ongoing compliance with the CE Act and the Standards.

In early 2024, one large-scale employer in the entertainment sector was proactively monitored for compliance against all 11 Standards, and they were determined to be compliant. As of 30 June 2024, 31 compliance assessments were still under review.

Table 45. Standards assessed by Wage Inspectorate and outcomes 2023–24

Standard	Number of times Standard assessed	Non-compliance identified	No non-compliance identified
1	1	0	1
2	1	0	1
3	1	0	1
4	1	0	1
5	1	0	1
6	143	12	131
7	129	7	122
8	1	0	1
9	1	0	1
10	1	0	1
11	1	0	1

²¹³ Available at <https://www.vic.gov.au/wage-inspectorate-victorias-compliance-and-enforcement-policy>.

The CE Act allows the Wage Inspectorate's authorised officers to issue a notice to produce to determine compliance with child employment laws. There were no compliance or enforcement actions taken using provisions of the CWSA; however, information requested through the CE Act would overlap with compliance actions against some of the Standards.

Enforcement action by all Standards regulators

The Commission is required to report on enforcement action taken by all Standards regulators.²¹⁴ In 2023–24, the Commission issued seven notices to produce, eight notices to comply and one official warning (Table 36).

DE (QARD) issued two services with a compliance notice related to non-compliance against the Standards, while another service was suspended for six months due to significant non-compliance, including non-compliance with the Standards.

VRQA has pre-existing powers under the *Education Training and Reform Act 2006*. Under these powers, it accepted one enforceable undertaking from a school.

All Standards regulators continued to take an educative approach in 2023–24 to support organisations in complying with the Standards or used enforcement tools available under other Acts they administer.

²¹⁴ Section 41K(3), CWSA.

Corporate services and financial summary

Corporate services and financial summary

On 20 July 2016, under section 53 of the *Financial Management Act 1994*, the Minister for Finance approved Commission financial statements to be included in the accounts of the former Department of Health and Human Services (now the Department of Families, Fairness and Housing) in its annual report.

Table 46 provides a summary of the Commission's expenditure for 2023–24.

Table 46. Commission expenditure 2021–22 to 2023–24

Expenditure	2023–24 (\$)	2022–23 (\$)	2021–22 (\$)
Salaries and on-costs	13,076,179	11,999,315	11,337,470
Grants and other transfers	–	–	–
Operating expenses	1,973,573	2,952,272	2,121,876
Depreciation	–	–	–
Total expenditure	15,049,752	14,951,587	13,459,346

Asset Management Accountability Framework maturity assessment

The Commission does not have any assets for the purposes of the *Asset Management Accountability Framework*.

Appendices

Appendix 1. Disclosure index

Commission for Children and Young People financial statements are now included in the Department of Families, Fairness and Housing's accounts 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 financial reporting directions (FRD) in notes to the financial statements' are referenced in the department's report of operations and disclosure index.

Table 47. Commission disclosures

Legislation	Requirement	Page
<i>Standing Directions and Financial Reporting Directions</i>		
<i>Report of operations</i>		
Charter and purpose		
FRD 22	Manner of establishment and the relevant ministers	9, 14
FRD 22	Purpose, functions, powers and duties	14–15
FRD 22	Key initiatives and projects	16–20
FRD 22	Nature and range of services provided	14
Management and structure		
FRD 22	Organisational structure	153
Financial and other information		
FRD 10	Disclosure index	150
FRD 12	Disclosure of major contracts	161
FRD 15	Executive disclosures	152, 157
FRD 22	Employment and conduct principles	154
FRD 22	Occupational health and safety policy	154
FRD 22	Summary of the financial results for the year	148
FRD 22	Significant changes in financial position during the year	N/A
FRD 22	Major changes or factors affecting performance	N/A
FRD 22	Subsequent events	N/A
FRD 22	Application and operation of the <i>Freedom of Information Act 1982</i>	161
FRD 22	Compliance with building and maintenance provisions of <i>Building Act 1993</i>	162
FRD 22	Statement on <i>National Competition Policy</i>	N/A
FRD 22	Application and operation of the <i>Public Interest Disclosures Act 2012</i>	162
FRD 22	Application and operation of the <i>Carers Recognition Act 2012</i>	163
FRD 22	Details of consultancies over \$10,000	160
FRD 22	Details of consultancies under \$10,000	160
FRD 22	Disclosure of government advertising expenditure	159
FRD 22	Disclosure of information and communication technology expenditure	160

Table 47. Commission disclosures (continued)

Legislation	Requirement	Page
<i>Standing Directions and Financial Reporting Directions</i>		
FRD 22	Reviews and studies expenditure	N/A
FRD 22	Statement of availability of other information	163
FRD 22	Asset Management Accountability Framework maturity assessment	148
FRD 22	Disclosure of emergency procurement	164
FRD 22	Disclosure of procurement complaints	164
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SD 5.2	Specific requirements under Standing Direction 5.2	1–164
<i>Compliance attestation and declaration</i>		
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SD 5.2.3	Declaration in report of operations	1
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<i>Freedom of Information Act 1982</i>		161
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<i>Public Interest Disclosures Act 2012</i>		162
<i>Carers Recognition Act 2012</i>		163
<i>Disability Act 2006</i>		163
<i>Local Jobs First Act 2003</i>		159
<i>Financial Management Act 1994</i>		164

Appendix 2. Governance and organisational structure

Commissioners

Principal Commissioner

Liana Buchanan was appointed Principal Commissioner for Children and Young People in April 2016 and was reappointed for an additional five-year term in April 2021. The Principal Commissioner has all the functions and powers of the Commission and any other powers or functions conferred on her by the *Commission for Children and Young People Act 2012* or any other Act.

Commissioner for Aboriginal Children and Young People

In April 2022 Meena Singh was appointed to the role of Commissioner for Aboriginal Children and Young People for a five-year term. The Commissioner for Aboriginal Children and Young People is responsible for leading the functions of the Commission relating to Aboriginal children and young people.

Executive officers

Leanne Barnes

In February 2022 Leanne Barnes commenced as the Commission's Chief Executive Officer for a five-year term. Leanne provides operational leadership to the Commission and ensures its effective and efficient management.

Emily Sanders

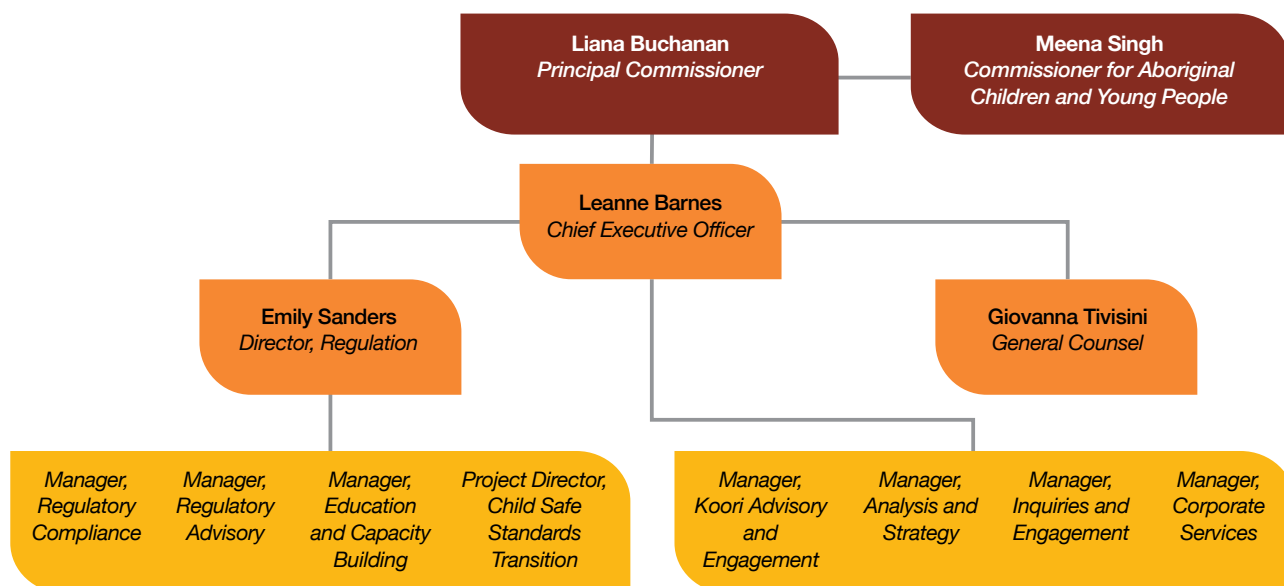
Emily Sanders was appointed Director, Regulation in February 2018 and has been reappointed to the role until February 2026. Emily is responsible for managing the operational components and regulatory functions of the Reportable Conduct Scheme and Child Safe Standards.

Giovanna Tivisini

Giovanna Tivisini was appointed to the executive role of General Counsel in 2019 and is responsible for delivering legal and investigation services across the Commission's portfolios.

Organisational structure as at 30 June 2024

Figure 10. Organisational chart²¹⁵



Audit and Risk Committee membership and roles

The Audit and Risk Committee consists of the following members:

- Fiona Green, Chairperson
- Mary Polis, Independent Member
- Michael Shatter, Independent Member.

Previous independent member Tony Nippard completed his term in August 2023. The Commission thanks Tony for his expertise and commitment to this role.

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

²¹⁵ In 2023–24 the Commission undertook a Clause 11 process, and from 1 July 2024 a new structure was implemented.

Occupational health and safety

The Commission is committed to ensuring all staff remain safe and healthy at work in keeping with our obligations under the *Occupational Health and Safety Act 2004* and the Occupational Health and Safety Regulations 2007.

In 2023–24, the Commission continued our ongoing internal safety reporting process, ergonomic assessments for staff and a tailored employee wellbeing program. Many of these processes and programs were tailored to support staff working both in the office and at home (hybrid working).

We continued our engagement with Medibank Health Solutions to deliver expert wellbeing support to all our staff. The employee wellbeing 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, other work-related issues or any personal concerns. The frequency of counselling sessions can be increased if required.

Uptake of the employee wellbeing program continued to increase from previous years.

In 2023–24, the Commission also arranged bespoke vicarious trauma group training sessions to teams at high risk of exposure to vicarious trauma.

New starters at the Commission receive an occupational health and safety induction program that includes a health and safety related tour of the Commission's office and demonstration of the evacuation process.

New staff must also complete a dedicated workplace health and safety eLearning module.

Occupational Health and Safety Committee meetings

The Commission has an Occupational Health and Safety Committee. The committee includes elected management and staff representatives, the Commission's health and safety representatives and a secretariat. The committee is

chaired by the Commission's Manager, Corporate Services.

Four occupational health and safety committee meetings were held in 2023–24.

Injuries and incident management

There were three reported injuries in 2023–24. In 2022–23 there was one reported injury.

Two of the three injuries in 2023–24 related to minor falls. Medical attention was not required for either incident. The third injury related to a staff member feeling dizzy and unwell in the office.

The low number of reported injuries over the past two years can largely be attributed to staff working both in the office and at home rather than just in an office-based environment. However, staff have been reminded regularly that any injuries incurred at home while working for the Commission are reportable injuries. In 2023–24 there were no WorkCover claims.

Employment and conduct principles

The Commission is committed to applying merit and equity principles when appointing staff. The Commission's selection processes ensure applicants are assessed and evaluated fairly and equitably based on the key selection criteria and other accountabilities without discrimination.

Employees have been correctly classified in workforce data collections.

Our commitment to child safety

The Commission is committed to providing a child-safe and child-friendly environment, where children and young people with whom the Commission has contact are safe, feel safe and can take part in decisions that affect their lives.

The Commission's *Child Safe Policy* and *Child Safe Code of Conduct* apply to the commissioners, staff, contractors, volunteers and authorised persons engaged by the Commission.

Appendix 3. Workforce data

Public sector values and employment principles

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

Comparative workforce data

The Commission employed 81 people as at 30 June 2024, which is an increase of one employee from the same time last year (Tables 48a and 48b). The data is consistent with 30 June 2023 across most indicators. There has been a slight increase to the number of Victorian Public Service employees due to the employment of two project support officer roles to assist the Commission with youth engagement. Ongoing employees have also increased from 57 as at 30 June 2023 to 62 as at 30 June 2024 (which has been offset by four fewer fixed-term employees since the previous financial year).

Table 48a. Workforce data as at 30 June 2024

30 June 2024		All employees		Ongoing			Fixed-term and casual	
		Number (headcount)	FTE	Full-time (headcount)	Part-time (headcount)	FTE	Number (headcount)	FTE
Demographic data	Gender							
	Men	14	12.9	10	0	10	4	2.9
	Women	67	61.8	37	15	48.6	15	13.2
	Self-described	nil	nil	nil	nil	nil	nil	nil
	Age							
	15–24	3	1.9	0	0	0	3	1.9
	25–34	21	19.7	13	1	13.8	7	5.9
	35–44	20	17.7	10	6	14.4	4	3.3
	45–54	20	19.4	14	3	16.4	3	3
	55–64	12	11.1	6	4	9.1	2	2
65+	5	4.9	4	1	4.9	0	0	
Classification data	Victorian Public Service 1–6 grades	78	71.7	47	15	58.6	16	13.1
	VPS 2	0	0	0	0	0	0	0
	VPS 3	3	1.9	0	0	0	3	1.9
	VPS 4	19	17.8	14	2	15.2	3	2.6
	VPS 5	33	30.4	19	7	24.6	7	5.8
	VPS 6	23	21.6	14	6	18.8	3	2.8
	Senior employees	3	3	0	0	0	3	3
	Executives	3	3	0	0	0	3	3
Other	0	0	0	0	0	0	0	
Total employees	81	74.7	47	15	58.6	19	16.1	

Appendix 3. Workforce data

continued

Table 48b. Workforce data as at 30 June 2023

30 June 2023		All employees		Ongoing			Fixed-term and casual	
		Number (headcount)	FTE	Full-time (headcount)	Part-time (headcount)	FTE	Number (headcount)	FTE
Demographic data	Gender							
	Men	13	13	8	0	8	5	5
	Women	67	62.4	35	14	45.3	18	17.1
	Self-described	nil	nil	nil	nil	nil	nil	nil
	Age							
	15–24	2	1.4	0	0	0	2	1.4
	25–34	13	13	8	0	8	5	5
	35–44	22	20	9	7	14	6	6
	45–54	25	23.9	14	3	16.2	8	7.7
	55–64	13	12.1	7	4	10.1	2	2
65+	5	5	5	0	5	0	0	
Classification data	Victorian Public Service 1–6 grades	77	72.4	43	14	53.3	20	19.1
	VPS 2	0	0	0	0	0	0	0
	VPS 3	1	0.4	0	0	0	1	0.4
	VPS 4	15	14	8	2	9	5	5
	VPS 5	32	30.6	20	7	25.6	5	5
	VPS 6	29	27.4	15	5	18.7	9	8.7
	Senior employees	3	3	0	0	0	3	3
	Executives	3	3	0	0	0	3	3
Other	0	0	0	0	0	0	0	
Total employees		80	75.4	43	14	53.3	23	22.1

The figures in Tables 48a and 48b exclude those on leave without pay or absent on secondment, external contractors/consultants, temporary staff employed by employment agencies, and a small number of people who are not employees but are appointees to a statutory office, as defined in the *Public Administration Act 2004*.

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

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

Workforce inclusion

Equal opportunity and workforce diversity and inclusion are highly valued at the Commission.

In 2021–22 the Commission undertook a workplace review under the *Gender Equality Act 2020* and, in 2022, the Commission developed and submitted our first *Gender Equality Action Plan 2022–25*.

The Commission's four-year *Gender Equality Action Plan* included an analysis of available workforce data to identify and address any inequities evident from the data. A number of strategies and actions were then developed to assist and further strengthen the Commission as a workplace that celebrates and promotes employee diversity and inclusion.

During 2023–24 the Commission continued to work on the strategies outlined in our *Gender Equality Action Plan* and we have completed 39 of 55 strategies.

The Commission also reported progress in relation to specific strategies and actions to the Commission for Gender Equality in the Public Sector in early 2024.

In 2023–24 the Commission also finalised a draft of our first *Reconciliation Action Plan* and consulted with Reconciliation Australia. It is anticipated that we will release our *Reconciliation Action Plan* in 2024–25.

Executives and other non-executive senior staff

Table 49 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.

Table 49. Annualised total salary by \$40,000 bands for executives and other senior non-executive staff as at 30 June 2024

Income band (salary)	Executives	Other
\$200,000 – \$239,999	1	0
\$240,000 – \$279,999	1	1
\$280,000 – \$319,999	1	1
Total	3	2

Executive data

The number of executive officers employed by the Commission is provided in Table 50, which also provides a reconciliation of executive officers and non-executive senior staff numbers in 2023–24 and 2022–23.

Table 50. Total number of executive officers (non-commissioners) for the Commission, by gender as of 30 June 2024

Class	Total		Men		Women		Self-described	
	No.	Var.	No.	Var.	No.	Var.	No.	Var.
SES*-1	2	0	0	0	2	0	nil	nil
SES*-2	1	0	0	0	1	0	nil	nil
Total	3	0	0	0	3	0	nil	nil

* Senior Executive Service

Table 51 lists the actual number of executives, non-executive senior staff (Commissioner for Aboriginal Children and Young People) and accountable officers (Principal Commissioner) over the reporting period.

Appendix 3. Workforce data

continued

Separations are those that have left the Commission during the reporting period.

Table 51. Reconciliation of executive and non-executive senior staff numbers

	2023–24	2022–23
Executives	3	3
Non-executive senior staff	1	1
Accountable officer	1	1
Separations	0	0
Total executive and non-executive senior staff as at 30 June 2024	5	5

Appendix 4. Other disclosures

Local jobs first

The *Local Jobs First Act 2003*, introduced in August 2018, brings together the *Victorian Industry Participation Policy* and the *Major Project Skills Guarantee* policy, which were previously administered separately.

Departments and public sector bodies (which includes special bodies such as the Commission) are required to apply the *Local Jobs First* policy in all projects valued at \$3 million or more in metropolitan Melbourne or, for statewide projects, \$1 million or more for projects in regional Victoria.

The *Major Project Skills Guarantee* applies to all construction projects valued at \$20 million or more. The Commission did not engage in any applicable tenders or projects during the reporting period.

Advertising expenditure

In 2023–24 the Commission did not commission any advertising campaigns.

Consultancy expenditure

Consultancies \$10,000 or greater

In 2023–24 the Commission engaged 20 consultancies with individual costs greater than \$10,000. The total value of those consultancies was \$739,092 (Table 52).

Investigations in Table 52 refer to own motion investigations concerning reportable allegations conducted under section 16O of the *Child Wellbeing and Safety Act 2005*.

Appendix 4. Other disclosures

continued

Table 52. Consultancies valued at \$10,000 or greater

Consultant	Purpose of consultancy	Total approved project fee (excl. GST)	Expenditure 2023–24 (excl. GST)	Future expenditure (excl. GST)
Allens Linklaters	Advice	\$45,000	\$19,777	–
Allens Linklaters	Investigation	\$34,000	\$34,000	–
Allens Linklaters	Advice	\$32,246	\$30,000	–
Cube Group	Operating model design and development	\$36,452	\$36,452	–
Demetrius Consulting	Investigation	\$26,000	\$26,000	–
Dever's List	Investigation	\$33,800	\$33,800	–
Djirra	Creating a culturally safe environment for Aboriginal children and young people	\$14,250	\$14,250	–
FCCV Education and Training Ltd	Sector profile of religious bodies in Victoria	\$49,545	\$49,500	–
Grange Advisory	Investigation	\$14,190	\$11,550	–
Justitia	Investigation	\$31,588	\$29,830	–
Justitia	Investigation	\$53,560	\$53,560	–
Justitia	Investigation	\$44,961	\$36,353	–
KPMG	Child Safe Standards compliance assessment guide and tools	\$109,676	\$107,821	–
List G Barristers	Advice	\$22,877	\$22,877	–
List G Barristers	Advice	\$12,000	\$11,800	–
Maddocks	Investigation	\$42,000	\$36,750	–
Minter Ellison	Advice	\$23,909	\$20,509	–
Victorian Government Solicitor's Office	Advice	\$155,725	\$73,863	–
Victorian Government Solicitor's Office	Advice	\$31,000	\$31,000	–
Viaggio Mather Consulting	Reportable Conduct Scheme risk-based intake process	\$60,000	\$59,400	–
Total		\$872,779	\$739,092	–

Consultancies less than \$10,000

In 2023–24, the Commission engaged 26 consultants with individual costs less than \$10,000. The total value of those consultancies was \$103,555.

Information and communication technology expenditure

For the 2023–24 reporting period, the Commission had a total information and communication technology expenditure of \$370,242 (Table 53).

Non-business-as-usual information and communication technology expenditure was \$124,624. This related to case management system enhancements and website functionality improvements. Business-as-usual expenditure predominantly related to system licences and hosting fees.

Table 53. Commission ICT expenditure

Business-as-usual	Non-business-as-usual	Operational expenditure	Capital expenditure
(Total)	(Total = Operational expenditure and capital expenditure)		
\$245,618	\$124,624	\$124,624	\$0

Disclosure of major contracts

The Commission did not enter into any contracts greater than \$10 million in value.

Freedom of information

The *Freedom of Information Act 1982* (FOI Act) allows the public a right of access to documents held by the Commission. The purpose of the FOI Act is to extend as far as possible the right of the community to access information held by government departments, local councils, ministers and other bodies subject to the FOI Act.

An applicant has a right to apply for access to documents held by the Commission. This comprises documents both created by the Commission or supplied to the Commission by an external organisation or individual and may also include maps, films, microfiche, photographs, computer printouts, computer discs, tape recordings and videotapes. Information about the type of material produced by the Commission is available on the Commission’s website under our Part II Information Statement.

The FOI Act allows the Commission to refuse access, either fully or partially, to certain documents or information. Examples of documents that may not be accessed include cabinet documents; some internal working documents; law enforcement documents; documents covered by legal professional privilege such as legal advice; personal information about other people; and information provided to the Commission in confidence or information that is confidential under another Act.

Under the FOI Act, the FOI processing time for requests received is 30 days. However, when external consultation is required under sections 29, 29A, 31, 31A, 33, 34 or 35 of the FOI Act, the processing time can be up to 45 days. In any case, processing time may also be extended by periods of 30 days, by agreement with the applicant. With the applicant’s agreement, this may occur any number of times. However, obtaining an applicant’s agreement for an extension cannot occur after the expiry of the timeframe for deciding a request.

If an applicant is not satisfied with a decision made by the Commission, under section 49A of the FOI Act, they have the right to seek a review by the Office of the Victorian Information Commissioner within 28 days of receiving a decision letter.

Making a freedom of information request

Freedom of information requests can be made using the options available on the Commission’s website. An application fee of \$31.80 applied in 2023–24. Access charges may also be payable if the document pool is large and the search for material is time consuming.

Access to documents can also be obtained through a written request to the Commission, as detailed in section 17 of the FOI Act.

When making a freedom of information request, applicants should ensure requests are in writing and clearly identify the documents sought.

Appendix 4. Other disclosures

continued

Requests for documents in the possession of the Commission should be addressed to:

Chief Executive Officer
Commission for Children and Young People
Level 18, 570 Bourke Street
Melbourne VIC 3000

Alternatively, email contact@ccyp.vic.gov.au and attention it to the Commission's Chief Executive Officer.

Freedom of information statistics

During 2023–24, the Commission received 16 applications from members of the public. This is double the number of applications received in 2022–23.

Of the 16 applications received, all decisions were made within the statutory 30-day period. For all 16 applications, access to documents was either denied in full or the documents did not exist.

No decisions made during 2023–24 by the Commission were reviewed by the Office of the Victorian Information Commissioner or referred to the Victorian Civil and Administrative Tribunal.

Further information

More information about the operation and scope of freedom of information can be obtained from the FOI Act, regulations made under the Act and the [Office of the Victorian Information Commissioner's website](#).

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 *Public Interest Disclosures Act 2012*

The *Public Interest Disclosures Act 2012* encourages and assists people in making disclosures of improper conduct by public officers and public bodies. The *Public Interest Disclosures 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 reprisal action 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. We 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:

Level 1, North Tower, 459 Collins Street
Melbourne VIC 3000
Phone: 1300 735 135
Website: www.ibac.vic.gov.au

Public interest disclosures statistics

During 2023–24, no disclosures were made to the Independent Broad Based Anti-corruption Commission by individuals regarding the Commission and/or its staff that we are aware of.

Compliance with the *Carers Recognition Act 2012*

The Commission supports the principles of the *Carers Recognition Act 2012* and demonstrates this through a commitment of providing flexible working arrangements for staff to support their roles as carers.

Continued flexibility was awarded to staff during 2023–24 and Commission staff were supported to adopt hybrid working arrangements to work both at home and in the office to support work-life balance.

Additional Commission information available on request

In compliance with the requirements of the Standing Directions of the Minister for Finance, details in respect of the items listed below have been retained by the Commission and are available on request, subject to the provisions of the FOI Act and any other relevant laws and Commission policies:

- a) a statement that declarations of pecuniary interests have been duly completed by all relevant officers
- b) details of shares held by a senior officer as nominee or held beneficially in a statutory authority or subsidiary
- c) details of publications produced by the entity about itself, and how these can be obtained
- d) details of changes in prices, fees, charges, rates and levies charged by the entity
- e) details of any major external reviews carried out on the entity
- f) details of major research and development activities undertaken by the entity
- g) details of overseas visits undertaken including a summary of the objectives and outcomes of each visit
- h) details of major promotional, public relations and marketing activities undertaken by the entity to develop community awareness of the entity and its services
- i) details of assessments and measures undertaken to improve the occupational health and safety of employees

- j) a general statement on industrial relations within the entity and details of time lost through industrial accidents and disputes
- k) a list of major committees sponsored by the entity, the purposes of each committee and the extent to which the purposes have been achieved
- l) details of all consultancies and contractors including:
 - consultants/contractors engaged
 - services provided
 - expenditure committed to for each engagement.

The information is available on request from:

Chief Executive Officer
Commission for Children and Young People
Level 18, 570 Bourke Street
Melbourne VIC 3000

Compliance with the *Disability Act 2006*

The Commission acknowledges the importance of strengthening the rights of people with a disability and we are committed to creating and maintaining an accessible and inclusive environment for all people with a disability. This includes Commission employees, stakeholders and members of the public.

The Commission supports the whole-of-government *Inclusive Victoria: State Disability Plan 2022–2026*, a four-year plan that outlines the actions the Victorian Government will take to ensure the Victorian community is inclusive and accessible.

In 2022 the Commission also released its first *Gender Equality Action Plan 2022–2025*, which focuses on intersectionality, including disability. A number of actions have been developed in this four-year plan to address potential gaps, pending the collection of improved data on experience of disability.

In 2023–24, a disability audit of the Commission's office was also undertaken. All recommendations made to the Commission were accepted.

Appendix 4. Other disclosures

continued

Disclosure of emergency procurement

The Commission did not activate any emergency procurement activities in 2023–24.

Disclosure of procurement complaints

The Commission did not receive any formal procurement complaints in 2023–24.

Environmental reporting

The Commission minimises the use of electricity and water by using efficient appliances and office equipment, including energy-efficient lighting. The Commission creates and stores records electronically and printing is generally discouraged. However, when printing documents, the Commission uses 100 per cent recycled paper and encourages double-sided printing.

The Commission also separates waste systems into recycled, landfill and compost, and bins are cleared periodically. Takeaway coffee cups are also separated and recycled through a dedicated coffee cup recycling system. A specific aluminium can recycling scheme was also introduced in 2023–24.

In 2023–24 Commission staff adopted hybrid working arrangements and worked both at home and in the office. Office ceiling lights are also set on timers to automatically turn off outside regular business hours.

As a benefit of staff working from home in some capacity during 2023–24, the Commission has also minimised water usage in the office and has significantly reduced the creation of waste.

Finally, the Commission does not have government fleet vehicles assigned to it. Staff are encouraged to use public transport when undertaking business activities.

Attestation for financial management compliance with Standing Direction 5.1.4

Commission for Children and Young People Financial Management Compliance Attestation Statement

I, Liana Buchanan, certify that the Commission for Children and Young People has no Material Compliance Deficiency with respect to the applicable Standing Directions under the *Financial Management Act 1994* and Instructions.



Liana Buchanan

Principal Commissioner

Commission for Children and Young People

Commission for Children and Young People

Level 18, 570 Bourke Street
Melbourne VIC 3000

Phone: 1300 78 29 78

Email: contact@ccyp.vic.gov.au

Website: ccyp.vic.gov.au



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE
