2026

STATE OF VICTORIA

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

CSCDR 2026

A Bill for an Act to establish mandatory death reporting, independent investigation, historical mortality reconciliation, public statistical transparency and accountability measures concerning children in out-of-home care and under state guardianship, to amend the Commission for Children and Young People Act 2012, the Children, Youth and Families Act 2005 and the Coroners Act 2008, and for other purposes.

The Parliament of Victoria enacts:

Part 1—Preliminary

1 Purposes

The purposes of this Act are—

(a) to ensure that every death of a child under state care or guardianship is recorded and independently reviewed;

(b) to prevent any death from being excluded from mortality statistics solely because of its medical or coronial classification;

(c) to distinguish deaths in out-of-home care from deaths of children who were otherwise known to Child Protection;

(d) to establish an independent public register of deaths of children in state care;

(e) to require the reconciliation of contradictory government mortality statistics;

(f) to provide for historical investigation and preservation of records;

(g) to identify systemic failures, neglect and potentially preventable deaths;

(h) to strengthen participation and information rights for surviving families;

(i) to establish enforceable public reporting and accountability obligations; and

(j) to address the absence of personal and professional accountability for caseworkers prior to removal of a child into out-of-home care.

2 Commencement

(1) This Act comes into operation on a day or days to be proclaimed.

(2) If a provision has not commenced within six months after Royal Assent, it commences on the following day.

3 Definitions

In this Act—

Commission means the Commission for Children and Young People established under the Commission for Children and Young People Act 2012;

Child means a person under 18 years of age;

Child in State Care means a child who, immediately before death, was—

(a) residing in foster care, kinship care or residential care under an arrangement made, approved, funded or supervised by the State;

(b) subject to an order or arrangement under which the Secretary, the State or an authorised entity exercised custody, guardianship or responsibility for the child's placement;

(c) accommodated under an emergency, temporary, respite or contingency care arrangement;

(d) temporarily absent from such accommodation, including while hospitalised, absent without permission or staying with a family member, while the relevant legal care or guardianship arrangement remained in force; or

(e) otherwise within a class of state care prescribed by regulations, provided that regulations cannot exclude a category otherwise covered by this definition;

Child Known to Child Protection means a child who was the subject of a report, referral, assessment, investigation or case management activity within the preceding 12 months, irrespective of whether that child was placed in state care;

Death includes death from any cause, whether natural, accidental, intentional, unexplained, undetermined or pending determination;

Historical State Care includes state wardship, boarded-out arrangements, institutional care and equivalent historical government care arrangements;

Independent Commissioner means the office established under section 5;

Relevant Agency means a government department, authorised Aboriginal agency, contracted care provider, placement service or other body with responsibility for a child's care or placement;

Register means the State Care Child Death Register established by this Act.

4 Guiding Principles

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

(2) The State's responsibilities to children in its care must be accompanied by transparent and independently verifiable accountability.

(3) No child death may be omitted from reporting on the basis that—

(a) the death was medically classified as natural;

(b) the child had a pre-existing medical condition or disability;

(c) the child was temporarily absent from a placement;

(d) the child was under guardianship but physically residing elsewhere;

(e) the child was not the subject of criminal proceedings; or

(f) the death did not result in an adverse coronial finding.

(4) A determination that a death was not preventable does not remove the obligation to record or review that death.

(5) Statistical reports must identify their populations, definitions, methods and limitations.

(6) Caseworkers must be subject to external independent accountability for the accuracy of evidence presented to courts and for compliance with statutory family preservation requirements prior to any removal.

Part 2—Independent Oversight

5 Establishment of the Independent Child Death Review Commissioner

(1) There is established an Independent Child Death Review Commissioner.

(2) The Commissioner is an independent statutory officer appointed by the Governor in Council following consultation with a parliamentary committee responsible for child welfare oversight.

(3) The Commissioner is not subject to ministerial direction concerning—

(a) the selection of deaths for investigation;

(b) findings or conclusions;

(c) the classification of statistical records; or

(d) the content of public reports.

(4) The Commissioner must have a separate appropriation or identifiable statutory funding allocation sufficient to discharge the functions under this Act.

6 Functions

The Commissioner must—

(a) maintain the Register;

(b) oversee the review of every death of a Child in State Care;

(c) audit and reconcile relevant mortality datasets;

(d) investigate systemic service failures;

(e) monitor the implementation of recommendations;

(f) commission historical investigations;

(g) publish quarterly and annual mortality statistics;

(h) refer suspected criminal or professional misconduct to appropriate authorities; and

(i) report independently to Parliament.

7 Investigative Powers

(1) The Commissioner may require a Relevant Agency to produce records, electronic data, correspondence, case files, placement information, medical records lawfully held by that agency and other relevant material.

(2) The Commissioner may require a person to attend an interview or provide information, subject to safeguards against self-incrimination and other applicable legal privileges.

(3) A Relevant Agency must comply with a lawful requirement within the period specified.

(4) The Commissioner may seek an order from the Supreme Court to enforce compliance.

(5) Investigations must observe procedural fairness, applicable privileges and lawful restrictions on the use or publication of compelled evidence.

Part 3—Mandatory Notification and Registration

8 Mandatory Notification of Death

(1) A Relevant Agency that becomes aware of the death of a Child in State Care must notify—

(a) the Independent Commissioner;

(b) the Coroners Court of Victoria; and

(c) Victoria Police where the circumstances require police notification.

(2) Notification to the Independent Commissioner must occur as soon as practicable and no later than 24 hours after the agency becomes aware of the death.

(3) The notification must identify the child, relevant placement, legal care status, responsible agencies and known circumstances.

(4) A medical certificate identifying natural causes does not remove the duty to notify.

9 Mandatory Registration

(1) Every qualifying death must receive a unique Register identifier.

(2) Registration must occur within seven days of notification.

(3) The Register must identify the date of death, legal care status, actual placement or location, responsible agency and status of any investigation.

(4) Where facts remain disputed or unknown, the relevant fields must state that they are disputed or unknown.

(5) A later correction must preserve an auditable record of the original entry and the reason for amendment.

10 Separate Classification of Child Protection Deaths

(1) The Commissioner must maintain and publish separate statistical categories for—

(a) children who died while in foster care;

(b) children who died while in kinship care;

(c) children who died while in residential care;

(d) children who died while in other state-arranged accommodation;

(e) children who died while under state guardianship but outside an active placement;

(f) children who died after leaving state care, including following reunification; and

(g) children known to Child Protection who were not in state care.

(2) A child may meet more than one classification. Reports must distinguish overlapping categories and must not double-count the child in overall totals.

Part 4—Independent Investigation of Every Death

11 Mandatory Independent Review

(1) Every death of a Child in State Care must be reviewed.

(2) The review must be undertaken or directed by a person independent of any agency responsible for that child's care.

(3) The review must examine—

(a) placement and guardianship history;

(b) medical history and relevant treatment;

(c) complaints, warnings and previous incidents;

(d) risk assessments and supervision;

(e) the conduct and decisions of responsible professionals and organisations;

(f) missed opportunities to prevent harm; and

(g) whether the circumstances indicate systemic or individual failures.

(4) The review must not presume that a death was preventable, negligent or caused by misconduct merely because it occurred in state care.

12 Medical Neglect and Delayed Treatment

(1) Where a child's death is attributed to illness or natural causes, the independent review must consider the adequacy and timeliness of medical attention where relevant.

(2) The review must consider whether—

(a) symptoms were appropriately recognised;

(b) necessary treatment was sought in a timely manner;

(c) prescribed treatment was provided;

(d) carers or professionals failed to act upon warnings;

(e) access to medical services was unreasonably delayed; or

(f) an act or omission contributed to the circumstances of death.

(3) A coronial determination of natural causes does not prevent findings about service failures or failures to obtain treatment.

(4) The Commissioner must distinguish established findings, credible unresolved concerns and allegations not substantiated by the evidence.

13 Relationship with Coronial and Criminal Proceedings

(1) Nothing in this Act limits the jurisdiction of the Coroners Court or the investigative powers of Victoria Police.

(2) The Independent Commissioner must coordinate with relevant authorities to avoid prejudicing criminal proceedings.

(3) A review may be deferred in whole or in part where necessary to protect an active investigation, but the death must remain registered and included in mortality statistics.

(4) The Commissioner must publish the reason for any deferral, subject to necessary confidentiality restrictions.

Part 5—Statistical Integrity and Reconciliation

14 Mandatory Statistical Disaggregation

All mortality reports must distinguish—

(a) placement type;

(b) legal guardianship status;

(c) age and age group;

(d) sex (biological), where reliably recorded;

(e) Aboriginal and Torres Strait Islander status, with culturally appropriate safeguards;

(f) region and responsible agency, where publication is safe;

(g) recorded medical cause and manner of death;

(h) confirmed or suspected neglect, separately from medical cause;

(i) investigation outcome; and

(j) the population and reporting period used to calculate the figures.

15 Prohibition on Misleading Aggregation

(1) A government agency must not publish a combined figure for children known to Child Protection in a manner that represents or implies that it is the number of children who died while in state care.

(2) Where an aggregate figure includes both populations, the publication must clearly disclose—

(a) the number who died in state care;

(b) the number who were known to Child Protection but not in state care;

(c) any overlapping categories;

(d) any unresolved classifications; and

(e) the statistical definitions and data sources used.

(3) A change in reporting methodology must be expressly identified, including its likely effect on comparisons with earlier years.

16 Reconciliation of Contradictory Government Statistics

(1) The Commissioner must independently reconcile historical mortality statistics published by DFFH, its predecessor departments and the Commission for Children and Young People.

(2) The initial reconciliation must examine the following published figures:

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**

(3) The Commissioner must determine, for each year—

(a) the definition of each dataset;

(b) the dates on which the deaths and notifications were recorded;

(c) the number of unique deceased children represented;

(d) the number in state care at death;

(e) the number not in state care at death;

(f) any duplication, omission or misclassification;

(g) whether discrepancies resulted from differing lawful criteria, data errors or other factors; and

(h) whether evidence warrants further investigation or referral.

(4) The figures specified in subsection (2) are historical reported figures to be verified and must not be presumed to be directly comparable.

(5) The Commissioner must publish an explanation for each annual difference.

(6) Any government agency identified as having published inaccurate information must publish a correction within 30 days after receiving the Commissioner's final findings, unless a court orders otherwise.

17 Public Reconciliation Statement

(1) The Commissioner must table the initial reconciliation report in Parliament within 12 months after commencement.

(2) The report must include an explanation of the discrepancies and identify any limitations in the underlying records.

(3) Where information cannot be reconciled, the report must identify it as unresolved and specify what information remains missing.

Part 6—Historical Child Death Investigation

18 Historical Review

(1) The Commissioner must establish a historical child death investigation program.

(2) The investigation must cover all reasonably identifiable deaths occurring while children were under historical state wardship, state-arranged foster care, boarded-out arrangements or institutional care.

(3) The program must examine records from the earliest surviving period of Victorian government child welfare administration to the commencement of this Act.

(4) The Commissioner must prioritise—

(a) deaths with conflicting or missing records;

(b) deaths involving possible neglect;

(c) deaths without adequate contemporaneous investigation;

(d) deaths involving multiple children at the same facility or with the same provider; and

(e) cases referred by relatives, care leavers or researchers.

19 Preservation of Historical Records

(1) A Relevant Agency and any successor organisation must preserve records relevant to a child death investigation.

(2) Destruction, alteration or disposal contrary to a preservation notice is prohibited.

(3) Where historical records are incomplete or unavailable, the Commissioner must record the limitations and seek alternative corroborating sources where reasonably practicable.

Part 7—Public Register and Annual Mortality Reports

20 State Care Child Death Register

(1) The Commissioner must maintain a public online register of deaths within the scope of this Act.

(2) The register must include lawfully releasable, de-identified information about each death, its investigation and any recommendations.

(3) The register must be searchable by year, placement category, geographic region, responsible agency and investigation outcome.

(4) Information must be withheld or aggregated where necessary to protect child and family privacy, cultural safety, criminal proceedings, coronial processes or another compelling legal interest.

(5) A suppression or privacy restriction must not remove the death from the statistical total.

21 Quarterly Reports

(1) The Commissioner must publish quarterly statistical reports within 60 days after the end of each quarter.

(2) Reports must include new notifications, deaths by care category, corrections to earlier figures and outstanding investigations.

22 Annual Mortality Report

(1) The Commissioner must table an annual report in Parliament.

(2) The report must disclose—

(a) total deaths by care category;

(b) deaths from each recorded cause;

(c) death rates per 100,000 child-years;

(d) relevant mortality comparisons with children outside state care;

(e) findings concerning potential failures to provide medical care;

(f) completed and outstanding investigations;

(g) recommendations and implementation status; and

(h) outstanding data discrepancies.

(3) Death-rate comparisons must identify relevant differences in age, underlying health status and other available risk factors.

(4) Both unadjusted and adjusted rates must be reported where statistically reliable.

(5) No statistical adjustment may change the underlying number of recorded deaths.

Part 8—Family Participation and Access to Information

23 Rights of Families

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

(2) The Commissioner must establish procedures for receiving family evidence, providing accessible information about the progress of an inquiry and communicating the final outcome.

(3) Participation may be restricted only where necessary for a lawful and proportionate purpose, including protecting another person's safety or an active criminal investigation.

(4) Previous child protection involvement must not, of itself, disqualify a person from participating.

24 Access to Findings

(1) The Commissioner must provide an appropriate findings summary to eligible family members, subject to lawful confidentiality and safety requirements.

(2) Decisions to withhold substantial information must be accompanied by reasons and an available review process.

(3) Nothing in this section overrides a court suppression order or lawful restrictions on protected information.

Part 9—Enforcement and Accountability

25 Failure to Notify

(1) A person or organisation subject to a reporting obligation must not, without reasonable excuse, fail to provide a required death notification.

(2) The penalty is—

(a) for a natural person, 60 penalty units; or

(b) for a body corporate, 300 penalty units.

26 Falsification or Concealment of Death Records

(1) A person commits an offence if the person intentionally—

(a) falsifies a record relevant to a child death;

(b) destroys or conceals evidence with the intention of obstructing an investigation;

(c) knowingly provides materially false information to the Commissioner; or

(d) knowingly manipulates a mortality dataset to conceal or misrepresent a death.

(2) The maximum penalty is—

(a) for a natural person, 600 penalty units or imprisonment for five years, or both; or

(b) for a body corporate, 3,000 penalty units.

(3) A person does not commit an offence solely because a statistical estimate is subsequently corrected or because a reasonable methodological disagreement exists.

27 Obstruction of Investigation

(1) A person must not intentionally obstruct the Commissioner in the lawful exercise of investigative powers.

Penalty: 240 penalty units or imprisonment for two years, or both.

28 Protection Against Retaliation

(1) A person must not take detrimental action against another person because that person—

(a) reports a child death;

(b) supplies information to an investigation;

(c) identifies an error in mortality reporting; or

(d) raises a concern about neglect or inadequate medical care.

(2) Protections under this section operate in addition to protections available under other Victorian laws.

(3) A person who suffers retaliation may seek remedies authorised by regulations or other applicable legislation.

29 Referral of Suspected Criminal Conduct

(1) Where the Commissioner has reasonable grounds to suspect a criminal offence, the Commissioner must refer the relevant information to Victoria Police or the appropriate investigative authority.

(2) The Commissioner must not make a binding determination of criminal guilt.

Part 10—Accountability of Departments and Service Providers

30 Mandatory Response to Recommendations

(1) A relevant department or service provider receiving a recommendation must provide a written response within 90 days.

(2) The response must indicate whether the recommendation is accepted and, if accepted, when and how it will be implemented.

(3) Rejection of a recommendation must be accompanied by reasons.

(4) The Commissioner must publish the response, subject to necessary confidentiality restrictions.

31 Failure to Implement Safety Measures

(1) Where the Commissioner identifies an immediate or continuing risk to children, the Commissioner may issue a safety notice to the relevant agency and refer the matter to the regulator with statutory power to direct remedial action.

(2) Failure to comply with a lawful direction issued by the competent regulator is subject to the enforcement provisions applicable to that direction.

Part 11—Amendments to Existing Legislation

32 Amendment of the Commission for Children and Young People Act 2012

(1) The Commission for Children and Young People Act 2012 is amended to require—

(a) coordination and information sharing with the Independent Child Death Review Commissioner;

(b) separate reporting of child deaths according to actual state care status;

(c) the provision of relevant historical child death inquiry material, subject to applicable privileges and safeguards; and

(d) cooperation in reconciling child death notification statistics.

(2) These amendments are to supplement, and not diminish, the Commission's existing child death inquiry functions.

33 Amendment of the Children, Youth and Families Act 2005

(1) The Children, Youth and Families Act 2005 is amended to establish an express duty for the Secretary and relevant care providers to—

(a) report every death of a child in state care;

(b) maintain accurate legal status and placement records;

(c) preserve relevant records following a death;

(d) cooperate with independent child death inquiries; and

(e) provide necessary placement information for mortality reporting.

34 Amendment of the Coroners Act 2008

(1) The Coroners Act 2008 is amended, to the extent necessary, to ensure that every death within the definition of Child in State Care is a reportable death.

(2) The Coroners Court may provide relevant data and findings to the Independent Commissioner subject to statutory safeguards, suppression orders and the integrity of ongoing proceedings.

(3) Nothing in this Act removes existing coronial powers or obligations.

Part 12—Transitional Provisions and Parliamentary Review

35 Initial Reconciliation

(1) The Commissioner must commence the reconciliation of existing Victorian child protection death records within 90 days of commencement.

36 Historical Audit

(1) The first historical audit must examine 2016–17 through to commencement.

(2) The Commissioner must publish the initial findings within 12 months.

(3) The Commissioner must continue investigations into earlier historical periods and issue further reports.

37 Independent Parliamentary Review

(1) A parliamentary committee must review the operation of this Act three years after commencement.

(2) The review must examine—

(a) completeness of death reporting;

(b) accuracy of mortality data;

(c) effectiveness of independent investigations;

(d) implementation of recommendations;

(e) access to information by families; and

(f) whether the legislation has improved accountability and the identification of preventable deaths.

(3) The committee must table its report in Parliament.

38 Regulations

(1) The Governor in Council may make regulations for matters necessary to give effect to this Act, including technical data standards, secure information sharing, publication safeguards and the administration of the Register.

(2) Regulations must not exempt any otherwise qualifying category of child death from mandatory reporting.

Schedule 1—Historical Statistical Reconciliation

The initial reconciliation must specifically examine the following reported records.

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

The Commissioner must determine the correct explanation for the 105-count difference between these reported series.

For avoidance of doubt, the difference is not deemed to represent 105 omitted or concealed deaths unless supported by the results of the independent reconciliation.

Schedule 2—Minimum State Care Child Death Dataset

The Commissioner must maintain, subject to appropriate access restrictions, at least the following information for each death:

Unique death record identifier.

Full name and identity details in the confidential record.

Date of birth and date of death.

Aboriginal and Torres Strait Islander status, if known.

Legal care and guardianship status.

Placement type and actual location at death.

Placement and agency history.

Responsible government department, office and care provider.

Recorded medical cause and manner of death.

Relevant prior illnesses, injuries and known medical needs.

Dates of requests for treatment and treatment provided, where relevant.

Previous reports, complaints or safety concerns.

Coronial investigation details and findings.

Independent investigation findings.

Established or unresolved concerns about neglect.

Recommendations and implementation dates.

Record corrections and reasons for amendment.

Publication, confidentiality and suppression status.

— End of Bill —