2026

STATE OF VICTORIA

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

Explanatory Memorandum

EM-CSCDR 2026/01

Circulated by authority of Alecomm (Australian Legislative Ethics Commission). 23 October 2026.

This Explanatory Memorandum accompanies the Children in State Care (Death Reporting, Independent Investigation and Transparency) Bill 2026 (CSCDR 2026). It explains the purpose, structure and effect of each Part and clause. The Bill is a principal Act that establishes mandatory death reporting, independent investigation, statistical integrity, historical reconciliation and public transparency for children in state care, and addresses the absence of accountability for caseworkers prior to removal.

Overview

The Bill responds to documented discrepancies between departmental mortality figures and Commission for Children and Young People notifications, the exclusion of deaths from statistics on the basis of medical classification, and the lack of independent review of every death of a child in state care. It also addresses the operational reality that caseworkers can present incomplete or misleading material to courts and fail to comply with statutory family preservation obligations without personal or professional consequence.

The principal objects are to ensure every death of a child in state care is recorded and independently reviewed; to prevent concealment through aggregation or classification; to reconcile contradictory government statistics; to preserve historical records; and to establish enforceable accountability for both deaths and the pre-removal conduct that leads to children entering care.

Part 1—Preliminary

Clause 1—Purposes

Clause 1 sets out the ten purposes of the Act. These include mandatory recording and independent review of every death of a child in state care; prohibition on exclusion from statistics solely by medical or coronial classification; clear distinction between deaths in out-of-home care and deaths of children merely known to Child Protection; establishment of a public register; reconciliation of contradictory statistics; historical investigation; identification of systemic failures; family participation rights; enforceable reporting obligations; and accountability for caseworker conduct prior to removal.

Clause 2—Commencement

Clause 2 provides for proclamation commencement, with a six-month default if any provision remains uncommenced. This allows orderly establishment of the Independent Commissioner and systems while ensuring the Act cannot be delayed indefinitely.

Clause 3—Definitions

Clause 3 defines key terms. “Child in State Care” is deliberately broad: it covers foster, kinship and residential care, emergency and temporary arrangements, and children temporarily absent from placement while the legal arrangement remains in force. It also covers children under state guardianship. “Child Known to Child Protection” is defined separately so that statistical reports cannot collapse the two

populations. “Death” includes every cause. “Relevant Agency” covers departments, authorised Aboriginal agencies and contracted providers.

Clause 4—Guiding Principles

Clause 4 establishes the interpretive principles. No death may be omitted from reporting because it was classified as natural, the child had a disability, was temporarily absent, was not the subject of criminal proceedings, or did not result in an adverse coronial finding. A finding that a death was not preventable does not remove the recording obligation. Caseworkers must be subject to external accountability for the accuracy of court material and for compliance with family preservation requirements.

Part 2—Independent Oversight

Clause 5—Establishment of the Independent Child Death Review Commissioner

Clause 5 creates an independent statutory officer appointed by the Governor in Council after parliamentary consultation. The Commissioner is insulated from ministerial direction on investigations, findings, classification and public reports, and must have dedicated funding.

Clause 6—Functions

Clause 6 lists the Commissioner’s functions: maintain the Register; oversee review of every death; audit and reconcile datasets; investigate systemic failures; monitor recommendations; commission historical investigations; publish statistics; refer suspected misconduct; and report to Parliament.

Clause 7—Investigative Powers

Clause 7 confers powers to compel production of records and attendance at interviews, subject to self-incrimination and privilege safeguards. Non-compliance may be enforced by Supreme Court order. Procedural fairness and lawful restrictions on publication of compelled evidence apply.

Part 3—Mandatory Notification and Registration

Clauses 8 and 9—Notification and Registration

Clause 8 requires Relevant Agencies to notify the Commissioner, the Coroners Court and, where appropriate, Victoria Police within 24 hours. A medical certificate of natural causes does not remove the duty. Clause 9 requires every qualifying death to receive a unique identifier and be registered within seven days. Disputed facts must be recorded as such, and corrections must preserve an auditable history.

Clause 10—Separate Classification

Clause 10 requires separate statistical categories for foster care, kinship care, residential care, other state-arranged accommodation, guardianship outside active placement, deaths after leaving care, and children known to Child Protection who were not in state care. Overlaps must be identified and double-counting avoided in totals.

Part 4—Independent Investigation of Every Death

Clauses 11 to 13

Clause 11 requires every death of a Child in State Care to be reviewed by a person independent of the responsible agency. The review must examine placement history, medical treatment, prior complaints, risk assessments, professional conduct and missed opportunities. It must not presume preventability or misconduct merely because the death occurred in care.

Clause 12 requires specific consideration of medical care adequacy and timeliness where death is attributed to illness. A coronial finding of natural causes does not preclude findings about service failures.

Clause 13 preserves coronial and police jurisdiction. Reviews may be deferred to protect active investigations, but the death remains registered and counted.

Part 5—Statistical Integrity and Reconciliation

Clauses 14 to 17

Clause 14 requires disaggregation by placement type, legal status, age, sex (biological) where reliably recorded, Aboriginal and Torres Strait Islander status (with safeguards), region, medical cause, neglect findings and investigation outcome.

Clause 15 prohibits publication of combined figures that imply children known to Child Protection died in state care. Where aggregates are used, the components must be disclosed and methodology changes identified.

Clause 16 requires the Commissioner to reconcile the published departmental figures (56) and CCYP notifications (161) for 2020–21 to 2023–24, and to publish an explanation for each annual difference. Agencies that published inaccurate information must correct it within 30 days of final findings.

Clause 17 requires the initial reconciliation report to be tabled within 12 months, with unresolved items identified.

Part 6—Historical Child Death Investigation

Clauses 18 and 19

Clause 18 establishes a historical investigation program covering state wardship, boarded-out arrangements and institutional care, prioritising incomplete records, possible neglect and multi-child cases.

Clause 19 prohibits destruction of relevant records contrary to a preservation notice and requires the Commissioner to record limitations where records are incomplete.

Part 7—Public Register and Annual Mortality Reports

Clauses 20 to 22

Clause 20 establishes a public online register of lawfully releasable de-identified information, searchable by year, placement, region, agency and outcome. Privacy restrictions cannot remove a death from statistical totals.

Clause 21 requires quarterly statistical reports within 60 days of quarter end.

Clause 22 requires an annual report to Parliament containing deaths by category, rates (unadjusted and adjusted), medical care findings, investigation status, recommendations and outstanding discrepancies. Statistical adjustment cannot alter the underlying count of deaths.

Part 8—Family Participation and Access to Information

Clauses 23 and 24

Clause 23 requires that parents, siblings and persons with a close established relationship be offered the opportunity to contribute information. Prior child protection involvement does not, of itself, disqualify participation. Restrictions must be lawful and proportionate.

Clause 24 requires provision of an appropriate findings summary, with reasons and a review process for any substantial withholding. Court suppression orders remain effective.

Part 9—Enforcement and Accountability

Clauses 25 to 29

Clause 25 creates an offence of failing to notify without reasonable excuse (60 penalty units for a natural person; 300 for a body corporate).

Clause 26 creates offences of intentional falsification, destruction of evidence, provision of false information or manipulation of mortality data (maximum 600 penalty units or five years' imprisonment, or both, for a natural person; 3,000 penalty units for a body corporate). Reasonable methodological disagreement is not an offence.

Clause 27 prohibits intentional obstruction (240 penalty units or two years' imprisonment, or both).

Clause 28 prohibits detrimental action against persons who report deaths, supply information or raise concerns about neglect. Remedies operate in addition to other Victorian protections.

Clause 29 requires referral of suspected criminal conduct to Victoria Police. The Commissioner must not determine criminal guilt.

Part 10—Accountability of Departments and Service Providers

Clauses 30 and 31

Clause 30 requires a written response to recommendations within 90 days, stating acceptance or rejection with reasons. The response must be published subject to confidentiality.

Clause 31 allows the Commissioner to issue a safety notice and refer matters to the competent regulator where immediate risk exists. Non-compliance is enforced under the regulator's existing powers.

Part 11—Amendments to Existing Legislation

Clauses 32 to 34

Clause 32 amends the Commission for Children and Young People Act 2012 to require coordination and information sharing with the Independent Commissioner, separate reporting by actual care status, and cooperation on reconciliation. Existing Commission functions are not diminished.

Clause 33 amends the Children, Youth and Families Act 2005 to impose express duties on the Secretary and care providers to report deaths, maintain accurate records, preserve records after death, and cooperate with inquiries.

Clause 34 amends the Coroners Act 2008 to the extent necessary to make every death of a Child in State Care a reportable death, and to facilitate data sharing subject to safeguards. Existing coronial powers are preserved.

Part 12—Transitional Provisions and Parliamentary Review

Clauses 35 to 38

Clause 35 requires reconciliation of existing records to commence within 90 days.

Clause 36 requires the first historical audit to cover 2016–17 to commencement, with initial findings published within 12 months, and ongoing work on earlier periods.

Clause 37 requires a parliamentary committee review three years after commencement, examining completeness, accuracy, investigation effectiveness, recommendation implementation, family access and overall accountability.

Clause 38 authorises regulations for data standards, secure sharing and Register administration. Regulations cannot exempt any qualifying death from mandatory reporting.

Schedules

Schedule 1 requires specific examination of the 2020–21 to 2023–24 figures (departmental 56; CCYP 161) and an explanation of the 105-count difference. The difference is not presumed to represent omitted deaths unless the reconciliation establishes that fact.

Schedule 2 lists the minimum data fields the Commissioner must maintain for each death, subject to access restrictions. These include identity details in the confidential record, legal status, placement history, medical cause, prior concerns, coronial and independent findings, and publication status.

Financial Impact and Human Rights

The Bill requires dedicated funding for the Independent Commissioner and associated systems. No new Commonwealth financial assistance is involved. The measures are intended to promote the protection of children, equality before the law, family participation and public accountability, consistently with the Charter of Human Rights and Responsibilities Act 2006. Safeguards are included for privacy, procedural fairness, the presumption of innocence and ongoing coronial and criminal investigations.

— End of Explanatory Memorandum —