Children in State Care (Death Reporting, Independent Investigation and Transparency) Policy 2026

CSCDR-P 2026/01

Companion instrument: Children in State Care (Death Reporting, Independent Investigation and Transparency) Bill 2026. 23 October 2026.

1 Purpose

This policy establishes mandatory requirements for the reporting, independent investigation, statistical integrity, historical reconciliation and public transparency of every death of a child in state care or under state guardianship in Victoria.

It also addresses the systemic absence of accountability for caseworkers prior to a child's removal into out-of-home care, which enables the unnecessary destruction of families through unchecked decision-making, misleading evidence and failure to comply with statutory family preservation obligations.

2 Scope

This policy applies to all deaths of children under 18 years of age who, immediately before death, were in state care (foster care, kinship care, residential care, emergency or temporary placements, or under state guardianship) or who were known to Child Protection.

It further applies to the conduct of caseworkers and departmental processes that precede removal, including the preparation of affidavits, kinship assessment, and responses to notifications.

3 Guiding Principles

1. The best interests, safety, dignity and rights of children are paramount.

1. No death of a child in state care may be omitted from reporting solely on the basis of medical classification, temporary absence from placement, absence of criminal proceedings, or lack of an adverse coronial finding.

2. A determination that a death was not preventable does not remove the obligation to record and independently review it.

3. Statistical reports must clearly identify populations, definitions, methods and limitations, and must not aggregate children in state care with children merely known to Child Protection in a manner that conceals the former.

4. Caseworkers and agencies must be subject to external, independent accountability for the accuracy of evidence presented to courts and for compliance with statutory requirements that removal is a measure of last resort.

5. Families must have meaningful rights to participate in reviews and to receive findings, subject only to lawful and proportionate restrictions.

4 Pre-Removal Accountability and Caseworker Conduct

The absence of personal and professional consequences for caseworkers prior to a child's removal into foster care enables the routine and unnecessary destruction of families. Public debate focused on funding and staffing has obscured the operational reality of an unchecked bureaucracy in which caseworkers can present incomplete or misleading material to courts, ignore statutory obligations, and face no deterrent.

4.1 Power Asymmetry and Unchecked Affidavits

When a caseworker presents a protection application, magistrates commonly accept departmental material as fact. There is a documented culture of confirmation bias and selective omission in affidavits. Material evidence favourable to families—including clean drug tests, stable housing, and willing kinship carers—is regularly excluded. When parents later demonstrate that material was false or incomplete, caseworkers are almost never dismissed, fined or referred for perjury. The department protects its staff under claims of operational pressure. The absence of consequence removes any deterrent against falsification or corner-cutting.

4.2 Failure to Apply Statutory Family Preservation Requirements

The Children, Youth and Families Act 2005 requires that removal is a measure of last resort and that active efforts be made to keep a child with family or extended kin. Caseworkers routinely fail to conduct basic kinship mapping. Children are removed and placed with strangers in emergency accommodation while available relatives are ignored. Statutory timelines are breached and internal review processes are ineffective. These failures occur because there is no external consequence for non-compliance.

4.3 Pre-emptive Removals and Anonymous Notifications

Anonymous and unverified notifications can trigger immediate, traumatising interventions. Caseworkers frequently enter homes with a presumption of risk. Parents are pressured to sign safety plans under the threat of immediate removal. Resistance is then characterised as uncooperative or aggressive behaviour and used as further justification for removal.

4.4 Closed Oversight Loop

Unlike police and medical practitioners, child protection workers who falsify records or cause wrongful removal face no independent disciplinary body with power to investigate facts or refer criminal conduct. Internal complaints units routinely dismiss parental complaints. The Ombudsman is limited to process compliance. The Children's Court lacks capacity to forensically audit affidavits in every matter. The result is a closed system in which removals proceed with minimal external scrutiny.

4.5 Required Accountability Measures

- Establishment of an independent external body with power to investigate caseworker conduct, including the accuracy of affidavits, and to refer suspected perjury or professional misconduct for criminal or disciplinary action.
- Mandatory recording and external audit of kinship assessments and active efforts to support family preservation prior to any removal.
- Personal consequences, including dismissal and referral for prosecution, for intentional omission or falsification of material facts in court documents.
- Prohibition on characterising lawful parental resistance as grounds for removal without independent corroboration.

5 Mandatory Death Notification and Registration

6. A Relevant Agency that becomes aware of the death of a Child in State Care must notify the Independent Commissioner, the Coroners Court of Victoria, and Victoria Police (where required) as soon as practicable and no later than 24 hours after becoming aware of the death.

7. A medical certificate of natural causes does not remove the notification duty.

8. Every qualifying death must be allocated a unique Register identifier and registered within seven days. Disputed or unknown facts must be recorded as such. Corrections must preserve an auditable history of the original entry.

6 Independent Review of Every Death

9. Every death of a Child in State Care must be independently reviewed by a person not employed by any agency responsible for the child's care.

10. The review must examine placement and guardianship history, medical treatment, prior complaints and warnings, risk assessments, professional conduct, and missed opportunities to prevent harm.

11. Where death is attributed to illness or natural causes, the review must specifically assess the adequacy and timeliness of medical attention, recognition of symptoms, and any failures to obtain or provide treatment.

12. The review must not presume preventability or misconduct solely because the death occurred in state care, and must distinguish established findings from unresolved concerns and unsubstantiated allegations.

7 Statistical Integrity and Reconciliation

13. Mortality reports must disaggregate by placement type, legal status, age, Aboriginal and Torres Strait Islander status (with cultural safeguards), region, medical cause, confirmed or suspected neglect (separately from medical cause), and investigation outcome.

14. Government agencies must not publish aggregated figures that represent or imply that the number of children known to Child Protection equals the number who died in state care. Where aggregates are published, the components must be separately disclosed.

15. The Independent Commissioner must reconcile historical departmental figures and Commission for Children and Young People notifications, including the following reported series, and publish an explanation for each annual difference:

Financial Year	Departmental Figures Reported In Media	CCYP Notifications
2020–21	19	45
2021–22	11	37
2022–23	9	36
2023–24	17	43
Total	**56**	**161**

The difference is not to be presumed to represent omitted or concealed deaths unless established by the independent reconciliation. Agencies that published inaccurate information must correct it within 30 days of final findings.

8 Historical Investigation and Record Preservation

16. An historical child death investigation program must cover all reasonably identifiable deaths of children under state wardship, boarded-out arrangements, institutional care and equivalent historical arrangements.

17. Relevant agencies and successors must preserve records relevant to child death investigations. Destruction or alteration contrary to a preservation notice is prohibited.

9 Public Register and Reporting

18. A public online State Care Child Death Register must be maintained, containing lawfully releasable de-identified information searchable by year, placement category, region, agency and outcome. Privacy or suppression restrictions must not remove a death from statistical totals.

19. Quarterly statistical reports must be published within 60 days of quarter end. An annual report must be tabled in Parliament containing deaths by category, rates, medical care findings, investigation status, recommendations and implementation, and outstanding discrepancies.

10 Family Participation

20. Parents, siblings and other persons with a close and established relationship with the deceased child must be offered the opportunity to contribute information to the independent review.

21. Previous child protection involvement must not, of itself, disqualify participation. Eligible family members must receive an appropriate findings summary, subject only to lawful confidentiality and safety requirements, with reasons and a review process for any substantial withholding.

11 Enforcement

22. Failure to provide a required death notification without reasonable excuse attracts penalties of 60 penalty units for a natural person and 300 penalty units for a body corporate.

23. Intentional falsification of records, destruction of evidence, provision of materially false information, or manipulation of mortality data to conceal a death attracts maximum penalties of 600 penalty units or five years' imprisonment (or both) for a natural person, and 3,000 penalty units for a body corporate.

24. Intentional obstruction of the Independent Commissioner attracts 240 penalty units or two years' imprisonment, or both.

25. Detrimental action against a person for reporting a death, supplying information, identifying errors or raising concerns about neglect is prohibited and is additional to other Victorian protections.

12 Implementation and Review

26. An Independent Child Death Review Commissioner is to be established as a statutory officer independent of ministerial direction on investigations, findings, classification and public reports, with dedicated funding.

27. Relevant departments and service providers must respond in writing to recommendations within 90 days, stating acceptance or rejection with reasons. The response is to be published subject to confidentiality.

28. A parliamentary committee must review the operation of the arrangements three years after commencement, examining completeness of reporting, data accuracy, effectiveness of investigations, implementation of recommendations, family access and improvement in accountability.

— End of Policy —